

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet S Parts I-III Date/Time Prepared: 5/21/2013 3:54 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/21/2013 Time: 3:54 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GOOD SAMARITAN REGIONAL HEALTH CTR. (140046) for the cost reporting period beginning 01/01/2012 and ending 12/31/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____
Officer or Administrator of Provider(s)

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-150,753	-14,479	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	-9,224	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	-159,977	-14,479	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/21/2013 3:41 pm					
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 605 NORTH 12TH STREET			PO Box:						1.00		
2.00	City: MT. VERNON			State: IL		Zip Code: 62864-		County: JEFFERSON		2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)					
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		GOOD SAMARITAN REGIONAL HEALTH CTR.	140046	99914	1	07/01/1966	N	P	P	3.00	
4.00	Subprovider - IPF										4.00	
5.00	Subprovider - IRF		GOOD SAMARITAN REHABILITATION UNIT	14T046	99914	5	01/01/1990	N	P	P	5.00	
6.00	Subprovider - (Other)										6.00	
7.00	Swing Beds - SNF										7.00	
8.00	Swing Beds - NF										8.00	
9.00	Hospital-Based SNF										9.00	
10.00	Hospital-Based NF										10.00	
11.00	Hospital-Based OLTC										11.00	
12.00	Hospital-Based HHA										12.00	
13.00	Separately Certified ASC										13.00	
14.00	Hospital-Based Hospice										14.00	
15.00	Hospital-Based Health Clinic - RHC										15.00	
16.00	Hospital-Based Health Clinic - FQHC										16.00	
17.00	Hospital-Based (CMHC) I										17.00	
17.10	Hospital-Based (CORF) I										17.10	
17.20	Hospital-Based (OPT) I										17.20	
17.30	Hospital-Based (OOT) I										17.30	
17.40	Hospital-Based (OSP) I										17.40	
18.00	Renal Dialysis										18.00	
19.00	Other										19.00	
						From:	To:					
						1.00	2.00					
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2012	12/31/2012				20.00	
21.00	Type of Control (see instructions)					1						21.00
Inpatient PPS Information												
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y		N				22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2		N				23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days					
		1.00	2.00	3.00	4.00	5.00	6.00					
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		4,042	200	0	0	0	0	0	0	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.		34	0	0	0	0	0	0	0	25.00	
						Urban/Rural S	Date of Geogr					
						1.00	2.00					
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2						26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2						27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0						35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/21/2013 3:41 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.	N	N			39.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00		61.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00				62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet S-2
Part I
Date/Time Prepared:
5/21/2013 3:41 pm

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
			1.00	2.00	3.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00

			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
			1.00	2.00	3.00	

Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
			1.00	2.00	3.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.		0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/21/2013 3:41 pm			
		1.00	2.00	3.00			
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N				70.00	
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		71.00	
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y				75.00	
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N		0		76.00	
		1.00					
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N				
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N				
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						
		V	XIX				
		1.00	2.00				
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y			
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N			
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N			
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N			
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00			
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N			
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00			
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N				105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)					107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00	
		1.00		2.00		3.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00	

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,187,187	0	0	
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		
119.00	DO NOT USE THIS LINE				
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N	
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	269020	
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: SSM HEALTHCARE	Contractor's Name: A		Contractor's Number: 05301	
142.00	Street: 12312 OLIVE BOULEVARD, SUITE 600	PO Box:			
143.00	City: ST. LOUIS	State: MO		Zip Code: 63141	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y		
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N		
				1.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC				
161.10	CORF				
161.20	OUTPATIENT PHYSICAL THERAPY				
161.30	OUTPATIENT OCCUPATIONAL THERAPY				
161.40	OUTPATIENT SPEECH PATHOLOGY				

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							1.00	
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/21/2013 3:41 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Type	Date
			1.00	2.00	3.00
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N	Legal Oper.	
			1.00	2.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/31/2013	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet S-2
Part II
Date/Time Prepared:
5/21/2013 3:41 pm

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MI KE		HOBBS	41.00
42.00	Enter the employer/company name of the cost report preparer.	SMGS			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	6184367566		MI KE_HOBBS@SSMHC.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/21/2013 3:41 pm
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		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	03/31/2013	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	FINANCIAL REIMBURSEMENT SPECIALIST	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet S-3
Part I
Date/Time Prepared:
5/21/2013 3:41 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Visi ts / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	119	43,554	0.00	0	1.00
2.00 HMO						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		119	43,554	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,392	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		131	47,946	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	13	4,758		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		144				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00
	I/P Days / O/P Visits / Trips			Full Time Equivalents		
Component	Title VIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	12,101	2,807	19,995			1.00
2.00 HMO	281	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	12,101	2,807	19,995			7.00
8.00 INTENSIVE CARE UNIT	2,088	364	3,305			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		886	1,425			13.00
14.00 Total (see instructions)	14,189	4,057	24,725	0.00	889.90	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	1,396	34	1,748	0.00	13.50	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet S-3
Part I
Date/Time Prepared:
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Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	903.40	27.00
28.00	Observation Bed Days		126	505			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			262			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)		185	316			32.00
33.00	LTCH non-covered days	0					33.00
Component		Discharges					
		Full Time Equivalents	Title V	Title XVIII	Title XIX	Total All Patients	
		Nonpaid Workers	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)		0	3,370	1,114	6,436	1.00
2.00	HMO			0			2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	3,370	1,114	6,436	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	131	4	166	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 140046		Period: From 01/01/2012 To 12/31/2012		Worksheet S-3 Part II Date/Time Prepared: 5/21/2013 3:41 pm	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	45,172,616	0	45,172,616	1,879,292.00	24.04	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		648,227	0	648,227	4,305.00	150.58	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,113,346	-295,404	2,817,942	53,899.00	52.28	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor (see instructions)		441,294	0	441,294	6,017.00	73.34	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		675,575	0	675,575	999.00	676.25	13.00
14.00	Home office salaries & wage-related costs		8,124,728	0	8,124,728	126,313.00	64.32	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		20,298,734	0	20,298,734			17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV line 25		0	0	0			18.00
19.00	Excluded areas		1,779,722	0	1,779,722			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		59,024	0	59,024			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FOHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits	4.00	317,209	295,404	612,613	42,191.00	14.52	26.00
27.00	Administrative & General	5.00	5,996,999	118,888	6,115,887	241,356.00	25.34	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	976,046	-446,151	529,895	26,499.00	20.00	29.00
30.00	Operation of Plant	7.00	0	446,151	446,151	22,311.00	20.00	30.00
31.00	Laundry & Linen Service	8.00	105,871	0	105,871	8,581.00	12.34	31.00
32.00	Housekeeping	9.00	973,812	0	973,812	79,491.00	12.25	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,344,046	-797,377	546,669	37,143.00	14.72	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	797,377	797,377	61,488.00	12.97	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,134,493	0	1,134,493	38,110.00	29.77	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	1,005,441	0	1,005,441	57,797.00	17.40	41.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet S-3
Part II
Date/Time Prepared:
5/21/2013 3:41 pm

		Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
42.00	Soci al Servi ce	17.00	379,834	0	379,834	15,933.00	23.84	42.00
43.00	Other General Servi ce	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet S-3
Part III
Date/Time Prepared:
5/21/2013 3:41 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	45,172,616	0	45,172,616	1,879,292.00	24.04	1.00
2.00	Excluded area salaries (see instructions)	3,113,346	-295,404	2,817,942	53,899.00	52.28	2.00
3.00	Subtotal salaries (line 1 minus line 2)	42,059,270	295,404	42,354,674	1,825,393.00	23.20	3.00
4.00	Subtotal other wages & related costs (see inst.)	9,241,597	0	9,241,597	133,329.00	69.31	4.00
5.00	Subtotal wage-related costs (see inst.)	20,357,758	0	20,357,758	0.00	48.06	5.00
6.00	Total (sum of lines 3 thru 5)	71,658,625	295,404	71,954,029	1,958,722.00	36.74	6.00
7.00	Total overhead cost (see instructions)	12,233,751	414,292	12,648,043	630,900.00	20.05	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet S-3 Part IV Date/Time Prepared: 5/21/2013 3:41 pm
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	237,020	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	2,593,911	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration Fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	13,059,192	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	288,151	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	110,523	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	9,959	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	158,964	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,719,161	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	2,519,058	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	58,875	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	264,516	22.00
23.00	Tuition Reimbursement	220,952	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	21,240,282	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COST	335,602	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet S-3 Part V Date/Time Prepared: 5/21/2013 3:41 pm
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		441,294	0
2.00	Hospital		441,294	0
3.00	Subprovider - IPF			0
4.00	Subprovider - IRF		0	0
5.00	Subprovider - (Other)		0	0
6.00	Swing Beds - SNF		0	0
7.00	Swing Beds - NF		0	0
8.00	Hospital-Based SNF			0
9.00	Hospital-Based NF			0
10.00	Hospital-Based OLTC			0
11.00	Hospital-Based HHA			0
12.00	Separately Certified ASC			0
13.00	Hospital-Based Hospice			0
14.00	Hospital-Based Health Clinic RHC			0
15.00	Hospital-Based Health Clinic FQHC			0
16.00	Hospital-Based-CMHC			0
16.10	Hospital-Based-CMHC 10		0	0
16.20	Hospital-Based-CMHC 20		0	0
16.30	Hospital-Based-CMHC 30		0	0
16.40	Hospital-Based-CMHC 40		0	0
17.00	Renal Dialysis			0
18.00	Other		0	0

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet S-10 Date/Time Prepared: 5/21/2013 3:41 pm
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			1.00			
Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.307557	1.00		
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid		10,702,686	2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00		
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		Y	4.00		
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00		
6.00	Medicaid charges		57,410,700	6.00		
7.00	Medicaid cost (line 1 times line 6)		17,657,063	7.00		
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		6,954,377	8.00		
State Children's Health Insurance Program (SCHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone SCHIP		0	9.00		
10.00	Stand-alone SCHIP charges		0	10.00		
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00		
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00		
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00		
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00		
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00		
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00		
Uncompensated care (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00		
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00		
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		6,954,377	19.00		
			Uninsured patients	Insured patients		
			1.00	2.00		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility		9,677,056	926,192	10,603,248	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)		2,976,246	284,857	3,261,103	21.00
22.00	Partial payment by patients approved for charity care		0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		2,976,246	284,857	3,261,103	23.00
			1.00			
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N			24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit				0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)				12,341,404	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)				895,116	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)				11,446,288	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)				3,520,386	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)				6,781,489	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)				13,735,866	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet A
Date/Time Prepared:
5/21/2013 3:41 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		3,577,486	3,577,486	79,950	3,657,436	1.00
2.00	00200		3,047,398	3,047,398	14,559	3,061,957	2.00
3.00	00300		94,509	94,509	-94,509	0	3.00
4.00	00400	317,209	20,137,536	20,454,745	305,621	20,760,366	4.00
5.04	00570	799,169	291,503	1,090,672	0	1,090,672	5.04
5.05	00580	449,870	567,995	1,017,865	0	1,017,865	5.05
5.06	00590	4,747,960	16,094,665	20,842,625	363,031	21,205,656	5.06
6.00	00600	976,046	2,034,842	3,010,888	-2,012,894	997,994	6.00
6.01	00601	0	1,248,610	1,248,610	0	1,248,610	6.01
7.00	00700	0	0	0	2,012,894	2,012,894	7.00
8.00	00800	105,871	521,019	626,890	0	626,890	8.00
9.00	00900	973,812	450,927	1,424,739	-145,181	1,279,558	9.00
10.00	01000	1,344,046	795,820	2,139,866	-1,307,733	832,133	10.00
11.00	01100	0	0	0	1,327,745	1,327,745	11.00
13.00	01300	1,134,493	22,392	1,156,885	0	1,156,885	13.00
16.00	01600	1,005,441	437,286	1,442,727	0	1,442,727	16.00
17.00	01700	379,834	26,866	406,700	0	406,700	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	9,788,363	1,315,012	11,103,375	-1,351,509	9,751,866	30.00
31.00	03100	2,678,349	450,349	3,128,698	64,689	3,193,387	31.00
41.00	04100	828,924	28,388	857,312	0	857,312	41.00
43.00	04300	0	0	0	837,118	837,118	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	4,740,660	11,492,094	16,232,754	22,718	16,255,472	50.00
52.00	05200	0	0	0	708,458	708,458	52.00
53.00	05300	0	1,357,145	1,357,145	0	1,357,145	53.00
54.00	05400	1,909,916	816,360	2,726,276	6,847	2,733,123	54.00
57.00	05700	289,728	58,473	348,201	0	348,201	57.00
58.00	05800	278,032	62,370	340,402	0	340,402	58.00
59.00	05900	767,179	2,983,744	3,750,923	31,190	3,782,113	59.00
60.00	06000	1,798,786	3,929,776	5,728,562	0	5,728,562	60.00
64.00	06400	209,893	50,456	260,349	0	260,349	64.00
65.00	06500	937,592	236,992	1,174,584	761	1,175,345	65.00
66.00	06600	786,793	56,094	842,887	0	842,887	66.00
67.00	06700	370,666	69,038	439,704	0	439,704	67.00
68.00	06800	220,671	17,891	238,562	0	238,562	68.00
69.00	06900	642,350	495,761	1,138,111	0	1,138,111	69.00
70.01	07001	53,826	18,264	72,090	0	72,090	70.01
71.00	07100	205,884	345,583	551,467	-538,122	13,345	71.00
73.00	07300	1,502,819	4,398,476	5,901,295	0	5,901,295	73.00
76.00	03950	0	672,059	672,059	0	672,059	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	182,700	56,203	238,903	0	238,903	90.00
90.01	09001	34,539	1,906	36,445	0	36,445	90.01
90.04	09005	81,233	380	81,613	0	81,613	90.04
90.05	09003	0	0	0	0	0	90.05
91.00	09100	2,345,540	846,032	3,191,572	0	3,191,572	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		42,888,194	79,107,700	121,995,894	325,633	122,321,527	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	393	393	0	393	190.00
192.00	19200	1,876,486	1,742,414	3,618,900	0	3,618,900	192.00
192.08	19208	0	0	0	0	0	192.08
193.06	19306	0	0	0	0	0	193.06
194.00	07950	383,163	33,265	416,428	-325,633	90,795	194.00
194.10	07951	24,773	9,555	34,328	0	34,328	194.10
194.20	07952	0	1,857	1,857	0	1,857	194.20
200.00		45,172,616	80,895,184	126,067,800	0	126,067,800	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet A
Date/Time Prepared:
5/21/2013 3:41 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,798,675	1,858,761	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	602,985	3,664,942	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	-5,618,351	15,142,015	4.00
5.04	00570	ADMINISTRATIVE	0	1,090,672	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,017,865	5.05
5.06	00590	ADMINISTRATIVE & GENERAL	-3,374,633	17,831,023	5.06
6.00	00600	MAINTENANCE & REPAIRS	-97,911	900,083	6.00
6.01	00601	BIO MEDICAL SERVICES	0	1,248,610	6.01
7.00	00700	OPERATION OF PLANT	0	2,012,894	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-9,552	617,338	8.00
9.00	00900	HOUSEKEEPING	-10,387	1,269,171	9.00
10.00	01000	DIETARY	-458,426	373,707	10.00
11.00	01100	CAFETERIA	-2,092	1,325,653	11.00
13.00	01300	NURSING ADMINISTRATION	-393	1,156,492	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,391	1,441,336	16.00
17.00	01700	SOCIAL SERVICE	0	406,700	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-12,088	9,739,778	30.00
31.00	03100	INTENSIVE CARE UNIT	-11,972	3,181,415	31.00
41.00	04100	SUBPROVIDER - IIRF	-165	857,147	41.00
43.00	04300	NURSERY	0	837,118	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-171	16,255,301	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	708,458	52.00
53.00	05300	ANESTHESIOLOGY	-873,207	483,938	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-34,414	2,698,709	54.00
57.00	05700	COMPUTED TOMOGRAPHY (CT) SCAN	0	348,201	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	340,402	58.00
59.00	05900	CARDIAC CATHETERIZATION	-30	3,782,083	59.00
60.00	06000	LABORATORY	-45,254	5,683,308	60.00
64.00	06400	INTRAVENOUS THERAPY	0	260,349	64.00
65.00	06500	RESPIRATORY THERAPY	-13,184	1,162,161	65.00
66.00	06600	PHYSICAL THERAPY	-39	842,848	66.00
67.00	06700	OCCUPATIONAL THERAPY	-132	439,572	67.00
68.00	06800	SPEECH PATHOLOGY	-55	238,507	68.00
69.00	06900	ELECTROCARDIOLOGY	-444,153	693,958	69.00
70.01	07001	NEUROLOGY	-14,374	57,716	70.01
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	-13,345	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-9,808	5,891,487	73.00
76.00	03950	ACUTE DIALYSIS	0	672,059	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	238,903	90.00
90.01	09001	DIABETES EDUCATION	0	36,445	90.01
90.04	09005	ANTI COAGULATION CLINIC	0	81,613	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	90.05
91.00	09100	EMERGENCY	-427,907	2,763,665	91.00
92.00	09200	OBSERVATION BEDS	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-12,669,124	109,652,403	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	393	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,618,900	192.00
192.08	19208	FOUNDATION	0	0	192.08
193.06	19306	OUTSIDE ACCOUNTING	0	0	193.06
194.00	07950	CHILD CARE	0	90,795	194.00
194.10	07951	RETAIL PHARMACY	0	34,328	194.10
194.20	07952	OTHER NON-REIMBURSABLE	0	1,857	194.20
200.00		TOTAL (SUM OF LINES 118-199)	-12,669,124	113,398,676	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - OBSTETRICS UNIT COST					
1.00	NURSERY	43.00	710,827	123,703	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	603,443	105,015	2.00
	TOTALS		1,314,270	228,718	
B - PLANT OPERATIONS					
1.00	OPERATION OF PLANT	7.00	446,151	1,566,743	1.00
	TOTALS		446,151	1,566,743	
C - MATERIALS MANAGEMENT					
1.00	ADMINISTRATIVE & GENERAL	5.06	108,842	0	1.00
2.00	OPERATING ROOM	50.00	42,628	0	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	7,830	0	3.00
4.00	RESPIRATORY THERAPY	65.00	870	0	4.00
5.00	CARDIAC CATHETERIZATION	59.00	35,668	0	5.00
6.00	MEDICAL SUPPLIES CHRGD TO PATIENTS	71.00	0	10,922	6.00
	TOTALS		195,838	10,922	
E - SHARED DIETARY COST					
1.00	CAFETERIA	11.00	797,377	530,368	1.00
	TOTALS		797,377	530,368	
F - MAILROOM COST					
1.00	ADMINISTRATIVE & GENERAL	5.06	10,046	0	1.00
	TOTALS		10,046	0	
G - CHILD CARE DIETARY					
1.00	DIETARY	10.00	0	20,012	1.00
	TOTALS		0	20,012	
H - EMPLOYEE CHILD CARE					
1.00	EMPLOYEE BENEFITS	4.00	295,404	10,217	1.00
	TOTALS		295,404	10,217	
I - IV PUMP EXPENSE					
1.00	ADULTS & PEDIATRICS	30.00	0	191,479	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	64,689	2.00
3.00	NURSERY	43.00	0	2,588	3.00
	TOTALS		0	258,756	
J - INVENTORY COST					
1.00	ADMINISTRATIVE & GENERAL	5.06	0	98,962	1.00
	TOTALS		0	98,962	
K - DOCUMENT SHREDDING COST					
1.00	ADMINISTRATIVE & GENERAL	5.06	0	145,181	1.00
	TOTALS		0	145,181	
L - RECLASS MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHRGD TO PATIENTS	71.00	0	14,558	1.00
	TOTALS		0	14,558	
500.00	Grand Total: Increases		3,059,086	2,884,437	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - OBSTETRICS UNIT COST							
1.00	ADULTS & PEDIATRICS	30.00	710,827	123,703	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	603,443	105,015	0		2.00
	TOTALS		1,314,270	228,718			
B - PLANT OPERATIONS							
1.00	MAINTENANCE & REPAIRS	6.00	446,151	1,566,743	0		1.00
	TOTALS		446,151	1,566,743			
C - MATERIALS MANAGEMENT							
1.00	MEDICAL SUPPLIES CHRGD TO PATIENTS	71.00	195,838	0	0		1.00
2.00	OPERATING ROOM	50.00	0	5,352	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	983	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	109	0		4.00
5.00	CARDIAC CATHETERIZATION	59.00	0	4,478	0		5.00
6.00		0.00	0	0	0		6.00
	TOTALS		195,838	10,922			
E - SHARED DIETARY COST							
1.00	DIETARY	10.00	797,377	530,368	0		1.00
	TOTALS		797,377	530,368			
F - MAILROOM COST							
1.00	MEDICAL SUPPLIES CHRGD TO PATIENTS	71.00	10,046	0	0		1.00
	TOTALS		10,046	0			
G - CHILD CARE DIETARY							
1.00	CHILD CARE	194.00	0	20,012	0		1.00
	TOTALS		0	20,012			
H - EMPLOYEE CHILD CARE							
1.00	CHILD CARE	194.00	295,404	10,217	0		1.00
	TOTALS		295,404	10,217			
I - IV PUMP EXPENSE							
1.00	MEDICAL SUPPLIES CHRGD TO PATIENTS	71.00	0	258,756	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	258,756			
J - INVENTORY COST							
1.00	MEDICAL SUPPLIES CHRGD TO PATIENTS	71.00	0	98,962	0		1.00
	TOTALS		0	98,962			
K - DOCUMENT SHREDDING COST							
1.00	HOUSEKEEPING	9.00	0	145,181	0		1.00
	TOTALS		0	145,181			
L - RECLASS MEDICAL SUPPLIES							
1.00	OPERATING ROOM	50.00	0	14,558	0		1.00
	TOTALS		0	14,558			
500.00	Grand Total: Decreases		3,059,086	2,884,437			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-7
Part I
Date/Time Prepared:
5/21/2013 3:41 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	3.00	4.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	864,622	0	0	0	0	1.00
2.00	Land Improvements	1,480,528	0	0	0	2,917	2.00
3.00	Buildings and Fixtures	19,448,040	0	0	0	0	3.00
4.00	Building Improvements	324,963	3,555,004	0	3,555,004	61,604	4.00
5.00	Fixed Equipment	115,775,383	95,472,387	0	95,472,387	56,394	5.00
6.00	Movable Equipment	42,423,930	1,772,503	0	1,772,503	1,232,474	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	180,317,466	100,799,894	0	100,799,894	1,353,389	8.00
9.00	Reconciling Items	62,197	32,312	0	32,312	0	9.00
10.00	Total (line 8 minus line 9)	180,255,269	100,767,582	0	100,767,582	1,353,389	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	864,622	0				1.00
2.00	Land Improvements	1,477,611	0				2.00
3.00	Buildings and Fixtures	19,448,040	0				3.00
4.00	Building Improvements	3,818,363	0				4.00
5.00	Fixed Equipment	211,191,376	0				5.00
6.00	Movable Equipment	42,963,959	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	279,763,971	0				8.00
9.00	Reconciling Items	94,509	0				9.00
10.00	Total (line 8 minus line 9)	279,669,462	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-7
Part II
Date/Time Prepared:
5/21/2013 3:41 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	3,577,486	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,047,398	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	6,624,884	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	3,577,486				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,047,398				2.00
3.00	Total (sum of lines 1-2)	0	6,624,884				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-7
Part III
Date/Time Prepared:
5/21/2013 3:41 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	235,935,390	0	235,935,390	0.845952	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	42,963,959	0	42,963,959	0.154048	0	2.00
3.00	Total (sum of lines 1-2)	278,899,349	0	278,899,349	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	79,950	79,950	1,778,811	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	14,559	14,559	3,650,383	0	2.00
3.00	Total (sum of lines 1-2)	0	94,509	94,509	5,429,194	0	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	79,950	1,858,761	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	14,559	3,664,942	2.00
3.00	Total (sum of lines 1-2)	0	0	0	94,509	5,523,703	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-8

Date/Time Prepared:
5/21/2013 3:41 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-13,345		MEDICAL SUPPLIES CHRGD TO PATIENTS	71.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-2,005,510				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	B	-7,267		RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-4,826,541				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-458,426		DIETARY	10.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients	B	-9,581		DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00 Sale of medical records and abstracts	B	-1,391		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines	B	-2,092		CAFETERIA	11.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3			RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3			PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	B	-1,959,922		CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	B	-373,978		CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3			OCCUPATIONAL THERAPY	67.00		30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3			SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 EDUCATION FEES	B	-393		EMPLOYEE BENEFITS	4.00	0	33.00
33.02 MANAGEMENT FEES	B	-61,585		ADMINISTRATIVE & GENERAL	5.06	0	33.02
34.00 ACCOUNTING FEES	B	-4,800		ADMINISTRATIVE & GENERAL	5.06	0	34.00
35.00 MISC. REVENUE	B	-1,015		ADMINISTRATIVE & GENERAL	5.06	0	35.00

Provider CCN: 140046

Period:
 From 01/01/2012
 To 12/31/2012

Worksheet A-8
 Date/Time Prepared:
 5/21/2013 3:41 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
36.00 RENT REVENUE	B	-96,854	MAINTENANCE & REPAIRS		6.00	0 36.00
37.00 LAUNDRY REVENUE	B	-9,552	LAUNDRY & LINEN SERVICE		8.00	0 37.00
38.00 VENDING COMMISSIONS AND RECYCLING	B	-10,167	HOUSEKEEPING		9.00	0 38.00
40.01 INVENTORY ADJUSTMENT	B	750	OPERATING ROOM		50.00	0 40.01
41.00 RADIOLOGY REVENUE	B	-12,100	RADIOLOGY-DIAGNOSTIC		54.00	0 41.00
41.01 CARDIAC EXERCISE	B	-6,440	ELECTROCARDIOLOGY		69.00	0 41.01
42.00 MANAGEMENT FEE	B	-8,244	NEUROLOGY		70.01	0 42.00
43.00 EMS REVENUE	B	-11,037	EMERGENCY		91.00	0 43.00
44.00 EXCESS PENSION EXPENSE	A	-481,820	EMPLOYEE BENEFITS		4.00	0 44.00
45.00 RENTAL INCOME	B	-6,784	ADMINISTRATIVE & GENERAL		5.06	0 45.00
45.01 PATIENT TELEPHONE COST	A	-69,661	ADMINISTRATIVE & GENERAL		5.06	0 45.01
45.02 PATIENT TELEPHONE DEPRECIATION	A	-4,457	CAP REL COSTS-MVBLE EQUIP		2.00	9 45.02
45.03 EMPLOYEE CHILD CARE	A	-234,449	EMPLOYEE BENEFITS		4.00	0 45.03
45.04 REAL ESTATE TAXES	A	-56	ADMINISTRATIVE & GENERAL		5.06	0 45.04
45.05 ADVERTISING	A	-600,253	ADMINISTRATIVE & GENERAL		5.06	0 45.05
45.06 PHYSICIAN RECRUITMENT	A	-921,232	ADMINISTRATIVE & GENERAL		5.06	0 45.06
45.07 PHYSICIAN BENEFITS	A	-113,301	EMPLOYEE BENEFITS		4.00	0 45.07
45.08 AHA LOBBING PORTION OF DUES	A	-3,688	ADMINISTRATIVE & GENERAL		5.06	0 45.08
45.09 IHA LOBBING PORTION OF DUES	A	-30,716	ADMINISTRATIVE & GENERAL		5.06	0 45.09
45.10 GIFTS & ENTERTAINMENT	A	-30,348	EMPLOYEE BENEFITS		4.00	0 45.10
45.11 GIFTS & ENTERTAINMENT	A	-131,271	ADMINISTRATIVE & GENERAL		5.06	0 45.11
45.12 GIFTS & ENTERTAINMENT	A	-1,057	MAINTENANCE & REPAIRS		6.00	0 45.12
45.13 GIFTS & ENTERTAINMENT	A	-220	HOUSEKEEPING		9.00	0 45.13
45.15 GIFTS & ENTERTAINMENT	A	-393	NURSING ADMINISTRATIVE		13.00	0 45.15
45.17 GIFTS & ENTERTAINMENT	A	-30	ADULTS & PEDIATRICS		30.00	0 45.17
45.18 GIFTS & ENTERTAINMENT	A	-171	INTENSIVE CARE UNIT		31.00	0 45.18
45.19 GIFTS & ENTERTAINMENT	A	-921	OPERATING ROOM		50.00	0 45.19
45.21 GIFTS & ENTERTAINMENT	A	-30	CARDIAC CATHETERIZATION		59.00	0 45.21
45.22 GIFTS & ENTERTAINMENT	A	-937	LABORATORY		60.00	0 45.22
45.23 GIFTS & ENTERTAINMENT	A	-39	PHYSICAL THERAPY		66.00	0 45.23
45.24 GIFTS & ENTERTAINMENT	A	-132	OCCUPATIONAL THERAPY		67.00	0 45.24
45.25 GIFTS & ENTERTAINMENT	A	-55	SPEECH PATHOLOGY		68.00	0 45.25
45.26 GIFTS & ENTERTAINMENT	A	-227	DRUGS CHARGED TO PATIENTS		73.00	0 45.26
45.27 GIFTS & ENTERTAINMENT	A	-650	EMERGENCY		91.00	0 45.27
45.28 EXCESS DEPRECIATION	A	-55,502	CAP REL COSTS-BLDG & FIXT		1.00	9 45.28
45.30 GIFTS & ENTERTAINMENT	A	-171	RESPIRATORY THERAPY		65.00	0 45.30
45.31 GIFTS & ENTERTAINMENT	A	-319	LABORATORY		60.00	0 45.31
46.00 BENEFITS	A	-100,744	EMPLOYEE BENEFITS		4.00	0 46.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-12,669,124				50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-8-1

Date/Time Prepared:
5/21/2013 3:41 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.06	ADMINISTRATIVE & GENERAL CORPORATE FEES	961,020	1,152,000	1.00
2.00	5.06	ADMINISTRATIVE & GENERAL DATA PROCESSING	5,919,858	7,096,292	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT DEPRECIATION	216,749	0	3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP DEPRECIATION	981,420	0	4.00
4.01	4.00	EMPLOYEE BENEFITS FLEX BENEFITS	6,678,740	11,336,036	4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.		14,757,787	19,584,328	5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	B	0.00	0.00	6.00
7.00		0.00	0.00	7.00
8.00		0.00	0.00	8.00
9.00		0.00	0.00	9.00
10.00		0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:			100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-8-1

Date/Time Prepared:
5/21/2013 3:41 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-190,980	0		1.00
2.00	-1,176,434	0		2.00
3.00	216,749	9		3.00
4.00	981,420	9		4.00
4.01	-4,657,296	0		4.01
5.00	-4,826,541			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Related Organization(s) and/or Home Office	Type of Business		
	6.00		
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:			

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet A-8-2

Date/Time Prepared:
5/21/2013 3:41 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.06	AGGREGATE-ADMINISTRATIVE & GENERAL	344,947	19,819	325,127	159,800	2,197	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	12,058	12,058	0	159,800	0	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	21,020	0	21,020	159,800	120	3.00
4.00	41.00	AGGREGATE-SUBPROVIDER - IRF	57,513	165	57,348	159,800	1,241	4.00
5.00	53.00	AGGREGATE-ANESTHESIOLOGY	913,310	830,510	82,800	167,500	498	5.00
6.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	30,739	739	30,000	217,600	150	6.00
7.00	60.00	AGGREGATE-LABORATORY	84,089	21,646	62,443	208,000	659	7.00
8.00	65.00	AGGREGATE-RESPIRATORY THERAPY	18,544	5,296	13,248	159,800	72	8.00
9.00	60.00	AGGREGATE-LABORATORY	22,352	22,352	0	159,800	0	9.00
10.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	446,932	428,674	18,258	159,800	120	10.00
11.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	0	0	0	0	0	11.00
12.00	70.01	AGGREGATE-NEUROLOGY	14,888	400	14,488	159,800	114	12.00
13.00	91.00	AGGREGATE-EMERGENCY	433,583	382,740	50,842	159,800	226	13.00
200.00			2,399,975	1,724,399	675,574		5,397	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.06	AGGREGATE-ADMINISTRATIVE & GENERAL	168,789	8,439	0	0	0	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	9,219	461	0	0	0	3.00
4.00	41.00	AGGREGATE-SUBPROVIDER - IRF	95,342	4,767	0	0	0	4.00
5.00	53.00	AGGREGATE-ANESTHESIOLOGY	40,103	2,005	0	0	0	5.00
6.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	15,692	785	0	0	0	6.00
7.00	60.00	AGGREGATE-LABORATORY	65,900	3,295	0	0	0	7.00
8.00	65.00	AGGREGATE-RESPIRATORY THERAPY	5,531	277	0	0	0	8.00
9.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	9.00
10.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	9,219	461	0	0	0	10.00
11.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	0	0	0	0	0	11.00
12.00	70.01	AGGREGATE-NEUROLOGY	8,758	438	0	0	0	12.00
13.00	91.00	AGGREGATE-EMERGENCY	17,363	868	0	0	0	13.00
200.00			435,916	21,796	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.06	AGGREGATE-ADMINISTRATIVE & GENERAL	0	168,789	156,338	176,158	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	12,058	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	9,219	11,801	11,801	3.00
4.00	41.00	AGGREGATE-SUBPROVIDER - IRF	0	95,342	0	165	4.00
5.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	40,103	42,697	873,207	5.00
6.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	15,692	14,308	15,047	6.00
7.00	60.00	AGGREGATE-LABORATORY	0	65,900	0	21,646	7.00
8.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	5,531	7,717	13,013	8.00
9.00	60.00	AGGREGATE-LABORATORY	0	0	0	22,352	9.00
10.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	9,219	9,039	437,713	10.00
11.00	59.00	AGGREGATE-CARDIAC CATHETERIZATION	0	0	0	0	11.00
12.00	70.01	AGGREGATE-NEUROLOGY	0	8,758	5,730	6,130	12.00
13.00	91.00	AGGREGATE-EMERGENCY	0	17,363	33,479	416,220	13.00
200.00			0	435,916	281,109	2,005,510	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet B
Part I
Date/Time Prepared:
5/21/2013 3:41 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	ADMITTING	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,858,761	1,858,761			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	3,664,942		3,664,942		2.00
4.00 00400	EMPLOYEE BENEFITS	15,142,015	45,498	322	15,187,835	4.00
5.04 00570	ADMITTING	1,090,672	5,946	0	286,966	1,383,584 5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	1,017,865	76,246	2,587	161,540	0 5.05
5.06 00590	ADMINISTRATIVE & GENERAL	17,831,023	526,718	156,408	1,630,845	0 5.06
6.00 00600	MAINTENANCE & REPAIRS	900,083	155,647	0	190,275	0 6.00
6.01 00601	BIO MEDICAL SERVICES	1,248,610	3,561	0	0	0 6.01
7.00 00700	OPERATION OF PLANT	2,012,894	0	521,890	160,204	0 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	617,338	7,458	1,107	38,016	0 8.00
9.00 00900	HOUSEKEEPING	1,269,171	7,116	10,410	349,677	0 9.00
10.00 01000	DIETARY	373,707	24,340	11,646	196,298	0 10.00
11.00 01100	CAFETERIA	1,325,653	48,686	23,296	286,323	0 11.00
13.00 01300	NURSING ADMINISTRATION	1,156,492	12,448	90,154	407,375	0 13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,441,336	28,508	1,538	361,035	0 16.00
17.00 01700	SOCIAL SERVICE	406,700	2,492	2,058	136,391	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	9,739,778	271,913	83,815	3,039,812	58,236 30.00
31.00 03100	INTENSIVE CARE UNIT	3,181,415	43,221	52,784	954,196	17,343 31.00
41.00 04100	SUBPROVIDER - IRF	857,147	46,308	1,367	276,999	3,966 41.00
43.00 04300	NURSERY	837,118	5,990	16,341	255,244	3,270 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	16,255,301	161,056	808,618	1,717,588	317,663 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	708,458	11,341	20,262	216,685	28,383 52.00
53.00 05300	ANESTHESIOLOGY	483,938	5,769	86,709	0	40,730 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,698,709	72,994	405,373	677,588	127,051 54.00
57.00 05700	COMPUTED TOMOGRAPHY (CT) SCAN	348,201	4,795	163,596	104,036	165,684 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	340,402	9,690	139,598	99,836	41,223 58.00
59.00 05900	CARDIAC CATHETERIZATION	3,782,083	32,316	340,957	288,287	102,329 59.00
60.00 06000	LABORATORY	5,683,308	42,506	167,880	637,884	195,497 60.00
64.00 06400	INTRAVENOUS THERAPY	260,349	12,644	4,856	75,369	5,636 64.00
65.00 06500	RESPIRATORY THERAPY	1,162,161	13,327	69,279	336,984	16,182 65.00
66.00 06600	PHYSICAL THERAPY	842,848	25,137	8,778	282,522	11,012 66.00
67.00 06700	OCCUPATIONAL THERAPY	439,572	10,494	0	133,099	5,992 67.00
68.00 06800	SPEECH PATHOLOGY	238,507	4,630	2,451	79,239	1,847 68.00
69.00 06900	ELECTROCARDIOLOGY	693,958	24,106	87,499	213,791	40,070 69.00
70.01 07001	NEUROLOGY	57,716	0	4,040	19,328	984 70.01
71.00 07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	0 71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	5,891,487	12,581	105,139	539,634	128,980 73.00
76.00 03950	ACUTE DIALYSIS	672,059	7,647	0	0	2,679 76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	238,903	1,354	0	65,604	1,383 90.00
90.01 09001	DIABETES EDUCATION	36,445	0	0	12,402	128 90.01
90.04 09005	ANTI COAGULATION CLINIC	81,613	0	0	29,169	279 90.04
90.05 09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	0 90.05
91.00 09100	EMERGENCY	2,763,665	32,240	29,948	840,870	67,037 91.00
92.00 09200	OBSERVATION BEDS					
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0 99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0 99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0 99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0 99.40
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	109,652,403	1,796,723	3,420,706	15,101,111	1,383,584 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	393	4,130	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	3,618,900	14,105	244,030	46,315	0 192.00
192.08 19208	FOUNDATION	0	0	0	0	0 192.08
193.06 19306	OUTSIDE ACCOUNTING	0	0	0	0	0 193.06
194.00 07950	CHILD CARE	90,795	43,803	206	31,513	0 194.00
194.10 07951	RETAIL PHARMACY	34,328	0	0	8,896	0 194.10
194.20 07952	OTHER NON-REIMBURSABLE	1,857	0	0	0	0 194.20
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	TOTAL (sum lines 118-201)	113,398,676	1,858,761	3,664,942	15,187,835	1,383,584 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140046

Period: 01/01/2012 To 12/31/2012

Worksheet B Part I Date/Time Prepared: 5/21/2013 3:41 pm

Cost Center Description			CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	BIOMEDICAL SERVICES	
			5.05	5A.05	5.06	6.00	6.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,258,238					5.05
5.06	00590	ADMINISTRATIVE & GENERAL	0	20,144,994	20,144,994			5.06
6.00	00600	MAINTENANCE & REPAIRS	0	1,246,005	269,167	1,515,172		6.00
6.01	00601	BIOMEDICAL SERVICES	0	1,252,171	270,499	0	1,522,670	6.01
7.00	00700	OPERATION OF PLANT	0	2,694,988	582,182	930	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	663,919	143,422	5,020	0	8.00
9.00	00900	HOUSEKEEPING	0	1,636,374	353,496	43,689	0	9.00
10.00	01000	DIETARY	0	605,991	130,909	44,804	0	10.00
11.00	01100	CAFETERIA	0	1,683,958	363,775	89,795	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,666,469	359,997	5,205	43,382	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,832,417	395,846	13,386	0	16.00
17.00	01700	SOCIAL SERVICE	0	547,641	118,304	1,859	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	53,004	13,246,558	2,861,574	422,760	130,147	30.00
31.00	03100	INTENSIVE CARE UNIT	15,784	4,264,743	921,287	74,736	32,418	31.00
41.00	04100	SUBPROVIDER - I RF	3,609	1,189,396	256,938	39,413	2,384	41.00
43.00	04300	NURSERY	2,976	1,120,939	242,150	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	289,074	19,549,300	4,223,082	163,044	331,803	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,833	1,010,962	218,392	0	1,907	52.00
53.00	05300	ANESTHESIOLOGY	37,070	654,216	141,326	0	123,473	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	114,655	4,096,370	884,914	5,391	348,009	54.00
57.00	05700	COMPUTED TOMOGRAPHY (CT) SCAN	150,797	937,109	202,438	28,630	85,334	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	37,519	668,268	144,362	27,143	28,604	58.00
59.00	05900	CARDIAC CATHETERIZATION	93,135	4,639,107	1,002,158	41,086	172,099	59.00
60.00	06000	LABORATORY	177,931	6,905,006	1,491,647	52,055	30,034	60.00
64.00	06400	INTRAVENOUS THERAPY	5,129	363,983	78,629	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	14,728	1,612,661	348,373	5,763	76,753	65.00
66.00	06600	PHYSICAL THERAPY	10,023	1,180,320	254,977	9,296	14,779	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,454	594,611	128,450	2,417	3,814	67.00
68.00	06800	SPEECH PATHOLOGY	1,681	328,355	70,933	744	1,430	68.00
69.00	06900	ELECTROCARDIOLOGY	36,469	1,095,893	236,739	14,873	46,243	69.00
70.01	07001	NEUROLOGY	895	82,963	17,922	558	2,384	70.01
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	117,391	6,795,212	1,467,929	16,918	0	73.00
76.00	03950	ACUTE DIALYSIS	2,438	684,823	147,938	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,258	308,502	66,644	0	0	90.00
90.01	09001	DIABETES EDUCATION	117	49,092	10,605	0	0	90.01
90.04	09005	ANTI COAGULATION CLINIC	254	111,315	24,047	0	0	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	61,014	3,794,774	819,762	60,607	40,522	91.00
92.00	09200	OBSERVATION BEDS	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,258,238	109,259,405	19,250,813	1,170,122	1,515,519	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,523	977	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,923,350	847,538	319,766	7,151	192.00
192.08	19208	FOUNDATION	0	0	0	0	0	192.08
193.06	19306	OUTSIDE ACCOUNTING	0	0	0	0	0	193.06
194.00	07950	CHILD CARE	0	166,317	35,928	25,284	0	194.00
194.10	07951	RETAIL PHARMACY	0	43,224	9,337	0	0	194.10
194.20	07952	OTHER NON-REIMBURSABLE	0	1,857	401	0	0	194.20
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,258,238	113,398,676	20,144,994	1,515,172	1,522,670	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet B
Part I
Date/Time Prepared:
5/21/2013 3:41 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.04	00570	ADMINISTRATIVE					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	ADMINISTRATIVE & GENERAL					5.06
6.00	00600	MAINTENANCE & REPAIRS					6.00
6.01	00601	BIO MEDICAL SERVICES					6.01
7.00	00700	OPERATION OF PLANT	3,278,100				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	23,391	835,752			8.00
9.00	00900	HOUSEKEEPING	22,319	3,343	2,059,221		9.00
10.00	01000	DIETARY	76,342	1,671	19,822	879,539	10.00
11.00	01100	CAFETERIA	152,704	3,343	9,911	0	2,303,486
13.00	01300	NURSING ADMINISTRATION	39,044	0	922	0	66,143
16.00	01600	MEDICAL RECORDS & LIBRARY	89,416	0	3,457	0	99,933
17.00	01700	SOCIAL SERVICE	7,817	0	1,152	0	27,679
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	852,853	459,663	1,018,088	563,542	654,237
31.00	03100	INTENSIVE CARE UNIT	135,562	69,368	149,129	46,377	153,134
41.00	04100	SUBPROVIDER - IIRF	145,244	71,039	63,155	31,509	48,528
43.00	04300	NURSERY	18,788	25,072	0	0	44,574
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	505,150	76,889	230,262	36,780	329,634
52.00	05200	DELIVERY ROOM & LABOR ROOM	35,572	0	74,910	0	38,104
53.00	05300	ANESTHESIOLOGY	18,094	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	228,946	25,072	54,627	0	130,128
57.00	05700	COMPUTED TOMOGRAPHY (CT) SCAN	15,038	0	5,762	0	20,130
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	30,394	4,179	9,681	0	17,974
59.00	05900	CARDIAC CATHETERIZATION	101,359	21,729	35,035	6,318	53,921
60.00	06000	LABORATORY	133,321	0	44,946	0	163,559
64.00	06400	INTRAVENOUS THERAPY	39,659	0	5,762	0	11,863
65.00	06500	RESPIRATORY THERAPY	41,802	1,672	2,305	0	74,051
66.00	06600	PHYSICAL THERAPY	78,842	13,373	9,681	0	57,515
67.00	06700	OCCUPATIONAL THERAPY	32,914	0	9,450	0	20,490
68.00	06800	SPEECH PATHOLOGY	14,522	0	691	0	12,222
69.00	06900	ELECTROCARDIOLOGY	75,608	3,343	30,656	0	46,372
70.01	07001	NEUROLOGY	0	1,672	461	0	3,954
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	39,461	0	18,439	0	68,299
76.00	03950	ACUTE DIALYSIS	23,986	4,179	10,603	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	4,246	0	0	0	0
90.01	09001	DIABETES EDUCATION	0	0	0	0	1,797
90.04	09005	ANTI COAGULATION CLINIC	0	0	1,383	0	3,235
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	0
91.00	09100	EMERGENCY	101,121	45,966	209,979	6,667	143,069
92.00	09200	OBSERVATION BEDS					
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,083,515	831,573	2,020,269	691,193	2,290,545
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,955	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	44,242	0	5,301	0	0
192.08	19208	FOUNDATION	0	0	691	0	0
193.06	19306	OUTSIDE ACCOUNTING	0	0	0	0	0
194.00	07950	CHILD CARE	137,388	4,179	32,960	188,346	11,863
194.10	07951	RETAIL PHARMACY	0	0	0	0	1,078
194.20	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	3,278,100	835,752	2,059,221	879,539	2,303,486

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet B
Part I
Date/Time Prepared:
5/21/2013 3:41 pm

Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.04	00570						5.04
5.05	00580						5.05
5.06	00590						5.06
6.00	00600						6.00
6.01	00601						6.01
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	2,181,162					13.00
16.00	01600		2,434,455				16.00
17.00	01700			704,452			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,011,136	102,549	302,914	21,626,021		30.00
31.00	03100	236,672	30,539	42,267	6,156,232		31.00
41.00	04100	75,002	6,983	7,045	1,936,636		41.00
43.00	04300	68,890	5,758	0	1,526,171		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	509,456	559,360	0	26,514,760		50.00
52.00	05200	58,890	49,980	0	1,488,717		52.00
53.00	05300	0	71,722	0	1,008,831		53.00
54.00	05400	0	221,829	0	5,995,286		54.00
57.00	05700	0	291,754	0	1,586,195		57.00
58.00	05800	0	72,589	0	1,003,194		58.00
59.00	05900	0	180,193	0	6,253,005		59.00
60.00	06000	0	344,252	0	9,164,820		60.00
64.00	06400	0	9,924	0	509,820		64.00
65.00	06500	0	28,495	0	2,191,875		65.00
66.00	06600	0	19,392	0	1,638,175		66.00
67.00	06700	0	10,552	0	802,698		67.00
68.00	06800	0	3,253	0	432,150		68.00
69.00	06900	0	70,559	0	1,620,286		69.00
70.01	07001	0	1,732	0	111,646		70.01
71.00	07100	0	0	0	0		71.00
73.00	07300	0	227,122	0	8,633,380		73.00
76.00	03950	0	4,718	0	876,247		76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	2,435	0	381,827		90.00
90.01	09001	0	226	0	61,720		90.01
90.04	09005	0	492	0	140,472		90.04
90.05	09003	0	0	0	0		90.05
91.00	09100	221,116	118,047	281,781	5,843,411		91.00
92.00	09200	0	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0		99.10
99.20	09920	0	0	0	0		99.20
99.30	09930	0	0	0	0		99.30
99.40	09940	0	0	0	0		99.40
SPECIAL PURPOSE COST CENTERS							
118.00		2,181,162	2,434,455	634,007	107,503,575		118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	70,445	88,900		190.00
192.00	19200	0	0	0	5,147,348		192.00
192.08	19208	0	0	0	691		192.08
193.06	19306	0	0	0	0		193.06
194.00	07950	0	0	0	602,265		194.00
194.10	07951	0	0	0	53,639		194.10
194.20	07952	0	0	0	2,258		194.20
200.00		0	0	0	0		200.00
201.00		0	0	0	0		201.00
202.00		2,181,162	2,434,455	704,452	113,398,676		202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet B
Part I
Date/Time Prepared:
5/21/2013 3:41 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS		4.00
5.04	00570 ADMI TTING		5.04
5.05	00580 CASHI ERING/ACCOUNTS RECEI VABLE		5.05
5.06	00590 ADMI NI STRATI VE & GENERAL		5.06
6.00	00600 MAI NTENANCE & REPAIRS		6.00
6.01	00601 BI OMEDI CAL SERVI CES		6.01
7.00	00700 OPERATI ON OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVI CE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DI ETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON		13.00
16.00	01600 MEDI CAL RECORDS & LI BRARY		16.00
17.00	01700 SOCI AL SERVI CE		17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	21,626,021	30.00
31.00	03100 INTENSIVE CARE UNIT	6,156,232	31.00
41.00	04100 SUBPROVIDER - IRF	1,936,636	41.00
43.00	04300 NURSERY	1,526,171	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	26,514,760	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,488,717	52.00
53.00	05300 ANESTHESIOLOGY	1,008,831	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,995,286	54.00
57.00	05700 COMPUTED TOMOGRAPHY (CT) SCAN	1,586,195	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,003,194	58.00
59.00	05900 CARDIAC CATHETERIZATION	6,253,005	59.00
60.00	06000 LABORATORY	9,164,820	60.00
64.00	06400 INTRAVENOUS THERAPY	509,820	64.00
65.00	06500 RESPIRATORY THERAPY	2,191,875	65.00
66.00	06600 PHYSICAL THERAPY	1,638,175	66.00
67.00	06700 OCCUPATIONAL THERAPY	802,698	67.00
68.00	06800 SPEECH PATHOLOGY	432,150	68.00
69.00	06900 ELECTROCARDIOLOGY	1,620,286	69.00
70.01	07001 NEUROLOGY	111,646	70.01
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,633,380	73.00
76.00	03950 ACUTE DIALYSIS	876,247	76.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	381,827	90.00
90.01	09001 DIABETES EDUCATION	61,720	90.01
90.04	09005 ANTI COAGULATION CLINIC	140,472	90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0	90.05
91.00	09100 EMERGENCY	5,843,411	91.00
92.00	09200 OBSERVATION BEDS		92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910 CORF	0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	99.40
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	107,503,575	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	88,900	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	5,147,348	192.00
192.08	19208 FOUNDATION	691	192.08
193.06	19306 OUTSIDE ACCOUNTING	0	193.06
194.00	07950 CHILD CARE	602,265	194.00
194.10	07951 RETAIL PHARMACY	53,639	194.10
194.20	07952 OTHER NON-REIMBURSABLE	2,258	194.20
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	113,398,676	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet B
Part II
Date/Time Prepared:
5/21/2013 3:41 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	63	45,498	322	45,883	45,883 4.00
5.04 00570	ADMINISTRATIVE	63	5,946	0	6,009	867 5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	11	76,246	2,587	78,844	488 5.05
5.06 00590	ADMINISTRATIVE & GENERAL	18,379	526,718	156,408	701,505	4,928 5.06
6.00 00600	MAINTENANCE & REPAIRS	49,667	155,647	0	205,314	575 6.00
6.01 00601	BIO MEDICAL SERVICES	0	3,561	0	3,561	0 6.01
7.00 00700	OPERATION OF PLANT	0	0	521,890	521,890	484 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	7,458	1,107	8,565	115 8.00
9.00 00900	HOUSEKEEPING	0	7,116	10,410	17,526	1,057 9.00
10.00 01000	DIETARY	447	24,340	11,646	36,433	593 10.00
11.00 01100	CAFETERIA	894	48,686	23,296	72,876	865 11.00
13.00 01300	NURSING ADMINISTRATION	0	12,448	90,154	102,602	1,231 13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	30	28,508	1,538	30,076	1,091 16.00
17.00 01700	SOCIAL SERVICE	0	2,492	2,058	4,550	412 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	248,613	271,913	83,815	604,341	9,178 30.00
31.00 03100	INTENSIVE CARE UNIT	87,104	43,221	52,784	183,109	2,883 31.00
41.00 04100	SUBPROVIDER - IRF	0	46,308	1,367	47,675	837 41.00
43.00 04300	NURSERY	2,588	5,990	16,341	24,919	771 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	95,613	161,056	808,618	1,065,287	5,190 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	11,341	20,262	31,603	655 52.00
53.00 05300	ANESTHESIOLOGY	5,324	5,769	86,709	97,802	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	45,700	72,994	405,373	524,067	2,047 54.00
57.00 05700	COMPUTED TOMOGRAPHY (CT) SCAN	0	4,795	163,596	168,391	314 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	9,690	139,598	149,288	302 58.00
59.00 05900	CARDIAC CATHETERIZATION	13,096	32,316	340,957	386,369	871 59.00
60.00 06000	LABORATORY	408	42,506	167,880	210,794	1,927 60.00
64.00 06400	INTRAVENOUS THERAPY	0	12,644	4,856	17,500	228 64.00
65.00 06500	RESPIRATORY THERAPY	6,446	13,327	69,279	89,052	1,018 65.00
66.00 06600	PHYSICAL THERAPY	745	25,137	8,778	34,660	854 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	10,494	0	10,494	402 67.00
68.00 06800	SPEECH PATHOLOGY	0	4,630	2,451	7,081	239 68.00
69.00 06900	ELECTROCARDIOLOGY	0	24,106	87,499	111,605	646 69.00
70.01 07001	NEUROLOGY	0	0	4,040	4,040	58 70.01
71.00 07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	0 71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	155,960	12,581	105,139	273,680	1,631 73.00
76.00 03950	ACUTE DIALYSIS	0	7,647	0	7,647	0 76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	1,354	0	1,354	198 90.00
90.01 09001	DIABETES EDUCATION	0	0	0	0	37 90.01
90.04 09005	ANTI COAGULATION CLINIC	0	0	0	0	88 90.04
90.05 09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	0 90.05
91.00 09100	EMERGENCY	443	32,240	29,948	62,631	2,541 91.00
92.00 09200	OBSERVATION BEDS	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0 99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0 99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0 99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0 99.40
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	731,594	1,796,723	3,420,706	5,949,023	45,621 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,130	0	4,130	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	840,837	14,105	244,030	1,098,972	140 192.00
192.08 19208	FOUNDATION	0	0	0	0	0 192.08
193.06 19306	OUTSIDE ACCOUNTING	0	0	0	0	0 193.06
194.00 07950	CHILD CARE	0	43,803	206	44,009	95 194.00
194.10 07951	RETAIL PHARMACY	0	0	0	0	27 194.10
194.20 07952	OTHER NON-REIMBURSABLE	0	0	0	0	0 194.20
200.00	Cross Foot Adjustments				0	0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	1,572,431	1,858,761	3,664,942	7,096,134	45,883 202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140046		Period: From 01/01/2012 To 12/31/2012		Worksheet B Part II Date/Time Prepared: 5/21/2013 3:41 pm	
Cost Center Description			ADMINISTRATIVE	CASHIERING/ACCOUNTS RECEIVABLE	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	BIOMEDICAL SERVICES	
			5.04	5.05	5.06	6.00	6.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.04	00570	ADMINISTRATIVE	6,876					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	79,332				5.05
5.06	00590	ADMINISTRATIVE & GENERAL	0	0	706,433			5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	9,438	215,327		6.00
6.01	00601	BIOMEDICAL SERVICES	0	0	9,485	0	13,046	6.01
7.00	00700	OPERATION OF PLANT	0	0	20,415	132		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	5,029	713		8.00
9.00	00900	HOUSEKEEPING	0	0	12,396	6,209		9.00
10.00	01000	DIETARY	0	0	4,590	6,367		10.00
11.00	01100	CAFETERIA	0	0	12,756	12,761		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	12,624	740	372	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	13,881	1,902	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	4,148	264	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	286	3,338	100,343	60,082	1,115	30.00
31.00	03100	INTENSIVE CARE UNIT	85	994	32,305	10,621	278	31.00
41.00	04100	SUBPROVIDER - I RF	19	227	9,010	5,601	20	41.00
43.00	04300	NURSERY	16	187	8,491	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,647	18,295	148,124	23,171	2,843	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	139	1,627	7,658	0	16	52.00
53.00	05300	ANESTHESIOLOGY	200	2,335	4,956	0	1,058	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	623	7,221	31,030	766	2,982	54.00
57.00	05700	COMPUTED TOMOGRAPHY (CT) SCAN	813	9,497	7,099	4,069	731	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	202	2,363	5,062	3,857	245	58.00
59.00	05900	CARDIAC CATHETERIZATION	502	5,866	35,141	5,839	1,475	59.00
60.00	06000	LABORATORY	959	11,206	52,305	7,398	257	60.00
64.00	06400	INTRAVENOUS THERAPY	28	323	2,757	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	79	928	12,216	819	658	65.00
66.00	06600	PHYSICAL THERAPY	54	631	8,941	1,321	127	66.00
67.00	06700	OCCUPATIONAL THERAPY	29	343	4,504	343	33	67.00
68.00	06800	SPEECH PATHOLOGY	9	106	2,487	106	12	68.00
69.00	06900	ELECTROCARDIOLOGY	197	2,297	8,301	2,114	396	69.00
70.01	07001	NEUROLOGY	5	56	628	79	20	70.01
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	633	7,393	51,474	2,404	0	73.00
76.00	03950	ACUTE DIALYSIS	13	154	5,188	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	7	79	2,337	0	0	90.00
90.01	09001	DIABETES EDUCATION	1	7	372	0	0	90.01
90.04	09005	ANTI COAGULATION CLINIC	1	16	843	0	0	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	329	3,843	28,745	8,613	347	91.00
92.00	09200	OBSERVATION BEDS						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,876	79,332	675,079	166,291	12,985	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	34	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	29,719	45,443	61	192.00
192.08	19208	FOUNDATION	0	0	0	0	0	192.08
193.06	19306	OUTSIDE ACCOUNTING	0	0	0	0	0	193.06
194.00	07950	CHILD CARE	0	0	1,260	3,593	0	194.00
194.10	07951	RETAIL PHARMACY	0	0	327	0	0	194.10
194.20	07952	OTHER NON-REIMBURSABLE	0	0	14	0	0	194.20
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	6,876	79,332	706,433	215,327	13,046	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet B
Part II
Date/Time Prepared:
5/21/2013 3:41 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.04	00570	ADMINISTRATIVE					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	ADMINISTRATIVE & GENERAL					5.06
6.00	00600	MAINTENANCE & REPAIRS					6.00
6.01	00601	BIO MEDICAL SERVICES					6.01
7.00	00700	OPERATION OF PLANT	542,921				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,874	18,296			8.00
9.00	00900	HOUSEKEEPING	3,697	73	40,958		9.00
10.00	01000	DIETARY	12,644	37	394	61,058	10.00
11.00	01100	CAFETERIA	25,291	73	197	0	124,819
13.00	01300	NURSING ADMINISTRATION	6,466	0	18	0	3,584
16.00	01600	MEDICAL RECORDS & LIBRARY	14,809	0	69	0	5,415
17.00	01700	SOCIAL SERVICE	1,295	0	23	0	1,500
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	141,251	10,063	20,247	39,122	35,451
31.00	03100	INTENSIVE CARE UNIT	22,452	1,519	2,966	3,219	8,298
41.00	04100	SUBPROVIDER - IRF	24,055	1,555	1,256	2,187	2,630
43.00	04300	NURSERY	3,112	549	0	0	2,415
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	83,663	1,683	4,580	2,553	17,862
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,891	0	1,490	0	2,065
53.00	05300	ANESTHESIOLOGY	2,997	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,918	549	1,087	0	7,051
57.00	05700	COMPUTED TOMOGRAPHY (CT) SCAN	2,491	0	115	0	1,091
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,034	91	193	0	974
59.00	05900	CARDIAC CATHETERIZATION	16,787	476	697	439	2,922
60.00	06000	LABORATORY	22,081	0	894	0	8,863
64.00	06400	INTRAVENOUS THERAPY	6,568	0	115	0	643
65.00	06500	RESPIRATORY THERAPY	6,923	37	46	0	4,013
66.00	06600	PHYSICAL THERAPY	13,058	293	193	0	3,117
67.00	06700	OCCUPATIONAL THERAPY	5,451	0	188	0	1,110
68.00	06800	SPEECH PATHOLOGY	2,405	0	14	0	662
69.00	06900	ELECTROCARDIOLOGY	12,522	73	610	0	2,513
70.01	07001	NEUROLOGY	0	37	9	0	214
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	6,535	0	367	0	3,701
76.00	03950	ACUTE DIALYSIS	3,973	91	211	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	703	0	0	0	0
90.01	09001	DIABETES EDUCATION	0	0	0	0	97
90.04	09005	ANTI COAGULATION CLINIC	0	0	28	0	175
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	0
91.00	09100	EMERGENCY	16,748	1,006	4,176	463	7,752
92.00	09200	OBSERVATION BEDS					
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	510,694	18,205	40,183	47,983	124,118
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,146	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,327	0	105	0	0
192.08	19208	FOUNDATION	0	0	14	0	0
193.06	19306	OUTSIDE ACCOUNTING	0	0	0	0	0
194.00	07950	CHILD CARE	22,754	91	656	13,075	643
194.10	07951	RETAIL PHARMACY	0	0	0	0	58
194.20	07952	OTHER NON-REIMBURSABLE	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	542,921	18,296	40,958	61,058	124,819

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet B
Part II
Date/Time Prepared:
5/21/2013 3:41 pm

Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.04	00570						5.04
5.05	00580						5.05
5.06	00590						5.06
6.00	00600						6.00
6.01	00601						6.01
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	127,637					13.00
16.00	01600		67,243				16.00
17.00	01700			12,192			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	59,170	2,827	5,242	1,092,056		30.00
31.00	03100	13,850	842	732	284,153		31.00
41.00	04100	4,389	192	122	99,775		41.00
43.00	04300	4,031	159	0	44,650		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	29,812	15,553	0	1,420,263		50.00
52.00	05200	3,446	1,378	0	55,968		52.00
53.00	05300	0	1,977	0	111,325		53.00
54.00	05400	0	6,115	0	621,456		54.00
57.00	05700	0	8,042	0	202,653		57.00
58.00	05800	0	2,001	0	169,612		58.00
59.00	05900	0	4,967	0	462,351		59.00
60.00	06000	0	9,490	0	326,174		60.00
64.00	06400	0	274	0	28,436		64.00
65.00	06500	0	785	0	116,574		65.00
66.00	06600	0	535	0	63,784		66.00
67.00	06700	0	291	0	23,188		67.00
68.00	06800	0	90	0	13,211		68.00
69.00	06900	0	1,945	0	143,219		69.00
70.01	07001	0	48	0	5,194		70.01
71.00	07100	0	0	0	0		71.00
73.00	07300	0	6,261	0	354,079		73.00
76.00	03950	0	130	0	17,407		76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	67	0	4,745		90.00
90.01	09001	0	6	0	520		90.01
90.04	09005	0	14	0	1,165		90.04
90.05	09003	0	0	0	0		90.05
91.00	09100	12,939	3,254	4,877	158,264		91.00
92.00	09200	0	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0		99.10
99.20	09920	0	0	0	0		99.20
99.30	09930	0	0	0	0		99.30
99.40	09940	0	0	0	0		99.40
SPECIAL PURPOSE COST CENTERS							
118.00		127,637	67,243	10,973	5,820,222		118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	1,219	7,529		190.00
192.00	19200	0	0	0	1,181,767		192.00
192.08	19208	0	0	0	14		192.08
193.06	19306	0	0	0	0		193.06
194.00	07950	0	0	0	86,176		194.00
194.10	07951	0	0	0	412		194.10
194.20	07952	0	0	0	14		194.20
200.00		0	0	0	0		200.00
201.00		0	0	0	0		201.00
202.00		127,637	67,243	12,192	7,096,134		202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet B Part II Date/Time Prepared: 5/21/2013 3:41 pm
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS	4.00
5.04	00570	ADMITTING	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.05
5.06	00590	ADMINISTRATIVE & GENERAL	5.06
6.00	00600	MAINTENANCE & REPAIRS	6.00
6.01	00601	BIOMEDICAL SERVICES	6.01
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
57.00	05700	COMPUTED TOMOGRAPHY (CT) SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.01	07001	NEUROLOGY	70.01
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	ACUTE DIALYSIS	76.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	DIABETES EDUCATION	90.01
90.04	09005	ANTI COAGULATION CLINIC	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	90.05
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS	92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	99.40
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.08	19208	FOUNDATION	192.08
193.06	19306	OUTSIDE ACCOUNTING	193.06
194.00	07950	CHILD CARE	194.00
194.10	07951	RETAIL PHARMACY	194.10
194.20	07952	OTHER NON-REIMBURSABLE	194.20
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140046

Period: From 01/01/2012 To 12/31/2012

Worksheet B-1

Date/Time Prepared: 5/21/2013 3:41 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	ADMITTING (ADMITTING CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	
	BLDG & FIXT (SQ FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	293,860				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		2,664,265			2.00
4.00 00400	EMPLOYEE BENEFITS	7,193	234	42,296,416		4.00
5.04 00570	ADMITTING	940	0	799,169	357,245,166	5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	12,054	1,881	449,870	0	356,967,240
5.06 00590	ADMINISTRATIVE & GENERAL	83,271	113,702	4,541,720	0	0
6.00 00600	MAINTENANCE & REPAIRS	24,607	0	529,895	0	0
6.01 00601	BIOMEDICAL SERVICES	563	0	0	0	0
7.00 00700	OPERATION OF PLANT	0	379,393	446,151	0	0
8.00 00800	LAUNDRY & LINEN SERVICE	1,179	805	105,871	0	0
9.00 00900	HOUSEKEEPING	1,125	7,568	973,812	0	0
10.00 01000	DIETARY	3,848	8,466	546,669	0	0
11.00 01100	CAFETERIA	7,697	16,935	797,377	0	0
13.00 01300	NURSING ADMINISTRATION	1,968	65,538	1,134,493	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	4,507	1,118	1,005,441	0	0
17.00 01700	SOCIAL SERVICE	394	1,496	379,834	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	42,988	60,930	8,465,535	15,036,481	15,036,481
31.00 03100	INTENSIVE CARE UNIT	6,833	38,372	2,657,329	4,477,795	4,477,795
41.00 04100	SUBPROVIDER - IRF	7,321	994	771,412	1,023,935	1,023,935
43.00 04300	NURSERY	947	11,879	710,827	844,225	844,225
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	25,462	587,832	4,783,288	82,026,918	82,026,918
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,793	14,730	603,443	7,328,494	7,328,494
53.00 05300	ANESTHESIOLOGY	912	63,034	0	10,516,413	10,516,413
54.00 05400	RADIOLOGY-DIAGNOSTIC	11,540	294,690	1,887,007	32,804,186	32,526,260
57.00 05700	COMPUTED TOMOGRAPHY (CT) SCAN	758	118,928	289,728	42,779,229	42,779,229
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	1,532	101,482	278,032	10,643,611	10,643,611
59.00 05900	CARDIAC CATHETERIZATION	5,109	247,862	802,847	26,421,234	26,421,234
60.00 06000	LABORATORY	6,720	122,042	1,776,435	50,476,796	50,476,796
64.00 06400	INTRAVENOUS THERAPY	1,999	3,530	209,893	1,455,092	1,455,092
65.00 06500	RESPIRATORY THERAPY	2,107	50,363	938,462	4,178,098	4,178,098
66.00 06600	PHYSICAL THERAPY	3,974	6,381	786,793	2,843,334	2,843,334
67.00 06700	OCCUPATIONAL THERAPY	1,659	0	370,666	1,547,166	1,547,166
68.00 06800	SPEECH PATHOLOGY	732	1,782	220,671	476,945	476,945
69.00 06900	ELECTROCARDIOLOGY	3,811	63,608	595,385	10,345,924	10,345,924
70.01 07001	NEUROLOGY	0	2,937	53,826	253,980	253,980
71.00 07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	1,989	76,432	1,502,819	33,302,311	33,302,311
76.00 03950	ACUTE DIALYSIS	1,209	0	0	691,762	691,762
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	214	0	182,700	356,979	356,979
90.01 09001	DIABETES EDUCATION	0	0	34,539	33,178	33,178
90.04 09005	ANTI COAGULATION CLINIC	0	0	81,233	72,165	72,165
90.05 09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	0
91.00 09100	EMERGENCY	5,097	21,771	2,341,727	17,308,915	17,308,915
92.00 09200	OBSERVATION BEDS					
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	284,052	2,486,715	42,054,899	357,245,166	356,967,240
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	653	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	2,230	177,400	128,983	0	0
192.08 19208	FOUNDATION	0	0	0	0	0
193.06 19306	OUTSIDE ACCOUNTING	0	0	0	0	0
194.00 07950	CHILD CARE	6,925	150	87,759	0	0
194.10 07951	RETAIL PHARMACY	0	0	24,775	0	0
194.20 07952	OTHER NON-REIMBURSABLE	0	0	0	0	0
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,858,761	3,664,942	15,187,835	1,383,584	1,258,238
203.00	Unit cost multiplier (Wkst. B, Part I)	6.325328	1.375592	0.359081	0.003873	0.003525

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet B-1

Date/Time Prepared:
5/21/2013 3:41 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	ADMITTING (ADMITTING CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	
		BLDG & FIXT (SQ FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00				
204.00	Cost to be allocated (per Wkst. B, Part II)			45,883	6,876	79,332	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001085	0.000019	0.000222	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet B-1

Date/Time Prepared:
5/21/2013 3:41 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES SERVED)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.04	00570						5.04
5.05	00580						5.05
5.06	00590						5.06
6.00	00600						6.00
6.01	00601						6.01
7.00	00700						7.00
8.00	00800	825,781					8.00
9.00	00900	3,303	8,934				9.00
10.00	01000	1,651	86	153,693			10.00
11.00	01100	3,303	43	0	6,408		11.00
13.00	01300	0	4	0	184	816,608	13.00
16.00	01600	0	15	0	278	0	16.00
17.00	01700	0	5	0	77	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	454,180	4,417	98,475	1,820	378,560	30.00
31.00	03100	68,540	647	8,104	426	88,608	31.00
41.00	04100	70,191	274	5,506	135	28,080	41.00
43.00	04300	24,773	0	0	124	25,792	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	75,972	999	6,427	917	190,736	50.00
52.00	05200	0	325	0	106	22,048	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	24,773	237	0	362	0	54.00
57.00	05700	0	25	0	56	0	57.00
58.00	05800	4,129	42	0	50	0	58.00
59.00	05900	21,470	152	1,104	150	0	59.00
60.00	06000	0	195	0	455	0	60.00
64.00	06400	0	25	0	33	0	64.00
65.00	06500	1,652	10	0	206	0	65.00
66.00	06600	13,213	42	0	160	0	66.00
67.00	06700	0	41	0	57	0	67.00
68.00	06800	0	3	0	34	0	68.00
69.00	06900	3,303	133	0	129	0	69.00
70.01	07001	1,652	2	0	11	0	70.01
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	80	0	190	0	73.00
76.00	03950	4,129	46	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	5	0	90.01
90.04	09005	0	6	0	9	0	90.04
90.05	09003	0	0	0	0	0	90.05
91.00	09100	45,418	911	1,165	398	82,784	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		821,652	8,765	120,781	6,372	816,608	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	23	0	0	0	192.00
192.08	19208	0	3	0	0	0	192.08
193.06	19306	0	0	0	0	0	193.06
194.00	07950	4,129	143	32,912	33	0	194.00
194.10	07951	0	0	0	3	0	194.10
194.20	07952	0	0	0	0	0	194.20
200.00							200.00
201.00							201.00
202.00		835,752	2,059,221	879,539	2,303,486	2,181,162	202.00
203.00		1.012075	230.492612	5.722700	359.470350	2.671002	203.00
204.00		18,296	40,958	61,058	124,819	127,637	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet B-1

Date/Time Prepared:
5/21/2013 3:41 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES SERVED)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
		8.00	9.00	10.00	11.00	13.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.022156	4.584509	0.397272	19.478620	0.156301	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet B-1
Date/Time Prepared:
5/21/2013 3:41 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	
		16.00	17.00	
GENERAL SERVICE COST CENTERS				
1.00	00100			1.00
2.00	00200			2.00
4.00	00400			4.00
5.04	00570			5.04
5.05	00580			5.05
5.06	00590			5.06
6.00	00600			6.00
6.01	00601			6.01
7.00	00700			7.00
8.00	00800			8.00
9.00	00900			9.00
10.00	01000			10.00
11.00	01100			11.00
13.00	01300			13.00
16.00	01600	356,967,240		16.00
17.00	01700	0	100	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	15,036,481	43	30.00
31.00	03100	4,477,795	6	31.00
41.00	04100	1,023,935	1	41.00
43.00	04300	844,225	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	82,026,918	0	50.00
52.00	05200	7,328,494	0	52.00
53.00	05300	10,516,413	0	53.00
54.00	05400	32,526,260	0	54.00
57.00	05700	42,779,229	0	57.00
58.00	05800	10,643,611	0	58.00
59.00	05900	26,421,234	0	59.00
60.00	06000	50,476,796	0	60.00
64.00	06400	1,455,092	0	64.00
65.00	06500	4,178,098	0	65.00
66.00	06600	2,843,334	0	66.00
67.00	06700	1,547,166	0	67.00
68.00	06800	476,945	0	68.00
69.00	06900	10,345,924	0	69.00
70.01	07001	253,980	0	70.01
71.00	07100	0	0	71.00
73.00	07300	33,302,311	0	73.00
76.00	03950	691,762	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	356,979	0	90.00
90.01	09001	33,178	0	90.01
90.04	09005	72,165	0	90.04
90.05	09003	0	0	90.05
91.00	09100	17,308,915	40	91.00
92.00	09200			92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	0	0	99.10
99.20	09920	0	0	99.20
99.30	09930	0	0	99.30
99.40	09940	0	0	99.40
SPECIAL PURPOSE COST CENTERS				
118.00		356,967,240	90	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	0	10	190.00
192.00	19200	0	0	192.00
192.08	19208	0	0	192.08
193.06	19306	0	0	193.06
194.00	07950	0	0	194.00
194.10	07951	0	0	194.10
194.20	07952	0	0	194.20
200.00				200.00
201.00				201.00
202.00		2,434,455	704,452	202.00
203.00		0.006820	7,044.520000	203.00
204.00		67,243	12,192	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet B-1
Date/Time Prepared:
5/21/2013 3:41 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	
205.00	Unit cost multiplier (Wkst. B, Part II)	16.00 0.000188	17.00 121.920000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet C
Part I
Date/Time Prepared:
5/21/2013 3:41 pm

			Title XVIII		Hospital		PPS		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			
			Total Costs	RCE Diallowance	Total Costs	Inpatient			
			1.00	2.00	3.00	4.00	5.00	6.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	21,626,021		21,626,021	0	21,626,021	13,321,246	30.00
31.00	03100	INTENSIVE CARE UNIT	6,156,232		6,156,232	11,801	6,168,033	4,441,669	31.00
41.00	04100	SUBPROVIDER - IRF	1,936,636		1,936,636	0	1,936,636	1,019,840	41.00
43.00	04300	NURSERY	1,526,171		1,526,171	0	1,526,171	818,795	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	26,514,760		26,514,760	0	26,514,760	40,645,128	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,488,717		1,488,717	0	1,488,717	4,931,111	52.00
53.00	05300	ANESTHESIOLOGY	1,008,831		1,008,831	42,697	1,051,528	4,330,435	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,995,286		5,995,286	14,308	6,009,594	7,986,434	54.00
57.00	05700	COMPUTED TOMOGRAPHY (CT) SCAN	1,586,195		1,586,195	0	1,586,195	9,494,452	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,003,194		1,003,194	0	1,003,194	1,096,438	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,253,005		6,253,005	0	6,253,005	17,079,719	59.00
60.00	06000	LABORATORY	9,164,820		9,164,820	0	9,164,820	24,674,838	60.00
64.00	06400	INTRAVENOUS THERAPY	509,820		509,820	0	509,820	193,443	64.00
65.00	06500	RESPIRATORY THERAPY	2,191,875	0	2,191,875	7,717	2,199,592	3,604,546	65.00
66.00	06600	PHYSICAL THERAPY	1,638,175	0	1,638,175	0	1,638,175	2,193,568	66.00
67.00	06700	OCCUPATIONAL THERAPY	802,698	0	802,698	0	802,698	1,320,705	67.00
68.00	06800	SPEECH PATHOLOGY	432,150	0	432,150	0	432,150	251,173	68.00
69.00	06900	ELECTROCARDIOLOGY	1,620,286		1,620,286	9,039	1,629,325	5,106,046	69.00
70.01	07001	NEUROLOGY	111,646		111,646	5,730	117,376	171,762	70.01
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0		0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,633,380		8,633,380	0	8,633,380	21,260,483	73.00
76.00	03950	ACUTE DIALYSIS	876,247		876,247	0	876,247	661,762	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	381,827		381,827	0	381,827	81,480	90.00
90.01	09001	DIABETES EDUCATION	61,720		61,720	0	61,720	1,554	90.01
90.04	09005	ANTI COAGULATION CLINIC	140,472		140,472	0	140,472	165	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0		0	0	0	0	90.05
91.00	09100	EMERGENCY	5,843,411		5,843,411	33,479	5,876,890	3,510,929	91.00
92.00	09200	OBSERVATION BEDS	532,740		532,740		532,740	230,681	92.00
OTHER REIMBURSABLE COST CENTERS									
99.10	09910	CORF	0		0		0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0	0	99.40
200.00		Subtotal (see instructions)	108,036,315	0	108,036,315	124,771	108,161,086	168,428,402	200.00
201.00		Less Observation Beds	532,740		532,740		532,740		201.00
202.00		Total (see instructions)	107,503,575	0	107,503,575	124,771	107,628,346	168,428,402	202.00
Cost Center Description	Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio				
	Outpatient	Total (col. 6 + col. 7)							
	7.00	8.00							
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	13,321,246						30.00
31.00	03100	INTENSIVE CARE UNIT	4,441,669						31.00
41.00	04100	SUBPROVIDER - IRF	1,019,840						41.00
43.00	04300	NURSERY	818,795						43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	39,211,167	79,856,295	0.332031	0.000000	0.332031		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,197,007	7,128,118	0.208851	0.000000	0.208851		52.00
53.00	05300	ANESTHESIOLOGY	5,867,101	10,197,536	0.098929	0.000000	0.103116		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,114,897	32,101,331	0.186761	0.000000	0.187207		54.00
57.00	05700	COMPUTED TOMOGRAPHY (CT) SCAN	32,355,459	41,849,911	0.037902	0.000000	0.037902		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	9,088,301	10,184,739	0.098500	0.000000	0.098500		58.00
59.00	05900	CARDIAC CATHETERIZATION	8,940,825	26,020,544	0.240310	0.000000	0.240310		59.00
60.00	06000	LABORATORY	24,609,871	49,284,709	0.185957	0.000000	0.185957		60.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description			Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
			Outpatient	Total (col. 6 + col. 7)					
			7.00	8.00	9.00	10.00	11.00		
64.00	06400	INTRAVENOUS THERAPY	1,221,094	1,414,537	0.360415	0.000000	0.360415		64.00
65.00	06500	RESPIRATORY THERAPY	545,715	4,150,261	0.528129	0.000000	0.529989		65.00
66.00	06600	PHYSICAL THERAPY	592,393	2,785,961	0.588011	0.000000	0.588011		66.00
67.00	06700	OCCUPATIONAL THERAPY	217,442	1,538,147	0.521860	0.000000	0.521860		67.00
68.00	06800	SPEECH PATHOLOGY	222,648	473,821	0.912053	0.000000	0.912053		68.00
69.00	06900	ELECTROCARDIOLOGY	5,031,522	10,137,568	0.159830	0.000000	0.160721		69.00
70.01	07001	NEUROLOGY	78,714	250,476	0.445735	0.000000	0.468612		70.01
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0.000000	0.000000	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,540,861	32,801,344	0.263202	0.000000	0.263202		73.00
76.00	03950	ACUTE DIALYSIS	30,000	691,762	1.266689	0.000000	1.266689		76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	270,761	352,241	1.083994	0.000000	1.083994		90.00
90.01	09001	DIABETES EDUCATION	30,778	32,332	1.908945	0.000000	1.908945		90.01
90.04	09005	ANTI COAGULATION CLINIC	71,475	71,640	1.960804	0.000000	1.960804		90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0.000000	0.000000	0.000000		90.05
91.00	09100	EMERGENCY	13,501,881	17,012,810	0.343471	0.000000	0.345439		91.00
92.00	09200	OBSERVATION BEDS	1,371,783	1,602,464	0.332451	0.000000	0.332451		92.00
OTHER REIMBURSABLE COST CENTERS									
99.10	09910	CORF	0	0					99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0					99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0					99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0					99.40
200.00		Subtotal (see instructions)	181,111,695	349,540,097					200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	181,111,695	349,540,097					202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet C
Part I
Date/Time Prepared:
5/21/2013 3:41 pm

			Title XIX		Hospital		PPS		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			
			Total Costs	RCE Diallowance	Total Costs	Inpatient			
			1.00	2.00	3.00	4.00	5.00	6.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	21,626,021		21,626,021	0	21,626,021	13,321,246	30.00
31.00	03100	INTENSIVE CARE UNIT	6,156,232		6,156,232	11,801	6,168,033	4,441,669	31.00
41.00	04100	SUBPROVIDER - IRF	1,936,636		1,936,636	0	1,936,636	1,019,840	41.00
43.00	04300	NURSERY	1,526,171		1,526,171	0	1,526,171	818,795	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	26,514,760		26,514,760	0	26,514,760	40,645,128	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,488,717		1,488,717	0	1,488,717	4,931,111	52.00
53.00	05300	ANESTHESIOLOGY	1,008,831		1,008,831	42,697	1,051,528	4,330,435	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,995,286		5,995,286	14,308	6,009,594	7,986,434	54.00
57.00	05700	COMPUTED TOMOGRAPHY (CT) SCAN	1,586,195		1,586,195	0	1,586,195	9,494,452	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,003,194		1,003,194	0	1,003,194	1,096,438	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,253,005		6,253,005	0	6,253,005	17,079,719	59.00
60.00	06000	LABORATORY	9,164,820		9,164,820	0	9,164,820	24,674,838	60.00
64.00	06400	INTRAVENOUS THERAPY	509,820		509,820	0	509,820	193,443	64.00
65.00	06500	RESPIRATORY THERAPY	2,191,875	0	2,191,875	7,717	2,199,592	3,604,546	65.00
66.00	06600	PHYSICAL THERAPY	1,638,175	0	1,638,175	0	1,638,175	2,193,568	66.00
67.00	06700	OCCUPATIONAL THERAPY	802,698	0	802,698	0	802,698	1,320,705	67.00
68.00	06800	SPEECH PATHOLOGY	432,150	0	432,150	0	432,150	251,173	68.00
69.00	06900	ELECTROCARDIOLOGY	1,620,286		1,620,286	9,039	1,629,325	5,106,046	69.00
70.01	07001	NEUROLOGY	111,646		111,646	5,730	117,376	171,762	70.01
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0		0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,633,380		8,633,380	0	8,633,380	21,260,483	73.00
76.00	03950	ACUTE DIALYSIS	876,247		876,247	0	876,247	661,762	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	381,827		381,827	0	381,827	81,480	90.00
90.01	09001	DIABETES EDUCATION	61,720		61,720	0	61,720	1,554	90.01
90.04	09005	ANTI COAGULATION CLINIC	140,472		140,472	0	140,472	165	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0		0	0	0	0	90.05
91.00	09100	EMERGENCY	5,843,411		5,843,411	33,479	5,876,890	3,510,929	91.00
92.00	09200	OBSERVATION BEDS	532,740		532,740		532,740	230,681	92.00
OTHER REIMBURSABLE COST CENTERS									
99.10	09910	CORF	0		0		0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0	0	99.40
200.00		Subtotal (see instructions)	108,036,315	0	108,036,315	124,771	108,161,086	168,428,402	200.00
201.00		Less Observation Beds	532,740		532,740		532,740		201.00
202.00		Total (see instructions)	107,503,575	0	107,503,575	124,771	107,628,346	168,428,402	202.00
Cost Center Description	Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio				
	Outpatient	Total (col. 6 + col. 7)							
	7.00	8.00							
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	13,321,246						30.00
31.00	03100	INTENSIVE CARE UNIT	4,441,669						31.00
41.00	04100	SUBPROVIDER - IRF	1,019,840						41.00
43.00	04300	NURSERY	818,795						43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	39,211,167	79,856,295	0.332031	0.000000	0.332031		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,197,007	7,128,118	0.208851	0.000000	0.208851		52.00
53.00	05300	ANESTHESIOLOGY	5,867,101	10,197,536	0.098929	0.000000	0.103116		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,114,897	32,101,331	0.186761	0.000000	0.187207		54.00
57.00	05700	COMPUTED TOMOGRAPHY (CT) SCAN	32,355,459	41,849,911	0.037902	0.000000	0.037902		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	9,088,301	10,184,739	0.098500	0.000000	0.098500		58.00
59.00	05900	CARDIAC CATHETERIZATION	8,940,825	26,020,544	0.240310	0.000000	0.240310		59.00
60.00	06000	LABORATORY	24,609,871	49,284,709	0.185957	0.000000	0.185957		60.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet C
Part I
Date/Time Prepared:
5/21/2013 3:41 pm

Cost Center Description			Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	PPS
			Outpatient	Total (col. 6 + col. 7)				
			7.00	8.00	9.00	10.00	11.00	
64.00	06400	INTRAVENOUS THERAPY	1,221,094	1,414,537	0.360415	0.000000	0.360415	64.00
65.00	06500	RESPIRATORY THERAPY	545,715	4,150,261	0.528129	0.000000	0.529989	65.00
66.00	06600	PHYSICAL THERAPY	592,393	2,785,961	0.588011	0.000000	0.588011	66.00
67.00	06700	OCCUPATIONAL THERAPY	217,442	1,538,147	0.521860	0.000000	0.521860	67.00
68.00	06800	SPEECH PATHOLOGY	222,648	473,821	0.912053	0.000000	0.912053	68.00
69.00	06900	ELECTROCARDIOLOGY	5,031,522	10,137,568	0.159830	0.000000	0.160721	69.00
70.01	07001	NEUROLOGY	78,714	250,476	0.445735	0.000000	0.468612	70.01
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0.000000	0.000000	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,540,861	32,801,344	0.263202	0.000000	0.263202	73.00
76.00	03950	ACUTE DIALYSIS	30,000	691,762	1.266689	0.000000	1.266689	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	270,761	352,241	1.083994	0.000000	1.083994	90.00
90.01	09001	DIABETES EDUCATION	30,778	32,332	1.908945	0.000000	1.908945	90.01
90.04	09005	ANTI COAGULATION CLINIC	71,475	71,640	1.960804	0.000000	1.960804	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0.000000	0.000000	0.000000	90.05
91.00	09100	EMERGENCY	13,501,881	17,012,810	0.343471	0.000000	0.345439	91.00
92.00	09200	OBSERVATION BEDS	1,371,783	1,602,464	0.332451	0.000000	0.332451	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0				99.40
200.00		Subtotal (see instructions)	181,111,695	349,540,097				200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	181,111,695	349,540,097				202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet C
Part II
Date/Time Prepared:
5/21/2013 3:41 pm

Cost Center Description		Title XIX					Hospital	PPS
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	26,514,760	1,420,263	25,094,497	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,488,717	55,968	1,432,749	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,008,831	111,325	897,506	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,995,286	621,456	5,373,830	0	0	54.00
57.00	05700	COMPUTED TOMOGRAPHY (CT) SCAN	1,586,195	202,653	1,383,542	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,003,194	169,612	833,582	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,253,005	462,351	5,790,654	0	0	59.00
60.00	06000	LABORATORY	9,164,820	326,174	8,838,646	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	509,820	28,436	481,384	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,191,875	116,574	2,075,301	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,638,175	63,784	1,574,391	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	802,698	23,188	779,510	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	432,150	13,211	418,939	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,620,286	143,219	1,477,067	0	0	69.00
70.01	07001	NEUROLOGY	111,646	5,194	106,452	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,633,380	354,079	8,279,301	0	0	73.00
76.00	03950	ACUTE DIALYSIS	876,247	17,407	858,840	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	381,827	4,745	377,082	0	0	90.00
90.01	09001	DIABETES EDUCATION	61,720	520	61,200	0	0	90.01
90.04	09005	ANTI COAGULATION CLINIC	140,472	1,165	139,307	0	0	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	5,843,411	158,264	5,685,147	0	0	91.00
92.00	09200	OBSERVATION BEDS	532,740	26,902	505,838	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
200.00		Subtotal (sum of lines 50 thru 199)	76,791,255	4,326,490	72,464,765	0	0	200.00
201.00		Less Observation Beds	532,740	26,902	505,838	0	0	201.00
202.00		Total (line 200 minus line 201)	76,258,515	4,299,588	71,958,927	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 140046

Period: From 01/01/2012 To 12/31/2012

Worksheet C Part II Date/Time Prepared: 5/21/2013 3:41 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	26,514,760	79,856,295	0.332031		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,488,717	7,128,118	0.208851		52.00
53.00	05300 ANESTHESIOLOGY	1,008,831	10,197,536	0.098929		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,995,286	32,101,331	0.186761		54.00
57.00	05700 COMPUTED TOMOGRAPHY (CT) SCAN	1,586,195	41,849,911	0.037902		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1,003,194	10,184,739	0.098500		58.00
59.00	05900 CARDIAC CATHETERIZATION	6,253,005	26,020,544	0.240310		59.00
60.00	06000 LABORATORY	9,164,820	49,284,709	0.185957		60.00
64.00	06400 INTRAVENOUS THERAPY	509,820	1,414,537	0.360415		64.00
65.00	06500 RESPIRATORY THERAPY	2,191,875	4,150,261	0.528129		65.00
66.00	06600 PHYSICAL THERAPY	1,638,175	2,785,961	0.588011		66.00
67.00	06700 OCCUPATIONAL THERAPY	802,698	1,538,147	0.521860		67.00
68.00	06800 SPEECH PATHOLOGY	432,150	473,821	0.912053		68.00
69.00	06900 ELECTROCARDIOLOGY	1,620,286	10,137,568	0.159830		69.00
70.01	07001 NEUROLOGY	111,646	250,476	0.445735		70.01
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0.000000		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,633,380	32,801,344	0.263202		73.00
76.00	03950 ACUTE DIALYSIS	876,247	691,762	1.266689		76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	381,827	352,241	1.083994		90.00
90.01	09001 DIABETES EDUCATION	61,720	32,332	1.908945		90.01
90.04	09005 ANTI COAGULATION CLINIC	140,472	71,640	1.960804		90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0.000000		90.05
91.00	09100 EMERGENCY	5,843,411	17,012,810	0.343471		91.00
92.00	09200 OBSERVATION BEDS	532,740	1,602,464	0.332451		92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910 CORF	0	0	0.000000		99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0.000000		99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0.000000		99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0.000000		99.40
200.00	Subtotal (sum of lines 50 thru 199)	76,791,255	329,938,547			200.00
201.00	Less Observation Beds	532,740	0			201.00
202.00	Total (line 200 minus line 201)	76,258,515	329,938,547			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140046		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part I Date/Time Prepared: 5/21/2013 3:41 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,092,056	0	1,092,056	20,500	53.27	30.00
31.00	INTENSIVE CARE UNIT	284,153		284,153	3,305	85.98	31.00
41.00	SUBPROVIDER - IRF	99,775	0	99,775	1,748	57.08	41.00
43.00	NURSERY	44,650		44,650	1,425	31.33	43.00
200.00	Total (lines 30-199)	1,520,634		1,520,634	26,978		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	12,101	644,620				
31.00	INTENSIVE CARE UNIT	2,088	179,526				
41.00	SUBPROVIDER - IRF	1,396	79,684				
43.00	NURSERY	0	0				
200.00	Total (lines 30-199)	15,585	903,830				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet D
Part II
Date/Time Prepared:
5/21/2013 3:41 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,420,263	79,856,295	0.017785	19,811,849	352,354	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	55,968	7,128,118	0.007852	18,025	142	52.00
53.00	05300 ANESTHESIOLOGY	111,325	10,197,536	0.010917	1,560,579	17,037	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	621,456	32,101,331	0.019359	6,363,186	123,185	54.00
57.00	05700 COMPUTED TOMOGRAPHY (CT) SCAN	202,653	41,849,911	0.004842	5,456,839	26,422	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	169,612	10,184,739	0.016654	559,657	9,321	58.00
59.00	05900 CARDIAC CATHETERIZATION	462,351	26,020,544	0.017769	10,116,199	179,755	59.00
60.00	06000 LABORATORY	326,174	49,284,709	0.006618	15,186,705	100,506	60.00
64.00	06400 INTRAVENOUS THERAPY	28,436	1,414,537	0.020103	168,229	3,382	64.00
65.00	06500 RESPIRATORY THERAPY	116,574	4,150,261	0.028088	2,205,439	61,946	65.00
66.00	06600 PHYSICAL THERAPY	63,784	2,785,961	0.022895	1,117,059	25,575	66.00
67.00	06700 OCCUPATIONAL THERAPY	23,188	1,538,147	0.015075	461,894	6,963	67.00
68.00	06800 SPEECH PATHOLOGY	13,211	473,821	0.027882	111,945	3,121	68.00
69.00	06900 ELECTROCARDIOLOGY	143,219	10,137,568	0.014128	3,334,061	47,104	69.00
70.01	07001 NEUROLOGY	5,194	250,476	0.020737	119,214	2,472	70.01
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0.000000	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	354,079	32,801,344	0.010795	11,929,961	128,784	73.00
76.00	03950 ACUTE DIALYSIS	17,407	691,762	0.025163	512,227	12,889	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	4,745	352,241	0.013471	79,850	1,076	90.00
90.01	09001 DIABETES EDUCATION	520	32,332	0.016083	1,032	17	90.01
90.04	09005 ANTI COAGULATION CLINIC	1,165	71,640	0.016262	150	2	90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0.000000	0	0	90.05
91.00	09100 EMERGENCY	158,264	17,012,810	0.009303	1,945,826	18,102	91.00
92.00	09200 OBSERVATION BEDS	26,902	1,602,464	0.016788	92,808	1,558	92.00
200.00	Total (lines 50-199)	4,326,490	329,938,547		81,152,734	1,121,713	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140046		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part III Date/Time Prepared: 5/21/2013 3:41 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	PPS Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	20,500	0.00	12,101	0		30.00
31.00	03100	INTENSIVE CARE UNIT	3,305	0.00	2,088	0		31.00
41.00	04100	SUBPROVIDER - IRF	1,748	0.00	1,396	0		41.00
43.00	04300	NURSERY	1,425	0.00	0	0		43.00
200.00		Total (lines 30-199)	26,978		15,585	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet D
Part IV
Date/Time Prepared:
5/21/2013 3:41 pm

Cost Center Description		Title XVIII				Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
57.00	05700	COMPUTED TOMOGRAPHY (CT) SCAN	0	0	0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
70.01	07001	NEUROLOGY	0	0	0	0	0	70.01	
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
76.00	03950	ACUTE DIALYSIS	0	0	0	0	0	76.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	90.00	
90.01	09001	DIABETES EDUCATION	0	0	0	0	0	90.01	
90.04	09005	ANTI COAGULATION CLINIC	0	0	0	0	0	90.04	
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	0	90.05	
91.00	09100	EMERGENCY	0	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS	0	0	0	0	0	92.00	
200.00		Total (lines 50-199)	0	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet D
Part IV
Date/Time Prepared:
5/21/2013 3:41 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	79,856,295	0.000000	0.000000	19,811,849	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,128,118	0.000000	0.000000	18,025	52.00
53.00	05300	ANESTHESIOLOGY	0	10,197,536	0.000000	0.000000	1,560,579	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	32,101,331	0.000000	0.000000	6,363,186	54.00
57.00	05700	COMPUTED TOMOGRAPHY (CT) SCAN	0	41,849,911	0.000000	0.000000	5,456,839	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	10,184,739	0.000000	0.000000	559,657	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	26,020,544	0.000000	0.000000	10,116,199	59.00
60.00	06000	LABORATORY	0	49,284,709	0.000000	0.000000	15,186,705	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,414,537	0.000000	0.000000	168,229	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,150,261	0.000000	0.000000	2,205,439	65.00
66.00	06600	PHYSICAL THERAPY	0	2,785,961	0.000000	0.000000	1,117,059	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,538,147	0.000000	0.000000	461,894	67.00
68.00	06800	SPEECH PATHOLOGY	0	473,821	0.000000	0.000000	111,945	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,137,568	0.000000	0.000000	3,334,061	69.00
70.01	07001	NEUROLOGY	0	250,476	0.000000	0.000000	119,214	70.01
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0.000000	0.000000	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	32,801,344	0.000000	0.000000	11,929,961	73.00
76.00	03950	ACUTE DIALYSIS	0	691,762	0.000000	0.000000	512,227	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	352,241	0.000000	0.000000	79,850	90.00
90.01	09001	DIABETES EDUCATION	0	32,332	0.000000	0.000000	1,032	90.01
90.04	09005	ANTI COAGULATION CLINIC	0	71,640	0.000000	0.000000	150	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0.000000	0.000000	0	90.05
91.00	09100	EMERGENCY	0	17,012,810	0.000000	0.000000	1,945,826	91.00
92.00	09200	OBSERVATION BEDS	0	1,602,464	0.000000	0.000000	92,808	92.00
200.00		Total (lines 50-199)	0	329,938,547			81,152,734	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/21/2013 3:41 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	10,958,237	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	25,769	0	52.00
53.00	05300 ANESTHESIOLOGY	0	1,668,473	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	10,434,310	0	54.00
57.00	05700 COMPUTED TOMOGRAPHY (CT) SCAN	0	9,595,981	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	3,411,875	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	5,145,370	0	59.00
60.00	06000 LABORATORY	0	1,009,659	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	576,941	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	219,719	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	2,139,981	0	69.00
70.01	07001 NEUROLOGY	0	23,220	0	70.01
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	4,968,552	0	73.00
76.00	03950 ACUTE DIALYSIS	0	24,725	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	192,132	0	90.00
90.01	09001 DIABETES EDUCATION	0	52	0	90.01
90.04	09005 ANTI COAGULATION CLINIC	0	0	0	90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	90.05
91.00	09100 EMERGENCY	0	2,591,230	0	91.00
92.00	09200 OBSERVATION BEDS	0	475,432	0	92.00
200.00	Total (lines 50-199)	0	53,461,658	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/21/2013 3:41 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0.332031	10,958,237	0	0	3,638,474	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.208851	25,769	0	0	5,382	52.00	
53.00 05300 ANESTHESIOLOGY	0.098929	1,668,473	0	0	165,060	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.186761	10,434,310	0	0	1,948,722	54.00	
57.00 05700 COMPUTED TOMOGRAPHY (CT) SCAN	0.037902	9,595,981	0	0	363,707	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.098500	3,411,875	0	0	336,070	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0.240310	5,145,370	0	0	1,236,484	59.00	
60.00 06000 LABORATORY	0.185957	1,009,659	0	0	187,753	60.00	
64.00 06400 INTRAVENOUS THERAPY	0.360415	576,941	0	0	207,938	64.00	
65.00 06500 RESPIRATORY THERAPY	0.528129	219,719	0	0	116,040	65.00	
66.00 06600 PHYSICAL THERAPY	0.588011	0	0	0	0	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0.521860	0	0	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0.912053	0	0	0	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	0.159830	2,139,981	0	0	342,033	69.00	
70.01 07001 NEUROLOGY	0.445735	23,220	0	0	10,350	70.01	
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0.000000	0	0	0	0	71.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0.263202	4,968,552	0	100,502	1,307,733	73.00	
76.00 03950 ACUTE DIALYSIS	1.266689	24,725	0	0	31,319	76.00	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	1.083994	192,132	0	0	208,270	90.00	
90.01 09001 DIABETES EDUCATION	1.908945	52	0	0	99	90.01	
90.04 09005 ANTI COAGULATION CLINIC	1.960804	0	0	0	0	90.04	
90.05 09003 OUTPATIENT PSYCHIATRIC SERVICES	0.000000	0	0	0	0	90.05	
91.00 09100 EMERGENCY	0.343471	2,591,230	0	0	890,012	91.00	
92.00 09200 OBSERVATION BEDS	0.332451	475,432	0	0	158,058	92.00	
200.00		Subtotal (see instructions)	53,461,658	0	100,502	11,153,504	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0	0		201.00
202.00		Net Charges (line 200 +/- line 201)	53,461,658	0	100,502	11,153,504	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/21/2013 3:41 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00 05700 COMPUTED TOMOGRAPHY (CT) SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.01 07001 NEUROLOGY	0	0		70.01
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0		71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	26,452		73.00
76.00 03950 ACUTE DIALYSIS	0	0		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 DIABETES EDUCATION	0	0		90.01
90.04 09005 ANTI COAGULATION CLINIC	0	0		90.04
90.05 09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0		90.05
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS	0	0		92.00
200.00 Subtotal (see instructions)	0	26,452		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	26,452		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part II Date/Time Prepared: 5/21/2013 3:41 pm
		Component CCN: 14T046	Title XVIII	Subprovider - IRF
				PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,420,263	79,856,295	0.017785	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	55,968	7,128,118	0.007852	0	0	52.00
53.00	05300 ANESTHESIOLOGY	111,325	10,197,536	0.010917	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	621,456	32,101,331	0.019359	9,987	193	54.00
57.00	05700 COMPUTED TOMOGRAPHY (CT) SCAN	202,653	41,849,911	0.004842	1,958	9	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	169,612	10,184,739	0.016654	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	462,351	26,020,544	0.017769	0	0	59.00
60.00	06000 LABORATORY	326,174	49,284,709	0.006618	179,710	1,189	60.00
64.00	06400 INTRAVENOUS THERAPY	28,436	1,414,537	0.020103	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	116,574	4,150,261	0.028088	30,145	847	65.00
66.00	06600 PHYSICAL THERAPY	63,784	2,785,961	0.022895	532,886	12,200	66.00
67.00	06700 OCCUPATIONAL THERAPY	23,188	1,538,147	0.015075	550,737	8,302	67.00
68.00	06800 SPEECH PATHOLOGY	13,211	473,821	0.027882	79,447	2,215	68.00
69.00	06900 ELECTROCARDIOLOGY	143,219	10,137,568	0.014128	0	0	69.00
70.01	07001 NEUROLOGY	5,194	250,476	0.020737	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0.000000	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	354,079	32,801,344	0.010795	186,780	2,016	73.00
76.00	03950 ACUTE DIALYSIS	17,407	691,762	0.025163	15,188	382	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	4,745	352,241	0.013471	0	0	90.00
90.01	09001 DIABETES EDUCATION	520	32,332	0.016083	0	0	90.01
90.04	09005 ANTI COAGULATION CLINIC	1,165	71,640	0.016262	0	0	90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0.000000	0	0	90.05
91.00	09100 EMERGENCY	158,264	17,012,810	0.009303	0	0	91.00
92.00	09200 OBSERVATION BEDS	0	1,602,464	0.000000	0	0	92.00
200.00	Total (lines 50-199)	4,299,588	329,938,547		1,586,838	27,353	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140046 Component CCN: 14T046	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/21/2013 3:41 pm
		Title XVIII	Subprovider - IRF

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700 COMPUTED TOMOGRAPHY (CT) SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.01	07001 NEUROLOGY	0	0	0	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950 ACUTE DIALYSIS	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 DIABETES EDUCATION	0	0	0	0	0	90.01
90.04	09005 ANTI COAGULATION CLINIC	0	0	0	0	0	90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	0	90.05
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140046 Component CCN: 14T046	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/21/2013 3:41 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	79,856,295	0.000000	0.000000	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	7,128,118	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	10,197,536	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	32,101,331	0.000000	0.000000	9,987	54.00
57.00	05700 COMPUTED TOMOGRAPHY (CT) SCAN	0	41,849,911	0.000000	0.000000	1,958	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	10,184,739	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	26,020,544	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	49,284,709	0.000000	0.000000	179,710	60.00
64.00	06400 INTRAVENOUS THERAPY	0	1,414,537	0.000000	0.000000	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	4,150,261	0.000000	0.000000	30,145	65.00
66.00	06600 PHYSICAL THERAPY	0	2,785,961	0.000000	0.000000	532,886	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,538,147	0.000000	0.000000	550,737	67.00
68.00	06800 SPEECH PATHOLOGY	0	473,821	0.000000	0.000000	79,447	68.00
69.00	06900 ELECTROCARDIOLOGY	0	10,137,568	0.000000	0.000000	0	69.00
70.01	07001 NEUROLOGY	0	250,476	0.000000	0.000000	0	70.01
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0.000000	0.000000	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	32,801,344	0.000000	0.000000	186,780	73.00
76.00	03950 ACUTE DIALYSIS	0	691,762	0.000000	0.000000	15,188	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	352,241	0.000000	0.000000	0	90.00
90.01	09001 DIABETES EDUCATION	0	32,332	0.000000	0.000000	0	90.01
90.04	09005 ANTI COAGULATION CLINIC	0	71,640	0.000000	0.000000	0	90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0.000000	0.000000	0	90.05
91.00	09100 EMERGENCY	0	17,012,810	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS	0	1,602,464	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	329,938,547			1,586,838	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/21/2013 3:41 pm
	Component CCN: 14T046	Title XVIII	Subprovider - IRF PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
57.00 05700 COMPUTED TOMOGRAPHY (CT) SCAN	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.01 07001 NEUROLOGY	0	0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00 03950 ACUTE DIALYSIS	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0	0	90.00
90.01 09001 DIABETES EDUCATION	0	0	0	90.01
90.04 09005 ANTI COAGULATION CLINIC	0	0	0	90.04
90.05 09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	90.05
91.00 09100 EMERGENCY	0	0	0	91.00
92.00 09200 OBSERVATION BEDS	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140046		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part I Date/Time Prepared: 5/21/2013 3:41 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,092,056	0	1,092,056	20,500	53.27	30.00
31.00	INTENSIVE CARE UNIT	284,153		284,153	3,305	85.98	31.00
41.00	SUBPROVIDER - IRF	99,775	0	99,775	1,748	57.08	41.00
43.00	NURSERY	44,650		44,650	1,425	31.33	43.00
200.00	Total (lines 30-199)	1,520,634		1,520,634	26,978		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	2,807	149,529				
31.00	INTENSIVE CARE UNIT	364	31,297				
41.00	SUBPROVIDER - IRF	34	1,941				
43.00	NURSERY	886	27,758				
200.00	Total (lines 30-199)	4,091	210,525				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet D
Part II
Date/Time Prepared:
5/21/2013 3:41 pm

Cost Center Description		Title XIX			Hospital	PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,420,263	79,856,295	0.017785	4,215,092	74,965	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	55,968	7,128,118	0.007852	2,885,436	22,656	52.00
53.00	05300 ANESTHESIOLOGY	111,325	10,197,536	0.010917	1,071,227	11,695	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	621,456	32,101,331	0.019359	807,437	15,631	54.00
57.00	05700 COMPUTED TOMOGRAPHY (CT) SCAN	202,653	41,849,911	0.004842	1,085,696	5,257	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	169,612	10,184,739	0.016654	106,691	1,777	58.00
59.00	05900 CARDIAC CATHETERIZATION	462,351	26,020,544	0.017769	1,155,482	20,532	59.00
60.00	06000 LABORATORY	326,174	49,284,709	0.006618	2,935,518	19,427	60.00
64.00	06400 INTRAVENOUS THERAPY	28,436	1,414,537	0.020103	1,315	26	64.00
65.00	06500 RESPIRATORY THERAPY	116,574	4,150,261	0.028088	416,986	11,712	65.00
66.00	06600 PHYSICAL THERAPY	63,784	2,785,961	0.022895	98,484	2,255	66.00
67.00	06700 OCCUPATIONAL THERAPY	23,188	1,538,147	0.015075	44,035	664	67.00
68.00	06800 SPEECH PATHOLOGY	13,211	473,821	0.027882	10,314	288	68.00
69.00	06900 ELECTROCARDIOLOGY	143,219	10,137,568	0.014128	397,745	5,619	69.00
70.01	07001 NEUROLOGY	5,194	250,476	0.020737	14,934	310	70.01
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0.000000	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	354,079	32,801,344	0.010795	2,958,168	31,933	73.00
76.00	03950 ACUTE DIALYSIS	17,407	691,762	0.025163	29,371	739	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	4,745	352,241	0.013471	0	0	90.00
90.01	09001 DIABETES EDUCATION	520	32,332	0.016083	0	0	90.01
90.04	09005 ANTI COAGULATION CLINIC	1,165	71,640	0.016262	0	0	90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0.000000	0	0	90.05
91.00	09100 EMERGENCY	158,264	17,012,810	0.009303	394,644	3,671	91.00
92.00	09200 OBSERVATION BEDS	26,902	1,602,464	0.016788	0	0	92.00
200.00	Total (lines 50-199)	4,326,490	329,938,547		18,628,575	229,157	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140046		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part III Date/Time Prepared: 5/21/2013 3:41 pm	
Cost Center Description			Title XIX		Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	20,500	0.00	2,807	0		30.00
31.00	03100	INTENSIVE CARE UNIT	3,305	0.00	364	0		31.00
41.00	04100	SUBPROVIDER - IRF	1,748	0.00	34	0		41.00
43.00	04300	NURSERY	1,425	0.00	886	0		43.00
200.00		Total (lines 30-199)	26,978		4,091	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/21/2013 3:41 pm
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Cost Center Description	Title XIX				Hospital	PPS
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00 05700 COMPUTED TOMOGRAPHY (CT) SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.01 07001 NEUROLOGY	0	0	0	0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03950 ACUTE DIALYSIS	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 DIABETES EDUCATION	0	0	0	0	0	90.01
90.04 09005 ANTI COAGULATION CLINIC	0	0	0	0	0	90.04
90.05 09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	0	90.05
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet D
Part IV
Date/Time Prepared:
5/21/2013 3:41 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	79,856,295	0.000000	0.000000	4,215,092	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,128,118	0.000000	0.000000	2,885,436	52.00
53.00	05300	ANESTHESIOLOGY	0	10,197,536	0.000000	0.000000	1,071,227	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	32,101,331	0.000000	0.000000	807,437	54.00
57.00	05700	COMPUTED TOMOGRAPHY (CT) SCAN	0	41,849,911	0.000000	0.000000	1,085,696	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	10,184,739	0.000000	0.000000	106,691	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	26,020,544	0.000000	0.000000	1,155,482	59.00
60.00	06000	LABORATORY	0	49,284,709	0.000000	0.000000	2,935,518	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,414,537	0.000000	0.000000	1,315	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,150,261	0.000000	0.000000	416,986	65.00
66.00	06600	PHYSICAL THERAPY	0	2,785,961	0.000000	0.000000	98,484	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,538,147	0.000000	0.000000	44,035	67.00
68.00	06800	SPEECH PATHOLOGY	0	473,821	0.000000	0.000000	10,314	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,137,568	0.000000	0.000000	397,745	69.00
70.01	07001	NEUROLOGY	0	250,476	0.000000	0.000000	14,934	70.01
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0.000000	0.000000	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	32,801,344	0.000000	0.000000	2,958,168	73.00
76.00	03950	ACUTE DIALYSIS	0	691,762	0.000000	0.000000	29,371	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	352,241	0.000000	0.000000	0	90.00
90.01	09001	DIABETES EDUCATION	0	32,332	0.000000	0.000000	0	90.01
90.04	09005	ANTI COAGULATION CLINIC	0	71,640	0.000000	0.000000	0	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0.000000	0.000000	0	90.05
91.00	09100	EMERGENCY	0	17,012,810	0.000000	0.000000	394,644	91.00
92.00	09200	OBSERVATION BEDS	0	1,602,464	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	329,938,547			18,628,575	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet D
Part IV
Date/Time Prepared:
5/21/2013 3:41 pm

Cost Center Description		Title XIX			Hospital	PPS
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700 COMPUTED TOMOGRAPHY (CT) SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
70.01	07001 NEUROLOGY	0	0	0		70.01
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03950 ACUTE DIALYSIS	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
90.01	09001 DIABETES EDUCATION	0	0	0		90.01
90.04	09005 ANTI COAGULATION CLINIC	0	0	0		90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0		90.05
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS	0	0	0		92.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part II Date/Time Prepared: 5/21/2013 3:41 pm
		Component CCN: 14T046	Title XIX	Subprovider - IRF
				PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,420,263	79,856,295	0.017785	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	55,968	7,128,118	0.007852	0	0	52.00
53.00	05300 ANESTHESIOLOGY	111,325	10,197,536	0.010917	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	621,456	32,101,331	0.019359	1,264	24	54.00
57.00	05700 COMPUTED TOMOGRAPHY (CT) SCAN	202,653	41,849,911	0.004842	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	169,612	10,184,739	0.016654	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	462,351	26,020,544	0.017769	0	0	59.00
60.00	06000 LABORATORY	326,174	49,284,709	0.006618	6,252	41	60.00
64.00	06400 INTRAVENOUS THERAPY	28,436	1,414,537	0.020103	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	116,574	4,150,261	0.028088	154	4	65.00
66.00	06600 PHYSICAL THERAPY	63,784	2,785,961	0.022895	12,315	282	66.00
67.00	06700 OCCUPATIONAL THERAPY	23,188	1,538,147	0.015075	12,233	184	67.00
68.00	06800 SPEECH PATHOLOGY	13,211	473,821	0.027882	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	143,219	10,137,568	0.014128	0	0	69.00
70.01	07001 NEUROLOGY	5,194	250,476	0.020737	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0.000000	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	354,079	32,801,344	0.010795	12,386	134	73.00
76.00	03950 ACUTE DIALYSIS	17,407	691,762	0.025163	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	4,745	352,241	0.013471	0	0	90.00
90.01	09001 DIABETES EDUCATION	520	32,332	0.016083	0	0	90.01
90.04	09005 ANTI COAGULATION CLINIC	1,165	71,640	0.016262	0	0	90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0.000000	0	0	90.05
91.00	09100 EMERGENCY	158,264	17,012,810	0.009303	0	0	91.00
92.00	09200 OBSERVATION BEDS	0	1,602,464	0.000000	0	0	92.00
200.00	Total (lines 50-199)	4,299,588	329,938,547		44,604	669	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140046 Component CCN: 14T046	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/21/2013 3:41 pm
Title XIX		Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	COMPUTED TOMOGRAPHY (CT) SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.01	07001	NEUROLOGY	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	ACUTE DIALYSIS	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	DIABETES EDUCATION	0	0	0	0	90.01
90.04	09005	ANTI COAGULATION CLINIC	0	0	0	0	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140046 Component CCN: 14T046	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/21/2013 3:41 pm
Title XIX		Subprovider - IRF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient Program Charges	
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 + col. 7)	Ratio of Cost to Charges (col. 6 + col. 7)		
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	79,856,295	0.000000	0.000000	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	7,128,118	0.000000	0.000000	0	52.00
53.00 05300 ANESTHESIOLOGY	0	10,197,536	0.000000	0.000000	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	32,101,331	0.000000	0.000000	1,264	54.00
57.00 05700 COMPUTED TOMOGRAPHY (CT) SCAN	0	41,849,911	0.000000	0.000000	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	10,184,739	0.000000	0.000000	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	26,020,544	0.000000	0.000000	0	59.00
60.00 06000 LABORATORY	0	49,284,709	0.000000	0.000000	6,252	60.00
64.00 06400 INTRAVENOUS THERAPY	0	1,414,537	0.000000	0.000000	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	4,150,261	0.000000	0.000000	154	65.00
66.00 06600 PHYSICAL THERAPY	0	2,785,961	0.000000	0.000000	12,315	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	1,538,147	0.000000	0.000000	12,233	67.00
68.00 06800 SPEECH PATHOLOGY	0	473,821	0.000000	0.000000	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	10,137,568	0.000000	0.000000	0	69.00
70.01 07001 NEUROLOGY	0	250,476	0.000000	0.000000	0	70.01
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0.000000	0.000000	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	32,801,344	0.000000	0.000000	12,386	73.00
76.00 03950 ACUTE DIALYSIS	0	691,762	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	352,241	0.000000	0.000000	0	90.00
90.01 09001 DIABETES EDUCATION	0	32,332	0.000000	0.000000	0	90.01
90.04 09005 ANTI COAGULATION CLINIC	0	71,640	0.000000	0.000000	0	90.04
90.05 09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0.000000	0.000000	0	90.05
91.00 09100 EMERGENCY	0	17,012,810	0.000000	0.000000	0	91.00
92.00 09200 OBSERVATION BEDS	0	1,602,464	0.000000	0.000000	0	92.00
200.00 Total (lines 50-199)	0	329,938,547			44,604	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/21/2013 3:41 pm
	Component CCN: 14T046	Title XIX	Subprovider - IRF

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
57.00 05700 COMPUTED TOMOGRAPHY (CT) SCAN	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.01 07001 NEUROLOGY	0	0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00 03950 ACUTE DIALYSIS	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0	0	90.00
90.01 09001 DIABETES EDUCATION	0	0	0	90.01
90.04 09005 ANTICOAGULATION CLINIC	0	0	0	90.04
90.05 09003 OUTPATIENT PSYCHIATRIC SERVICES	0	0	0	90.05
91.00 09100 EMERGENCY	0	0	0	91.00
92.00 09200 OBSERVATION BEDS	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/21/2013 3:41 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		20,500	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		20,500	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		324	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		19,671	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		12,101	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		21,626,021	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		21,626,021	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		13,122,470	28.00
29.00	Private room charges (excluding swing-bed charges)		198,776	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		12,923,694	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.648015	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		613.51	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		656.99	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		21,626,021	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,054.93	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		12,765,708	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		12,765,708	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/21/2013 3:41 pm		
Cost Center Description			Title XVIII		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	6,168,033	3,305	1,866.27	2,088	3,896,772	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					20,852,973	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					37,515,453	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					824,146	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,121,713	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,945,859	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					35,569,594	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					505	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,054.93	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					532,740	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140046		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/21/2013 3:41 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,092,056	21,626,021	0.050497	532,740	26,902	90.00
91.00	Nursing School cost	0	21,626,021	0.000000	532,740	0	91.00
92.00	Allied health cost	0	21,626,021	0.000000	532,740	0	92.00
93.00	All other Medical Education	0	21,626,021	0.000000	532,740	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Component CCN: 14T046		Date/Time Prepared: 5/21/2013 3:41 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,748	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,748	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,748	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,396	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,936,636	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,936,636	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		793,252	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		793,252	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		2.441388	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		453.81	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,936,636	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,107.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,546,656	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,546,656	41.00

COMPUTATION OF INPATIENT OPERATING COST					Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
					Component CCN: 14T046		Date/Time Prepared: 5/21/2013 3:41 pm
					Title XVIII	Subprovider - IRF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					792,949		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,339,605		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					79,684		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					27,353		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					107,037		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,232,568		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140046 Component CCN: 14T046		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/21/2013 3:41 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	99,775	1,936,636	0.051520	0	0	90.00
91.00	Nursing School cost	0	1,936,636	0.000000	0	0	91.00
92.00	Allied health cost	0	1,936,636	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,936,636	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/21/2013 3:41 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		20,500	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		20,500	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		324	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		19,671	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,807	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		1,425	15.00
16.00	Nursery days (title V or XIX only)		886	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		21,626,021	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		21,626,021	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		13,122,470	28.00
29.00	Private room charges (excluding swing-bed charges)		198,776	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		12,923,694	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.648015	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		613.51	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		656.99	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		21,626,021	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,054.93	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,961,189	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,961,189	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/21/2013 3:41 pm		
Cost Center Description			Title XIX		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00	NURSERY (title V & XIX only)	1,526,171	1,425	1,071.00	886	948,906	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	6,168,033	3,305	1,866.27	364	679,322	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					4,473,817	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					9,063,234	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					208,584	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					229,157	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					437,741	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					8,625,493	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					505	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,054.93	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					532,740	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140046		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/21/2013 3:41 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,092,056	21,626,021	0.050497	532,740	26,902	90.00
91.00	Nursing School cost	0	21,626,021	0.000000	532,740	0	91.00
92.00	Allied health cost	0	21,626,021	0.000000	532,740	0	92.00
93.00	All other Medical Education	0	21,626,021	0.000000	532,740	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Component CCN: 14T046		Date/Time Prepared: 5/21/2013 3:41 pm
		Title XIX	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,748	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,748	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,748	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		34	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		1,425	15.00
16.00	Nursery days (title V or XIX only)		886	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,936,636	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,936,636	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		793,252	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		793,252	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		2.441388	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		453.81	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,936,636	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,107.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		37,669	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		37,669	41.00

COMPUTATION OF INPATIENT OPERATING COST					Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
					Component CCN: 14T046		Date/Time Prepared: 5/21/2013 3:41 pm
					Title XIX	Subprovider - IRF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
						1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						18,367	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						56,036	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						1,941	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						669	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						2,610	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53,426	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140046 Component CCN: 14T046		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/21/2013 3:41 pm	
		Title XIX		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	99,775	1,936,636	0.051520	0	0	90.00
91.00	Nursing School cost	0	1,936,636	0.000000	0	0	91.00
92.00	Allied health cost	0	1,936,636	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,936,636	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/21/2013 3:41 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		7,957,534	30.00
31.00	03100	INTENSIVE CARE UNIT		2,766,122	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.332031	19,811,849	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.208851	18,025	52.00
53.00	05300	ANESTHESIOLOGY	0.103116	1,560,579	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.187207	6,363,186	54.00
57.00	05700	COMPUTED TOMOGRAPHY (CT) SCAN	0.037902	5,456,839	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.098500	559,657	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.240310	10,116,199	59.00
60.00	06000	LABORATORY	0.185957	15,186,705	60.00
64.00	06400	INTRAVENOUS THERAPY	0.360415	168,229	64.00
65.00	06500	RESPIRATORY THERAPY	0.529989	2,205,439	65.00
66.00	06600	PHYSICAL THERAPY	0.588011	1,117,059	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.521860	461,894	67.00
68.00	06800	SPEECH PATHOLOGY	0.912053	111,945	68.00
69.00	06900	ELECTROCARDIOLOGY	0.160721	3,334,061	69.00
70.01	07001	NEUROLOGY	0.468612	119,214	70.01
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0.000000	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.263202	11,929,961	73.00
76.00	03950	ACUTE DIALYSIS	1.266689	512,227	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.083994	79,850	90.00
90.01	09001	DIABETES EDUCATION	1.908945	1,032	90.01
90.04	09005	ANTI COAGULATION CLINIC	1.960804	150	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0.000000	0	90.05
91.00	09100	EMERGENCY	0.345439	1,945,826	91.00
92.00	09200	OBSERVATION BEDS	0.332451	92,808	92.00
200.00		Total (sum of lines 50-94 and 96-98)		81,152,734	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		81,152,734	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140046 Component CCN: 14T046	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/21/2013 3:41 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
41.00	04100 SUBPROVIDER - IRF		817,338	41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.332031	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.208851	0	52.00
53.00	05300 ANESTHESIOLOGY	0.103116	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.187207	9,987	54.00
57.00	05700 COMPUTED TOMOGRAPHY (CT) SCAN	0.037902	1,958	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.098500	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.240310	0	59.00
60.00	06000 LABORATORY	0.185957	179,710	60.00
64.00	06400 INTRAVENOUS THERAPY	0.360415	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.529989	30,145	65.00
66.00	06600 PHYSICAL THERAPY	0.588011	532,886	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.521860	550,737	67.00
68.00	06800 SPEECH PATHOLOGY	0.912053	79,447	68.00
69.00	06900 ELECTROCARDIOLOGY	0.160721	0	69.00
70.01	07001 NEUROLOGY	0.468612	0	70.01
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0.000000	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.263202	186,780	73.00
76.00	03950 ACUTE DIALYSIS	1.266689	15,188	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	1.083994	0	90.00
90.01	09001 DIABETES EDUCATION	1.908945	0	90.01
90.04	09005 ANTI COAGULATION CLINIC	1.960804	0	90.04
90.05	09003 OUTPATIENT PSYCHIATRIC SERVICES	0.000000	0	90.05
91.00	09100 EMERGENCY	0.345439	0	91.00
92.00	09200 OBSERVATION BEDS	0.332451	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,586,838	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net Charges (line 200 minus line 201)		1,586,838	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/21/2013 3:41 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,741,168	30.00
31.00	03100	INTENSIVE CARE UNIT		514,106	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		507,037	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.332031	4,215,092	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.208851	2,885,436	52.00
53.00	05300	ANESTHESIOLOGY	0.103116	1,071,227	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.187207	807,437	54.00
57.00	05700	COMPUTED TOMOGRAPHY (CT) SCAN	0.037902	1,085,696	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.098500	106,691	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.240310	1,155,482	59.00
60.00	06000	LABORATORY	0.185957	2,935,518	60.00
64.00	06400	INTRAVENOUS THERAPY	0.360415	1,315	64.00
65.00	06500	RESPIRATORY THERAPY	0.529989	416,986	65.00
66.00	06600	PHYSICAL THERAPY	0.588011	98,484	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.521860	44,035	67.00
68.00	06800	SPEECH PATHOLOGY	0.912053	10,314	68.00
69.00	06900	ELECTROCARDIOLOGY	0.160721	397,745	69.00
70.01	07001	NEUROLOGY	0.468612	14,934	70.01
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0.000000	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.263202	2,958,168	73.00
76.00	03950	ACUTE DIALYSIS	1.266689	29,371	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.083994	0	90.00
90.01	09001	DIABETES EDUCATION	1.908945	0	90.01
90.04	09005	ANTI COAGULATION CLINIC	1.960804	0	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0.000000	0	90.05
91.00	09100	EMERGENCY	0.345439	394,644	91.00
92.00	09200	OBSERVATION BEDS	0.332451	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		18,628,575	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		18,628,575	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3	
		Component CCN: 14T046		Date/Time Prepared: 5/21/2013 3:41 pm	
		Title XIX	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
41.00	04100	SUBPROVIDER - IRF		16,965	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.332031	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.208851	0	52.00
53.00	05300	ANESTHESIOLOGY	0.103116	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.187207	1,264	54.00
57.00	05700	COMPUTED TOMOGRAPHY (CT) SCAN	0.037902	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.098500	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.240310	0	59.00
60.00	06000	LABORATORY	0.185957	6,252	60.00
64.00	06400	INTRAVENOUS THERAPY	0.360415	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.529989	154	65.00
66.00	06600	PHYSICAL THERAPY	0.588011	12,315	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.521860	12,233	67.00
68.00	06800	SPEECH PATHOLOGY	0.912053	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.160721	0	69.00
70.01	07001	NEUROLOGY	0.468612	0	70.01
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0.000000	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.263202	12,386	73.00
76.00	03950	ACUTE DIALYSIS	1.266689	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.083994	0	90.00
90.01	09001	DIABETES EDUCATION	1.908945	0	90.01
90.04	09005	ANTI COAGULATION CLINIC	1.960804	0	90.04
90.05	09003	OUTPATIENT PSYCHIATRIC SERVICES	0.000000	0	90.05
91.00	09100	EMERGENCY	0.345439	0	91.00
92.00	09200	OBSERVATION BEDS	0.332451	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		44,604	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		44,604	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/21/2013 3:41 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		25,889,191	1.00
2.00	Outlier payments for discharges. (see instructions)		929,385	2.00
2.01	Outlier reconciliation amount		0	2.01
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		129.62	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.83	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		16.76	31.00
32.00	Sum of lines 30 and 31		21.59	32.00
33.00	Allowable disproportionate share percentage (see instructions)		7.03	33.00
34.00	Disproportionate share adjustment (see instructions)		1,820,010	34.00
Additional payment for high percentage of ESRD beneficiary discharges				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0	46.00
47.00	Subtotal (see instructions)		28,638,586	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		28,638,586	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		2,108,929	50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0	56.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/21/2013 3:41 pm
		Title XVIII	Hospital	PPS
		1.00		
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).			0 57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)			0 58.00
59.00	Total (sum of amounts on lines 49 through 58)			30,747,515 59.00
60.00	Primary payer payments			5,165 60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			30,742,350 61.00
62.00	Deductibles billed to program beneficiaries			2,648,295 62.00
63.00	Coinurance billed to program beneficiaries			24,854 63.00
64.00	Allowable bad debts (see instructions)			740,336 64.00
65.00	Adjusted reimbursable bad debts (see instructions)			518,235 65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			606,985 66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			28,587,436 67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)			0 68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)			0 69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 70.00
70.93	HVBP incentive payment (see instructions)			13,763 70.93
70.94	Hospital readmissions reduction adjustment (see instructions)			-62,557 70.94
70.95	Recovery of Accelerated Depreciation			0 70.95
70.96	Low Volume Payment-1			0 70.96
70.97	Low Volume Payment-2			0 70.97
70.98	Low Volume Payment-3			0 70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			28,538,642 71.00
72.00	Interim payments			28,689,395 72.00
73.00	Tentative settlement (for contractor use only)			0 73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)			-150,753 74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			600,000 75.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)			0 90.00
91.00	Capital outlier from Worksheet L, Part I, line 2			0 91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0 92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0 93.00
94.00	The rate used to calculate the Time Value of Money			0.00 94.00
95.00	Time Value of Money for operating expenses(see instructions)			0 95.00
96.00	Time Value of Money for capital related expenses (see instructions)			0 96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/21/2013 3:41 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			26,452 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			11,153,504 2.00
3.00	PPS payments			9,613,606 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			26,452 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			100,502 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			100,502 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			100,502 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			74,050 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			26,452 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			9,613,606 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			0 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,118,411 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			7,521,647 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			7,521,647 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			7,521,647 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			538,401 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			376,881 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			447,592 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			7,898,528 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.98	AB Re-billing demo amount (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			7,898,528 40.00
41.00	Interim payments			7,913,007 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)			-14,479 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet E-1
Part I
Date/Time Prepared:
5/21/2013 3:41 pm

Title XVIII

Hospital

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		28,689,395		7,913,007	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		28,689,395		7,913,007	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		150,753		14,479	6.02
7.00	Total Medicare program liability (see instructions)		28,538,642		7,898,528	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140046
Component CCN: 14T046

Period:
From 01/01/2012
To 12/31/2012

Worksheet E-1
Part I
Date/Time Prepared:
5/21/2013 3:41 pm

Title XVIII

Subprovider -
IRF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider				0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		2,112,225		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,112,225		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		9,224		0	6.02
7.00	Total Medicare program liability (see instructions)		2,103,001		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

		Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet E-1 Part II Date/Time Prepared: 5/21/2013 3:41 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14		6,436	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12		14,189	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2		281	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12		23,300	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200		349,540,097	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20		10,603,248	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168		0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)		0	8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)		0	30.00
31.00	Other Adjustment (specify)		0	31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)		0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140046 Component CCN: 14T046	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part III Date/Time Prepared: 5/21/2013 3:41 pm
		Title XVIIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			2,067,842 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0464 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			61,737 3.00
4.00	Outlier Payments			1,918 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			4.775956 10.00
11.00	Medical Education Adjustment Factor {{{(1 + (line 9/line 10)) raised to the power of .6876 -1}}.			0.000000 11.00
12.00	Medical Education Adjustment (line 1 multiplied by line 11).			0 12.00
13.00	Total PPS Payment (sum of lines 1, 3, 4 and 12)			2,131,497 13.00
14.00	Nursing and Allied Health Managed Care payment (see instruction)			0 14.00
15.00	Organ acquisition			0 15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 16.00
17.00	Subtotal (see instructions)			2,131,497 17.00
18.00	Primary payer payments			10,000 18.00
19.00	Subtotal (line 17 less line 18).			2,121,497 19.00
20.00	Deductibles			12,716 20.00
21.00	Subtotal (line 19 minus line 20)			2,108,781 21.00
22.00	Coinsurance			5,780 22.00
23.00	Subtotal (line 21 minus line 22)			2,103,001 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			0 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			2,103,001 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			2,103,001 32.00
33.00	Interim payments			2,112,225 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus the sum lines 33 and 34)			-9,224 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4			1,918 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part VII Date/Time Prepared: 5/21/2013 3:41 pm	
		Title XIX	Hospital	PPS	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		18,628,575	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		18,628,575	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		18,628,575	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		18,628,575	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140046 Component CCN: 14T046	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part VII Date/Time Prepared: 5/21/2013 3:41 pm	
		Title XIX	Subprovider - IRF	PPS	
				Inpatient 1.00	Outpatient 2.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		44,604	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		44,604	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		44,604	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		44,604	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0	0	24.00
25.00	Capital exception payments (see instructions)		0	0	25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet G

Date/Time Prepared:
5/21/2013 3:41 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,516,631	0	0	0	1.00
2.00	Temporary investments	354,906	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	31,884,086	0	0	0	4.00
5.00	Other receivable	1,906,865	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-6,674,000	0	0	0	6.00
7.00	Inventory	3,902,014	0	0	0	7.00
8.00	Prepaid expenses	1,079,461	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	33,969,963	0	0	0	11.00
FIXED ASSETS						
12.00	Land	864,622	0	0	0	12.00
13.00	Land improvements	1,477,611	0	0	0	13.00
14.00	Accumulated depreciation	-1,099,776	0	0	0	14.00
15.00	Buildings	24,887,014	0	0	0	15.00
16.00	Accumulated depreciation	-14,238,330	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	204,898,193	0	0	0	19.00
20.00	Accumulated depreciation	-1,591,524	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	42,423,931	0	0	0	23.00
24.00	Accumulated depreciation	-35,659,462	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	221,962,279	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	9,842,756	1,068,929	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	9,842,756	1,068,929	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	265,774,998	1,068,929	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	18,582,228	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,247,902	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	7,467,203	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	29,297,333	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	118,472,567	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	7,248,747	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	125,721,314	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	155,018,647	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	110,756,351				52.00
53.00	Specific purpose fund		1,068,929			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	110,756,351	1,068,929	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	265,774,998	1,068,929	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet G-1

Date/Time Prepared:
5/21/2013 3:41 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		109,945,795		592,367		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		17,282,663				2.00
3.00	Total (sum of line 1 and line 2)		127,228,458		592,367		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	TRANSFERS	-16,472,107		476,562		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		-16,472,107		476,562		10.00
11.00	Subtotal (line 3 plus line 10)		110,756,351		1,068,929		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	TRANSFERS	0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		110,756,351		1,068,929		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	TRANSFERS		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	TRANSFERS		0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/21/2013 3:41 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	15,036,481		15,036,481	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	1,023,935		1,023,935	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	16,060,416		16,060,416	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	4,467,791		4,467,791	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	4,467,791		4,467,791	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	20,528,207		20,528,207	17.00
18.00	Ancillary services	148,318,327	174,859,787	323,178,114	18.00
19.00	Outpatient services	3,806,527	15,818,175	19,624,702	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	172,653,061	190,677,962	363,331,023	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		126,067,800		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		126,067,800		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140046

Period:
From 01/01/2012
To 12/31/2012

Worksheet G-3

Date/Time Prepared:
5/21/2013 3:41 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	363,331,023	1.00
2.00	Less contractual allowances and discounts on patients' accounts	225,246,587	2.00
3.00	Net patient revenues (line 1 minus line 2)	138,084,436	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	126,067,800	4.00
5.00	Net income from service to patients (line 3 minus line 4)	12,016,636	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	842,282	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	13,345	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	458,426	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	9,899	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	10,167	21.00
22.00	Rental of hospital space	572,644	22.00
23.00	Governmental appropriations	0	23.00
24.00	DONATIONS	1,218,734	24.00
24.01	EHR REVENUE	478,578	24.01
24.02	OTHER	1,661,952	24.02
25.00	Total other income (sum of lines 6-24)	5,266,027	25.00
26.00	Total (line 5 plus line 25)	17,282,663	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	17,282,663	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140046	Period: From 01/01/2012 To 12/31/2012	Worksheet L Parts I-III Date/Time Prepared: 5/21/2013 3:41 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		2,068,012	1.00
2.00	Capital DRG outlier payments		40,917	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		64.38	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		2,108,929	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00