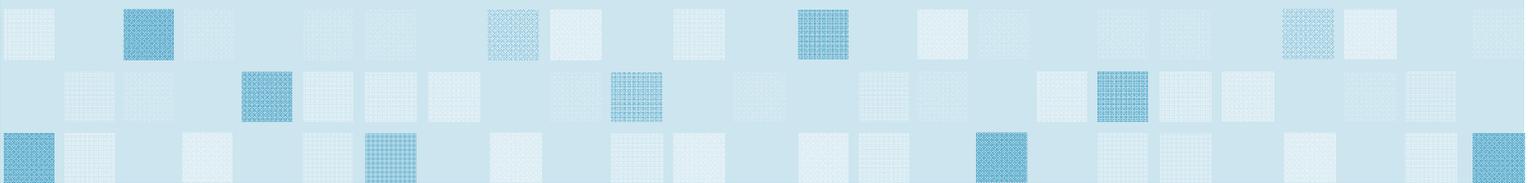


Presence Saint Joseph Hospital - Chicago

Medicare Cost Report

Six Months Ended 12.31.2012



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: 140224 Period: From 07/01/2012 To 12/31/2012 Worksheet S Parts I-III Date/Time Prepared: 5/24/2013 9:41 am

PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report Date: 5/24/2013 Time: 9:41 am
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only 5. Cost Report Status 6. Date Received: 10. NPR Date:
 (1) As Submitted 7. Contractor No. 11. Contractor's Vendor Code: 4
 (2) Settled without Audit 8. Initial Report for this Provider CCN 12. If line 5, column 1 is 4: Enter
 (3) Settled with Audit 9. Final Report for this Provider CCN number of times reopened = 0-9.
 (4) Reopened
 (5) Amended

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 PRESENCE SAINT JOSEPH HOSP-CHICAGO (140224) for the cost reporting period beginning 07/01/2012 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.

Encryption Information

ECR: Date: 5/24/2013 Time: 9:41 am
 ZCgK00sUnLI MeXVPowGwNWacxde2PO
 d: i t10HJEpyou53Up2Q. IZYwB00IU3
 OppJ1uGEvp0Kzmxr
 PI: Date: 5/24/2013 Time: 9:41 am
 cBLds9Zl kRE0A8FU54YZ2wT1f7X5WO
 : lbbT0uuwzVE5VD: 1uOKSghtDUgzvB
 SMmd0AXypC0x3ryM

(Signed)

Officer or Administrator of Provider(s)

Title

Date

	Title V 1.00	Title XVII		Title IX 5.00	Total
		Part A 2.00	Part B 3.00		
PART III - SETTLEMENT SUMMARY					
1.00 Hospital	0	352,857	288,733	0	1.00
2.00 Subprovider - IPF	0	0	0	0	2.00
3.00 Subprovider - IRF	0	-20,393	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	4.00
5.00 Swing bed - SNF	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	-2	0	7.00
8.00 NURSING FACILITY	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	12.00
200.00 Total	0	332,464	288,731	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: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/24/2013 9:40 am
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		1.00	2.00	3.00	4.00					
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 2900 NORTH LAKE SHORE DRIVE	PO Box:		Zip Code: 60657		County: COOK			1.00	
2.00	City: CHI CAGO	State: IL							2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		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	PRESENCE SAINT JOSEPH HOSP-CHI CAGO	140224	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	REHAB UNIT	14T224	16974	5	07/01/1985	N	P	O	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	SKILLED CARE	145568	16974		01/28/1987	N	P	N	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
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)					07/01/2012	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.	4,499	1,070	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.	113	46	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.					1			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.					1			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: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/24/2013 9:40 am		
		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.					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	Y	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.	Y				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)	Y				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1 / (col. 1 + col. 2)) 3.00		
64.00	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. 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)	8.12	29.85	0.213853		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 140224

Period:
From 07/01/2012
To 12/31/2012

Worksheet S-2
Part I
Date/Time Prepared:
5/24/2013 9:40 am

		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	4.00	5.00	
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)	FAMILY MEDICINE	1350	0.57	16.24	0.033908	65.00
65.01		INTERNAL MEDICINE	1400	2.88	62.28	0.044199	65.01
				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)			9.23	33.94	0.213806	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	4.00	5.00	
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.	FAMILY MEDICINE	1350	0.97	17.01	0.053949	67.00
67.01		INTERNAL MEDICINE	1400	0.50	74.45	0.006671	67.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/24/2013 9:40 am		
		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)	N	N	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			80.00
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			85.00
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.					86.00
		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		90.00
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		91.00
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		92.00
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		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00
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		
		1.00		2.00		
		Speech		Respiratory		
		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.	N				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.	0				118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/24/2013 9:40 am	
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	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		118.02
119.00	DO NOT USE THIS LINE				119.00
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	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
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		125.00
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.				126.00
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.				127.00
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.				128.00
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.				129.00
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.				130.00
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.				131.00
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.				132.00
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.				133.00
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.				134.00
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	14H082	140.00
		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: PRESENCE HEALTH	Contractor's Name: NGS		Contractor's Number: 00131	
142.00	Street: 100 NORTH RIVER ROAD	PO Box:			
143.00	City: DES PLAINES	State: IL		Zip Code: 60016	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y	144.00
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.			Y	145.00
				1.00	2.00
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		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00
		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		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140224			Period: From 07/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 5/24/2013 9:40 am		
							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.						Y		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)								0168.00
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)						1.00		169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/24/2013 9:40 am	
		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
		Y/N	Type	Date	
		1.00	2.00	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.	N			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.	Y			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
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.	Y			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			
		1.00			
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	
		Description	Y/N	Date	Y/N
		0	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)	Y	04/02/2013	Y	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)	N		N	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: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/24/2013 9:40 am	
	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.	0	1.00	2.00	3.00
			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?		Y		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.		Y		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.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		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.	MIKE	VOLANTE		41.00
42.00	Enter the employer/company name of the cost report preparer.	PRESENCE HEALTHCARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(847) 813-3719	MVOLANTE@PRESENCEHEALTH.ORG		43.00

		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)	04/02/2013		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)			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.	DIR. OF REIMBURSEMENT		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: 140224

Period:
From 07/01/2012
To 12/31/2012

Worksheet S-3
Part I
Date/Time Prepared:
5/24/2013 9:40 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	265	48,760	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)		265	48,760	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	25	4,600	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)		290	53,360	0.00	0	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00 SUBPROVIDER - IRF	41.00	23	4,232		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	27	4,968		0	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
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		340				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

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	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	9,960	5,718	22,495			1.00
2.00 HMO	709	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	7	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)	9,960	5,718	22,495			7.00
8.00 INTENSIVE CARE UNIT	1,194	1,050	4,215			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		2,145	2,323			13.00
14.00 Total (see instructions)	11,154	8,913	29,033	123.74	565.66	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00 SUBPROVIDER - IRF	1,222	136	1,584	0.00	8.76	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	1,911	0	2,440	0.00	10.10	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140224

Period:
From 07/01/2012
To 12/31/2012

Worksheet S-3
Part I
Date/Time Prepared:
5/24/2013 9:40 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title VIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				123.74	584.52	27.00
28.00	Observation Bed Days		0	2,070			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
33.00	LTCH non-covered days	0					33.00
Component		Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title VIII	Title XIX		Total All Patients
		11.00	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	2,016	760	4,752	1.00
2.00	HMO			134			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	2,016	760	4,752	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00	SUBPROVIDER - IRF	0.00	0	115	13	157	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					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
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: 140224		Period: From 07/01/2012 To 12/31/2012		Worksheet S-3 Part II Date/Time Prepared: 5/24/2013 9:40 am	
	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	38,053,870	0	38,053,870	1,215,817.00	31.30	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		1,065,306	0	1,065,306	10,784.00	98.79	4.00
4.01	Physicians - Part A - Teaching		760,598	0	760,598	11,375.00	66.87	4.01
5.00	Physician-Part B		210,082	0	210,082	1,695.00	123.94	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	3,635,668	3,635,668	148,423.00	24.50	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	644,669	0	644,669	21,017.00	30.67	9.00
10.00	Excluded area salaries (see instructions)		2,481,114	0	2,481,114	122,949.00	20.18	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor (see instructions)		2,242,000	0	2,242,000	61,118.00	36.68	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		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		5,961,529	0	5,961,529	150,376.00	39.64	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		6,304,839	0	6,304,839			17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV line 25		0	0	0			18.00
19.00	Excluded areas		677,540	0	677,540			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		194,708	0	194,708			22.00
22.01	Physician Part A - Teaching		36,753	0	36,753			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		785,898	0	785,898			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits	4.00	4,296	0	4,296	1,367.00	3.14	26.00
27.00	Administrative & General	5.00	2,200,339	54,375	2,254,714	69,504.00	32.44	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	266,478	0	266,478	8,308.00	32.07	29.00
30.00	Operation of Plant	7.00	348,038	0	348,038	9,540.00	36.48	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	642,500	0	642,500	49,261.00	13.04	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	927,217	-356,878	570,339	27,656.00	20.62	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	356,878	356,878	28,731.00	12.42	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	958,989	0	958,989	22,824.00	42.02	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	1,188,014	0	1,188,014	29,765.00	39.91	40.00

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HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140224

Period:
From 07/01/2012
To 12/31/2012

Worksheet S-3
Part II
Date/Time Prepared:
5/24/2013 9:40 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion 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		
41.00	Medical Records & Medical Records Library	16.00	463,537	0	463,537	21,234.00	21.83	41.00
42.00	Social Service	17.00	723,576	0	723,576	18,623.00	38.85	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140224

Period:
From 07/01/2012
To 12/31/2012

Worksheet S-3
Part III
Date/Time Prepared:
5/24/2013 9:40 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal ari es (from Worksheet A-6)	Adjus ted Sal ari es (col . 2 ± col . 3)	Pai d Hours Rel ated to Sal ari es i n 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)	37,083,190	-3,635,668	33,447,522	1,054,324.00	31.72	1.00
2.00	Excluded area salaries (see instructions)	3,125,783	0	3,125,783	143,966.00	21.71	2.00
3.00	Subtotal salaries (line 1 minus line 2)	33,957,407	-3,635,668	30,321,739	910,358.00	33.31	3.00
4.00	Subtotal other wages & related costs (see inst.)	8,203,529	0	8,203,529	211,494.00	38.79	4.00
5.00	Subtotal wage-related costs (see inst.)	6,499,547	0	6,499,547	0.00	21.44	5.00
6.00	Total (sum of lines 3 thru 5)	48,660,483	-3,635,668	45,024,815	1,121,852.00	40.13	6.00
7.00	Total overhead cost (see instructions)	7,722,984	54,375	7,777,359	286,813.00	27.12	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet S-3 Part IV Date/Time Prepared: 5/24/2013 9:40 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	1,490,253	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)	3,342,234	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	107,903	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	32,685	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	119,845	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	298,466	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	2,664,380	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	22,996	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	0	22.00
23.00	Tuition Reimbursement	73,987	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,152,749	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet S-3 Part V Date/Time Prepared: 5/24/2013 9:40 am
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	2,242,000	0	1.00
2.00	Hospital	2,242,000	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140224

Period:
From 07/01/2012
To 12/31/2012

Worksheet S-7

Date/Time Prepared:
5/24/2013 9:40 am

		1.00	2.00	3.00	4.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.					1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.					2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	9	0	9	4.00
5.00		RVX	11	0	11	5.00
6.00		RVL	23	0	23	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	86	0	86	8.00
9.00		RMX	36	0	36	9.00
10.00		RML	55	0	55	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	69	0	69	14.00
15.00		RVC	31	0	31	15.00
16.00		RVB	135	0	135	16.00
17.00		RVA	283	0	283	17.00
18.00		RHC	158	0	158	18.00
19.00		RHB	204	0	204	19.00
20.00		RHA	393	0	393	20.00
21.00		RMC	54	0	54	21.00
22.00		RMB	35	0	35	22.00
23.00		RMA	127	0	127	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	31	0	31	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	21	0	21	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	3	0	3	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	3	0	3	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	1	0	1	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	4	0	4	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	3	0	3	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	11	0	11	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	116	0	116	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140224

Period:
From 07/01/2012
To 12/31/2012

Worksheet S-7

Date/Time Prepared:
5/24/2013 9:40 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	3	0	3	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	5	0	5	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	1	0	1	199.00
200.00	TOTAL		1,911	0	1,911	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
201.00	SNF SERVICES	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).		16974	16974	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		2,138,420			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet S-10	Date/Time Prepared: 5/24/2013 9:40 am
				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)			0.204245	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			4,742,288	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?			N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			213,419	5.00
6.00	Medicaid charges			43,776,516	6.00
7.00	Medicaid cost (line 1 times line 6)			8,941,135	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)			3,985,428	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)			3,985,428	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	882,392	16,224	898,616	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	180,224	3,314	183,538	21.00
22.00	Partial payment by patients approved for charity care	7,550	400	7,950	22.00
23.00	Cost of charity care (line 21 minus line 22)	172,674	2,914	175,588	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)			-408,203	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			840,604	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)			-1,248,807	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)			-255,063	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			-79,475	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			3,905,953	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140224

Period:
From 07/01/2012
To 12/31/2012

Worksheet A
Date/Time Prepared:
5/24/2013 9:40 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (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		4,872,007	4,872,007	-4,552,712	319,295	1.00
2.00	00200		0	0	4,552,712	4,552,712	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	4,296	878	5,174	8,167,555	8,172,729	4.00
5.01	00540	0	0	0	119,188	119,188	5.01
5.02	00550	0	0	0	0	0	5.02
5.03	00560	0	0	0	0	0	5.03
5.04	00570	0	0	0	2,232	2,232	5.04
5.05	00580	0	0	0	0	0	5.05
5.06	00591	2,200,339	11,861,231	14,061,570	-525,774	13,535,796	5.06
6.00	00600	266,478	423,365	689,843	-64,433	625,410	6.00
7.00	00700	348,038	2,607,165	2,955,203	-78,336	2,876,867	7.00
8.00	00800	0	431,073	431,073	-5	431,068	8.00
9.00	00900	642,500	813,167	1,455,667	-316,381	1,139,286	9.00
10.00	01000	927,217	1,023,744	1,950,961	-1,022,345	928,616	10.00
11.00	01100	0	0	0	649,982	649,982	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	958,989	228,605	1,187,594	-171,393	1,016,201	13.00
14.00	01400	0	-58,066	-58,066	-17,311	-75,377	14.00
15.00	01500	1,188,014	2,364,394	3,552,408	-2,997,755	554,653	15.00
16.00	01600	463,537	404,059	867,596	-148,592	719,004	16.00
17.00	01700	723,576	474,956	1,198,532	-154,345	1,044,187	17.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	0	0	0	3,631,599	3,631,599	21.00
22.00	02200	5,833,701	1,756,873	7,590,574	-4,220,394	3,370,180	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	9,398,187	3,869,484	13,267,671	-3,038,028	10,229,643	30.00
31.00	03100	1,432,478	704,673	2,137,151	-465,211	1,671,940	31.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	566,372	188,056	754,428	-150,521	603,907	41.00
43.00	04300	753,949	216,588	970,537	17,218	987,755	43.00
44.00	04400	644,669	218,122	862,791	-184,190	678,601	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,035,461	7,973,217	11,008,678	-5,551,064	5,457,614	50.00
51.00	05100	362,852	86,645	449,497	-85,696	363,801	51.00
53.00	05300	60,739	349,033	409,772	-138,309	271,463	53.00
54.00	05400	1,686,304	1,346,857	3,033,161	-608,252	2,424,909	54.00
55.00	05500	491,428	267,060	758,488	-119,753	638,735	55.00
60.00	06000	0	3,509,206	3,509,206	0	3,509,206	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	541,684	283,949	825,633	-177,582	648,051	65.00
66.00	06600	1,537,148	633,364	2,170,512	-360,399	1,810,113	66.00
69.00	06900	761,795	858,304	1,620,099	-1,052,547	567,552	69.00
70.00	07000	42,242	17,262	59,504	-15,347	44,157	70.00
71.00	07100	0	0	0	3,635,423	3,635,423	71.00
72.00	07200	0	0	0	3,041,956	3,041,956	72.00
73.00	07300	0	0	0	3,246,494	3,246,494	73.00
74.00	07400	0	209,347	209,347	-2,140	207,207	74.00
76.00	03950	0	0	0	0	0	76.00
76.97	07697	21,902	7,095	28,997	-6,631	22,366	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	167,031	66,366	233,397	-56,743	176,654	90.00
91.00	09100	954,788	236,075	1,190,863	-326,031	864,832	91.00
91.01	04950	123,414	42,381	165,795	-30,604	135,191	91.01
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		36,139,128	48,286,535	84,425,663	425,535	84,851,198	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	1,914,742	1,382,238	3,296,980	-425,535	2,871,445	194.00
194.01	07951	0	0	0	0	0	194.01
200.00		38,053,870	49,668,773	87,722,643	0	87,722,643	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140224

Period:
From 07/01/2012
To 12/31/2012

Worksheet A
Date/Time Prepared:
5/24/2013 9:40 am

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	1,029,043	1,348,338	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	4,552,712	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	196,479	8,369,208	4.00
5.01	00540	NONPATIENT TELEPHONES	0	119,188	5.01
5.02	00550	DATA PROCESSING	1,793,331	1,793,331	5.02
5.03	00560	PURCHASING, RECEIVING&STORES	423,605	423,605	5.03
5.04	00570	ADMINISTRATIVE	670,468	672,700	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	1,857,759	1,857,759	5.05
5.06	00591	ADMINISTRATION & GENERAL	-6,856,482	6,679,314	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	625,410	6.00
7.00	00700	OPERATION OF PLANT	34,120	2,910,987	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	431,068	8.00
9.00	00900	HOUSEKEEPING	0	1,139,286	9.00
10.00	01000	DIETARY	0	928,616	10.00
11.00	01100	CAFETERIA	-640,467	9,515	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,016,201	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	215,857	140,480	14.00
15.00	01500	PHARMACY	0	554,653	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,251	714,753	16.00
17.00	01700	SOCIAL SERVICE	0	1,044,187	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	0	3,631,599	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	-2,076,473	1,293,707	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-12,883	10,216,760	30.00
31.00	03100	INTENSIVE CARE UNIT	30,100	1,702,040	31.00
40.00	04000	SUBPROVIDER - I/PF	0	0	40.00
41.00	04100	SUBPROVIDER - I/RF	0	603,907	41.00
43.00	04300	NURSERY	0	987,755	43.00
44.00	04400	SKILLED NURSING FACILITY	0	678,601	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-208,186	5,249,428	50.00
51.00	05100	RECOVERY ROOM	0	363,801	51.00
53.00	05300	ANESTHESIOLOGY	-150,000	121,463	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-566,682	1,858,227	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-22,876	615,859	55.00
60.00	06000	LABORATORY	130,927	3,640,133	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	-1,000	647,051	65.00
66.00	06600	PHYSICAL THERAPY	-11,540	1,798,573	66.00
69.00	06900	ELECTROCARDIOLOGY	0	567,552	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-5,629	38,528	70.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	3,635,423	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,041,956	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,246,494	73.00
74.00	07400	RENAL DIALYSIS	0	207,207	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	22,366	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	176,654	90.00
91.00	09100	EMERGENCY	0	864,832	91.00
91.01	04950	PARTIAL HOSPITALIZATION	-13,143	122,048	91.01
92.00	09200	OBSERVATION BEDS	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,187,923	80,663,275	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	OTHER	-547,789	2,323,656	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	194.01
200.00		TOTAL (SUM OF LINES 118-199)	-4,735,712	82,986,931	200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - DRUGS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,246,494	1.00	
2.00	ADULTS & PEDIATRICS	30.00	0	16	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
TOTALS			0	3,246,510		
B - IMPLANTS						
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	3,041,956	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
TOTALS			0	3,041,956		
C - CHARGABLE SUPPLIES						
1.00	MEDICAL SUPPLIES CHRGD TO PATIENTS	71.00	0	3,635,423	1.00	
2.00	ADMINISTRATION & GENERAL	5.06	0	6,808	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	
27.00		0.00	0	0	27.00	
28.00		0.00	0	0	28.00	
29.00		0.00	0	0	29.00	
30.00		0.00	0	0	30.00	
31.00		0.00	0	0	31.00	
TOTALS			0	3,642,231		
D - NURSEY						
1.00	NURSERY	43.00	153,362	64,356	1.00	
TOTALS			153,362	64,356		
E - CAFETERIA						
1.00	CAFETERIA	11.00	356,878	293,104	1.00	
TOTALS			356,878	293,104		
F - PHYSICIAN DEPR CHAIRMAN						
1.00	ADULTS & PEDIATRICS	30.00	89,400	4,069	1.00	
TOTALS			89,400	4,069		

RECLASSIFICATIONS

Provider CCN: 140224

Period:
From 07/01/2012
To 12/31/2012

Worksheet A-6

Date/Time Prepared:
5/24/2013 9:40 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
G - TEACHING PHYSICIAN ADMIN					
1.00	ADMINISTRATION & GENERAL	5.06	54,375	4,160	1.00
	TOTALS		54,375	4,160	
H - EQUIP DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,552,712	1.00
	TOTALS		0	4,552,712	
I - PHONES					
1.00	NONPATIENT TELEPHONES	5.01	0	119,188	1.00
	TOTALS		0	119,188	
J - CENTRAL SCHEDULING					
1.00	ADMINISTRATIVE	5.04	0	2,232	1.00
	TOTALS		0	2,232	
K - BENEFITS					
1.00	EMPLOYEE BENEFITS	4.00	0	8,167,555	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
	TOTALS		0	8,167,555	
L - INTERNS AND RESIDENTS SALARY					
1.00	I&R SRVCES-SALARY & FRINGES	21.00	3,725,068	0	1.00
	APPRVD				
	TOTALS		3,725,068	0	
500.00	Grand Total: Increases		4,379,083	23,138,073	500.00

RECLASSIFICATIONS

Provider CCN: 140224

Period:
From 07/01/2012
To 12/31/2012

Worksheet A-6
Date/Time Prepared:
5/24/2013 9:40 am

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00			
A - DRUGS							
1.00	ADMINISTRATION & GENERAL	5.06	0	2,649	0		1.00
2.00	OPERATION OF PLANT	7.00	0	30	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,785	0		3.00
4.00	PHARMACY	15.00	0	2,746,500	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	111,540	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	19,024	0		6.00
7.00	SUBPROVIDER - IRF	41.00	0	786	0		7.00
8.00	NURSERY	43.00	0	8,805	0		8.00
9.00	SKILLED NURSING FACILITY	44.00	0	2,594	0		9.00
10.00	OPERATING ROOM	50.00	0	54,736	0		10.00
11.00	RECOVERY ROOM	51.00	0	5,070	0		11.00
12.00	ANESTHESIOLOGY	53.00	0	30,296	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	166,800	0		13.00
14.00	RADIOLOGY-THERAPEUTIC	55.00	0	1,854	0		14.00
16.00	RESPIRATORY THERAPY	65.00	0	281	0		16.00
17.00	ELECTROCARDIOLOGY	69.00	0	26,065	0		17.00
18.00	RENAL DIALYSIS	74.00	0	252	0		18.00
19.00	CARDIAC REHABILITATION	76.97	0	5	0		19.00
20.00	CLINIC	90.00	0	4,271	0		20.00
21.00	EMERGENCY	91.00	0	36,960	0		21.00
22.00	OTHER	194.00	0	22,207	0		22.00
TOTALS			0	3,246,510			
B - IMPLANTS							
1.00	ADULTS & PEDIATRICS	30.00	0	31	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	62	0		2.00
3.00	OPERATING ROOM	50.00	0	2,298,891	0		3.00
4.00	PHYSICAL THERAPY	66.00	0	144	0		4.00
5.00	ELECTROCARDIOLOGY	69.00	0	742,828	0		5.00
TOTALS			0	3,041,956			
C - CHARGABLE SUPPLIES							
1.00	MAINTENANCE & REPAIRS	6.00	0	65	0		1.00
2.00	OPERATION OF PLANT	7.00	0	583	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	5	0		3.00
4.00	HOUSEKEEPING	9.00	0	3,264	0		4.00
5.00	DIETARY	10.00	0	40	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	4	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	11,526	0		7.00
8.00	PHARMACY	15.00	0	6,768	786		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	135	0		9.00
10.00	I&R SRVCES-OTHER PRGM COSTS APPRVD	22.00	0	637	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	467,988	0		11.00
12.00	INTENSIVE CARE UNIT	31.00	0	130,387	0		12.00
13.00	ADULTS & PEDIATRICS	30.00	0	10,356	0		13.00
14.00	SUBPROVIDER - IRF	41.00	0	10,190	0		14.00
15.00	NURSERY	43.00	0	28,543	0		15.00
16.00	SKILLED NURSING FACILITY	44.00	0	20,395	0		16.00
17.00	OPERATING ROOM	50.00	0	2,479,721	0		17.00
18.00	RECOVERY ROOM	51.00	0	5,718	0		18.00
19.00	ANESTHESIOLOGY	53.00	0	87,273	0		19.00
20.00	RADIOLOGY-DIAGNOSTIC	54.00	0	68,358	0		20.00
21.00	RADIOLOGY-THERAPEUTIC	55.00	0	7,296	0		21.00
23.00	RESPIRATORY THERAPY	65.00	0	39,043	0		23.00
24.00	PHYSICAL THERAPY	66.00	0	24,130	0		24.00
25.00	ELECTROCARDIOLOGY	69.00	0	124,667	0		25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	0	1,369	0		26.00
27.00	RENAL DIALYSIS	74.00	0	1,888	0		27.00
28.00	CARDIAC REHABILITATION	76.97	0	117	0		28.00
29.00	CLINIC	90.00	0	7,592	0		29.00
30.00	EMERGENCY	91.00	0	63,864	0		30.00
31.00	OTHER	194.00	0	40,309	0		31.00
TOTALS			0	3,642,231			
D - NURSEY							
1.00	ADULTS & PEDIATRICS	30.00	153,362	64,356	0		1.00
TOTALS			153,362	64,356			
E - CAFETERIA							
1.00	DIETARY	10.00	356,878	293,104	0		1.00
TOTALS			356,878	293,104			
F - PHYSICIAN DEPR CHAIRMAN							
1.00	I&R SRVCES-SALARY & FRINGES APPRVD	21.00	89,400	4,069	0		1.00
TOTALS			89,400	4,069			

RECLASSIFICATIONS

Provider CCN: 140224

Period:
From 07/01/2012
To 12/31/2012

Worksheet A-6
Date/Time Prepared:
5/24/2013 9:40 am

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
G - TEACHING PHYSICIAN ADMIN						
1.00	I&R SRVCES-OTHER PRGM COSTS	22.00	54,375	4,160	0	1.00
	APPRVD					
	TOTALS		54,375	4,160		
H - EQUIP DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,552,712	9	1.00
	TOTALS		0	4,552,712		
I - PHONES						
1.00	ADMINISTRATION & GENERAL	5.06	0	119,188	0	1.00
	TOTALS		0	119,188		
J - CENTRAL SCHEDULING						
1.00	ADMINISTRATION & GENERAL	5.06	0	2,232	0	1.00
	TOTALS		0	2,232		
K - BENEFITS						
1.00	ADMINISTRATION & GENERAL	5.06	0	467,048	0	1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	64,368	0	2.00
3.00	OPERATION OF PLANT	7.00	0	77,723	0	3.00
4.00	HOUSEKEEPING	9.00	0	313,117	0	4.00
5.00	DIETARY	10.00	0	372,323	0	5.00
6.00	NURSING ADMINISTRATION	13.00	0	171,389	0	6.00
7.00	PHARMACY	15.00	0	244,487	0	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	148,457	0	8.00
9.00	SOCIAL SERVICE	17.00	0	154,345	0	9.00
10.00	I&R SRVCES-OTHER PRGM COSTS	22.00	0	436,154	0	10.00
	APPRVD					
11.00	ADULTS & PEDIATRICS	30.00	0	2,010,334	0	11.00
12.00	INTENSIVE CARE UNIT	31.00	0	315,738	0	12.00
13.00	ADULTS & PEDIATRICS	30.00	0	313,546	0	13.00
14.00	SUBPROVIDER - IRF	41.00	0	139,545	0	14.00
15.00	NURSERY	43.00	0	163,152	0	15.00
16.00	SKILLED NURSING FACILITY	44.00	0	161,201	0	16.00
17.00	OPERATING ROOM	50.00	0	717,716	0	17.00
18.00	RECOVERY ROOM	51.00	0	74,908	0	18.00
19.00	ANESTHESIOLOGY	53.00	0	20,740	0	19.00
20.00	RADIOLOGY-DIAGNOSTIC	54.00	0	373,094	0	20.00
21.00	RADIOLOGY-THERAPEUTIC	55.00	0	110,603	0	21.00
22.00	RESPIRATORY THERAPY	65.00	0	138,258	0	22.00
23.00	PHYSICAL THERAPY	66.00	0	336,125	0	23.00
24.00	ELECTROCARDIOLOGY	69.00	0	158,987	0	24.00
25.00	ELECTROENCEPHALOGRAPHY	70.00	0	13,978	0	25.00
26.00	CARDIAC REHABILITATION	76.97	0	6,509	0	26.00
27.00	PARTIAL HOSPITALIZATION	91.01	0	30,604	0	27.00
28.00	CLINIC	90.00	0	44,880	0	28.00
29.00	EMERGENCY	91.00	0	225,207	0	29.00
30.00	OTHER	194.00	0	363,019	0	30.00
	TOTALS		0	8,167,555		
L - INTERNS AND RESIDENTS SALARY						
1.00	I&R SRVCES-OTHER PRGM COSTS	22.00	3,725,068	0	0	1.00
	APPRVD					
	TOTALS		3,725,068	0		
500.00	Grand Total: Decreases		4,379,083	23,138,073		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140224

Period:
From 07/01/2012
To 12/31/2012

Worksheet A-7
Part I
Date/Time Prepared:
5/24/2013 9:40 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	7,327,665	0	0	0	1.00
2.00	Land Improvements	11,980,239	0	0	0	2.00
3.00	Buildings and Fixtures	53,814,141	3,667,970	0	3,667,970	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	202,305,869	0	0	0	153,292,655
7.00	HIT designated Assets	0	0	0	0	0
8.00	Subtotal (sum of lines 1-7)	275,427,914	3,667,970	0	3,667,970	153,292,655
9.00	Reconciling Items	0	0	0	0	0
10.00	Total (line 8 minus line 9)	275,427,914	3,667,970	0	3,667,970	153,292,655
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	7,327,665	0			1.00
2.00	Land Improvements	11,980,239	0			2.00
3.00	Buildings and Fixtures	57,482,111	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	49,013,214	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	125,803,229	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	125,803,229	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140224

Period:
From 07/01/2012
To 12/31/2012

Worksheet A-7
Part II
Date/Time Prepared:
5/24/2013 9:40 am

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	4,872,007	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,872,007	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	4,872,007				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	4,872,007				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140224

Period:
From 07/01/2012
To 12/31/2012

Worksheet A-7
Part III
Date/Time Prepared:
5/24/2013 9:40 am

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	76,790,015	0	76,790,015	0.610398	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	49,013,214	0	49,013,214	0.389602	0	2.00
3.00	Total (sum of lines 1-2)	125,803,229	0	125,803,229	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	0	0	461,738	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	4,552,712	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,014,450	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	886,600	0	0	0	1,348,338	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	4,552,712	2.00
3.00	Total (sum of lines 1-2)	886,600	0	0	0	5,901,050	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140224

Period:
From 07/01/2012
To 12/31/2012

Worksheet A-8

Date/Time Prepared:
5/24/2013 9:40 am

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.		
			3.00	4.00	5.00		
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)			0		0.00	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	-2,821,278				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	75,710				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-640,467	CAFETERIA		11.00	0	14.00
15.00 Rental of quarters to employees 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			0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-4,251	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			0		0.00	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		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	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			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	NONPHYSICIAN ANESTHETISTS	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		0	*** Cost Center Deleted ***	67.00		30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00

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
33.00 OTHER ADJUSTMENTS (SPECIFY (3))		0			0.00	0	33.00
34.00 MISC REVENUE	B	-2,500	RADIOLOGY-DIAGNOSTIC		54.00	0	34.00
38.00 ASBESTOS AMORTIZATION	A	180,398	OPERATION OF PLANT		7.00	0	38.00
39.00 MOONLIGHTERS	A	-17,250	I&R SRVCES-OTHER PRGM COSTS APPRVD		22.00	0	39.00
40.00 MEDICARE TO BOOK DEPRECIATION	A	142,443	CAP REL COSTS-BLDG & FIXT		1.00	9	40.00
42.00 PHYS FEES	A	-547,789	OTHER		194.00	0	42.00
43.01 MISC INCOME	B	10,682	EMPLOYEE BENEFITS		4.00	0	43.01
43.02 MISC INCOME	B	0			0.00	9	43.02
43.03 MISC INCOME	B	-505,300	ADMINISTRATION & GENERAL		5.06	0	43.03
43.04 MISC INCOME	B	-146,278	OPERATION OF PLANT		7.00	0	43.04
43.05 MISC INCOME	B	-2,026	ADULTS & PEDIATRICS		30.00	0	43.05
43.10 AHA DUES	A	-11,283	ADMINISTRATION & GENERAL		5.06	0	43.10
44.00 MISC INCOME	B	-416,635	I&R SRVCES-OTHER PRGM COSTS APPRVD		22.00	0	44.00
45.00 MISC INCOME	B	-5,629	ELECTROENCEPHALOGRAPHY		70.00	0	45.00
46.00 MISC INCOME	B	-1,000	RESPIRATORY THERAPY		65.00	0	46.00
47.00 MISC INCOME	B	-23,259	OPERATING ROOM		50.00	0	47.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,735,712					50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS
 Provider CCN: 140224
 Period: From 07/01/2012 To 12/31/2012
 Worksheet A-8-1
 Date/Time Prepared: 5/24/2013 9:40 am

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	4.00	EMPLOYEE BENEFITS	EMPLOYEE BENEFITS	378,485	0
2.00	5.02	DATA PROCESSING	DATA PROCESSING	1,793,331	0
3.00	5.03	PURCHASING, RECEIVING&STORES	PURCH, RECEIVING	423,605	0
4.00	5.04	ADMINITTING	ADMINITTING	670,468	0
4.01	5.05	CASHIERING/ACCTS RECEIVABLE	CASHIERING/AR	1,857,759	0
4.02	5.06	ADMINISTRATION & GENERAL	A&G	5,897,155	12,208,577
4.03	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SERVICES	215,857	0
4.04	31.00	INTENSIVE CARE UNIT	ICU	30,100	0
4.05	1.00	CAP REL COSTS-BLDG & FIXT	CAP REL BLDG	886,600	0
4.06	60.00	LABORATORY	LAB	3,277,654	3,146,727
5.00	0		0	15,431,014	15,355,304

* 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	100.00	RESURRECTION HEALTH CARE	100.00	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: 140224

Period:
From 07/01/2012
To 12/31/2012

Worksheet A-8-1

Date/Time Prepared:
5/24/2013 9:40 am

	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	378,485	0		1.00
2.00	1,793,331	0		2.00
3.00	423,605	0		3.00
4.00	670,468	0		4.00
4.01	1,857,759	0		4.01
4.02	-6,311,422	0		4.02
4.03	215,857	0		4.03
4.04	30,100	0		4.04
4.05	886,600	11		4.05
4.06	130,927	0		4.06
5.00	75,710			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	SOLE CORPORATE MEMBER		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: 140224

Period:
From 07/01/2012
To 12/31/2012

Worksheet A-8-2

Date/Time Prepared:
5/24/2013 9:40 am

1.00	2.00	3.00	4.00	5.00	6.00	7.00	
Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
1.00	22.00 I&R SRVCES-OTHER PRGM COSTS APPRVD	2,492,466	1,531,935	960,531	177,200	9,976	1.00
2.00	30.00 ADULTS & PEDIATRICS	71,514	250	71,264	177,200	712	2.00
3.00	40.00 SUBPROVIDER - IPF	0	0	0	0	0	3.00
4.00	50.00 OPERATING ROOM	184,927	184,927	0	0	0	4.00
5.00	53.00 ANESTHESIOLOGY	150,000	150,000	0	0	0	5.00
6.00	54.00 RADIOLOGY-DIAGNOSTIC	564,182	564,182	0	0	0	6.00
7.00	55.00 RADIOLOGY-THERAPEUTIC	22,876	22,876	0	0	0	7.00
8.00	66.00 PHYSICAL THERAPY	11,540	11,540	0	0	0	8.00
9.00	91.01 PARTIAL HOSPITALIZATION	13,143	13,143	0	0	0	9.00
10.00	5.06 ADMINISTRATION & GENERAL	54,375	0	54,375	177,200	304	10.00
11.00	4.00 EMPLOYEE BENEFITS	192,688	192,688	0	0	0	11.00
200.00		3,757,711	2,671,541	1,086,170		10,992	200.00

1.00	2.00	8.00	9.00	12.00	13.00	14.00	
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	22.00 I&R SRVCES-OTHER PRGM COSTS APPRVD	849,878	42,494	0	0	0	1.00
2.00	30.00 ADULTS & PEDIATRICS	60,657	3,033	0	0	0	2.00
3.00	40.00 SUBPROVIDER - IPF	0	0	0	0	0	3.00
4.00	50.00 OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00 ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	7.00
8.00	66.00 PHYSICAL THERAPY	0	0	0	0	0	8.00
9.00	91.01 PARTIAL HOSPITALIZATION	0	0	0	0	0	9.00
10.00	5.06 ADMINISTRATION & GENERAL	25,898	1,295	0	0	0	10.00
11.00	4.00 EMPLOYEE BENEFITS	0	0	0	0	0	11.00
200.00		936,433	46,822	0	0	0	200.00

1.00	2.00	15.00	16.00	17.00	18.00	
Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
1.00	22.00 I&R SRVCES-OTHER PRGM COSTS APPRVD	0	849,878	110,653	1,642,588	1.00
2.00	30.00 ADULTS & PEDIATRICS	0	60,657	10,607	10,857	2.00
3.00	40.00 SUBPROVIDER - IPF	0	0	0	0	3.00
4.00	50.00 OPERATING ROOM	0	0	0	184,927	4.00
5.00	53.00 ANESTHESIOLOGY	0	0	0	150,000	5.00
6.00	54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	564,182	6.00
7.00	55.00 RADIOLOGY-THERAPEUTIC	0	0	0	22,876	7.00
8.00	66.00 PHYSICAL THERAPY	0	0	0	11,540	8.00
9.00	91.01 PARTIAL HOSPITALIZATION	0	0	0	13,143	9.00
10.00	5.06 ADMINISTRATION & GENERAL	0	25,898	28,477	28,477	10.00
11.00	4.00 EMPLOYEE BENEFITS	0	0	0	192,688	11.00
200.00		0	936,433	149,737	2,821,278	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140224

Period:
From 07/01/2012
To 12/31/2012

Worksheet B
Part I
Date/Time Prepared:
5/24/2013 9:40 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	NONPATIENT TELEPHONES		
		BLDG & FIXT	MVBLE EQUIP				
		1.00	2.00				4.00
GENERAL SERVICE COST CENTERS							
1.00 00100 CAP REL COSTS-BLDG & FIXT	1,348,338	1,348,338				1.00	
2.00 00200 CAP REL COSTS-MVBLE EQUIP	4,552,712		4,552,712			2.00	
4.00 00400 EMPLOYEE BENEFITS	8,369,208	9,754	32,935	8,411,897		4.00	
5.01 00540 NONPATIENT TELEPHONES	119,188	0	0	0	119,188	5.01	
5.02 00550 DATA PROCESSING	1,793,331	14,544	49,108	0	0	5.02	
5.03 00560 PURCHASING, RECEIVING&STORES	423,605	0	0	0	1,928	5.03	
5.04 00570 ADMINITTING	672,700	0	0	0	3,427	5.04	
5.05 00580 CASHIERING/ACCTS RECEIVABLE	1,857,759	0	0	0	5,354	5.05	
5.06 00591 ADMINISTRATION & GENERAL	6,679,314	388,121	1,310,502	498,465	14,564	5.06	
6.00 00600 MAINTENANCE & REPAIRS	625,410	0	0	58,912	0	6.00	
7.00 00700 OPERATION OF PLANT	2,910,987	91,294	308,259	76,943	4,926	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	431,068	2,539	8,574	0	428	8.00	
9.00 00900 HOUSEKEEPING	1,139,286	44,849	151,433	142,042	643	9.00	
10.00 01000 DIETARY	928,616	42,799	144,513	126,089	857	10.00	
11.00 01100 CAFETERIA	9,515	0	0	78,898	1,285	11.00	
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00	
13.00 01300 NURSING ADMINISTRATION	1,016,201	4,318	14,579	212,010	5,140	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	140,480	39,508	133,402	0	535	14.00	
15.00 01500 PHARMACY	554,653	8,271	27,927	262,643	2,142	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	714,753	17,085	57,689	102,477	4,069	16.00	
17.00 01700 SOCIAL SERVICE	1,044,187	0	0	159,966	1,606	17.00	
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00	
21.00 02100 I&R SRVCES-SALARY & FRINGES APPRVD	3,631,599	0	0	803,763	0	21.00	
22.00 02200 I&R SRVCES-OTHER PRGM COSTS APPRVD	1,293,707	22,475	75,886	454,149	5,676	22.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	10,216,760	270,619	913,756	2,063,594	18,206	30.00	
31.00 03100 INTENSIVE CARE UNIT	1,702,040	31,983	107,990	316,688	4,176	31.00	
40.00 04000 SUBPROVIDER - IPF	0	0	0	0	0	40.00	
41.00 04100 SUBPROVIDER - IRF	603,907	14,436	48,745	125,212	2,463	41.00	
43.00 04300 NURSERY	987,755	2,107	7,116	200,586	857	43.00	
44.00 04400 SKILLED NURSING FACILITY	678,601	33,913	114,509	142,521	1,285	44.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	5,249,428	90,634	306,031	671,071	8,781	50.00	
51.00 05100 RECOVERY ROOM	363,801	4,629	15,629	80,218	0	51.00	
53.00 05300 ANESTHESIOLOGY	121,463	1,958	6,610	13,428	214	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,858,227	59,388	200,525	372,803	8,674	54.00	
55.00 05500 RADIOLOGY-THERAPEUTIC	615,859	20,765	70,115	108,643	0	55.00	
60.00 06000 LABORATORY	3,640,133	24,410	82,420	0	6,211	60.00	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30	
65.00 06500 RESPIRATORY THERAPY	647,051	7,190	24,278	119,754	1,499	65.00	
66.00 06600 PHYSICAL THERAPY	1,798,573	14,662	49,508	339,828	2,998	66.00	
69.00 06900 ELECTROCARDIOLOGY	567,552	22,023	74,360	168,415	1,713	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	38,528	85	287	9,339	1,392	70.00	
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	3,635,423	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	3,041,956	0	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	3,246,494	0	0	0	0	73.00	
74.00 07400 RENAL DIALYSIS	207,207	0	0	0	643	74.00	
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00	
76.97 07697 CARDIAC REHABILITATION	22,366	0	0	4,842	321	76.97	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	176,654	15,211	51,359	36,927	4,498	90.00	
91.00 09100 EMERGENCY	864,832	0	0	211,082	2,677	91.00	
91.01 04950 PARTIAL HOSPITALIZATION	122,048	4,362	14,730	27,284	0	91.01	
92.00 09200 OBSERVATION BEDS						92.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	80,663,275	1,303,932	4,402,775	7,988,592	119,188	118.00
NONREIMBURSABLE COST CENTERS							
194.00 07950 OTHER	2,323,656	44,406	149,937	423,305	0	194.00	
194.01 07951 LAKESHORE GUEST UNIT	0	0	0	0	0	194.01	
200.00	Cross Foot Adjustments					200.00	
201.00	Negative Cost Centers					201.00	
202.00	TOTAL (sum lines 118-201)	82,986,931	1,348,338	4,552,712	8,411,897	119,188	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140224

Period: From 07/01/2012 To 12/31/2012

Worksheet B Part I Date/Time Prepared: 5/24/2013 9:40 am

Cost Center Description		DATA PROCESSING	PURCHASING, RECEIVING & STORES	ADMINISTRATIVE	CASHIERING/ACCTS RECEIVABLE	Subtotal	
		5.02	5.03	5.04	5.05	5A.05	
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
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING	1,856,983				5.02
5.03	00560	PURCHASING, RECEIVING & STORES	0	425,533			5.03
5.04	00570	ADMINISTRATIVE	0	0	676,127		5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	0	0	1,863,113	5.05
5.06	00591	ADMINISTRATION & GENERAL	1,856,983	9,876	0	0	10,757,825
6.00	00600	MAINTENANCE & REPAIRS	0	45	0	0	684,367
7.00	00700	OPERATION OF PLANT	0	146	0	0	3,392,555
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	442,609
9.00	00900	HOUSEKEEPING	0	5,985	0	0	1,484,238
10.00	01000	DIETARY	0	8,167	0	0	1,251,041
11.00	01100	CAFETERIA	0	0	0	0	89,698
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	231	0	0	1,252,479
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,512	0	0	322,437
15.00	01500	PHARMACY	0	2,163	0	0	857,799
16.00	01600	MEDICAL RECORDS & LIBRARY	0	601	0	0	896,674
17.00	01700	SOCIAL SERVICE	0	123	0	0	1,205,882
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	0	0	0	0	4,435,362
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	13,910	0	0	1,865,803
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	50,908	187,250	349,971	14,071,064
31.00	03100	INTENSIVE CARE UNIT	0	12,605	22,871	40,527	2,238,880
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	1,296	8,368	14,828	819,255
43.00	04300	NURSERY	0	3,046	8,765	15,532	1,225,764
44.00	04400	SKILLED NURSING FACILITY	0	2,524	6,251	11,076	990,680
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	248,930	39,340	216,904	6,831,119
51.00	05100	RECOVERY ROOM	0	556	6,947	34,586	506,366
53.00	05300	ANESTHESIOLOGY	0	8,245	10,414	49,158	211,490
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,507	43,361	202,146	2,752,631
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,248	819	17,421	834,870
60.00	06000	LABORATORY	0	187	79,726	211,922	4,045,009
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	3,940	17,865	33,757	855,334
66.00	06600	PHYSICAL THERAPY	0	2,696	13,121	42,521	2,263,907
69.00	06900	ELECTROCARDIOLOGY	0	15,395	32,825	101,545	983,828
70.00	07000	ELECTROENCEPHALOGRAPHY	0	154	767	4,050	54,602
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	39,153	109,492	3,784,068
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	20,483	57,231	3,119,670
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	112,687	238,101	3,597,282
74.00	07400	RENAL DIALYSIS	0	175	3,592	6,544	218,161
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	35	15	718	28,297
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	1,423	278	6,706	293,056
91.00	09100	EMERGENCY	0	7,267	21,225	95,045	1,202,128
91.01	04950	PARTIAL HOSPITALIZATION	0	288	4	3,332	172,048
92.00	09200	OBSERVATION BEDS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,856,983	418,184	676,127	1,863,113	80,038,278
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER	0	7,349	0	0	2,948,653
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,856,983	425,533	676,127	1,863,113	82,986,931

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140224

Period: From 07/01/2012 To 12/31/2012

Worksheet B Part I Date/Time Prepared: 5/24/2013 9:40 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.06	6.00	7.00	8.00	9.00	
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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING, RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL	10,757,825					5.06
6.00	00600	MAINTENANCE & REPAIRS	101,930	786,297				6.00
7.00	00700	OPERATION OF PLANT	505,287	76,699	3,974,541			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	65,922	2,133	11,949	522,613		8.00
9.00	00900	HOUSEKEEPING	221,062	37,679	211,043	713	1,954,735	9.00
10.00	01000	DIETARY	186,330	35,957	201,400	0	104,939	10.00
11.00	01100	CAFETERIA	13,360	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	186,544	3,627	20,318	0	10,587	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	48,024	33,192	185,914	97	96,870	14.00
15.00	01500	PHARMACY	127,761	6,949	38,920	0	20,279	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	133,551	14,354	80,398	0	41,891	16.00
17.00	01700	SOCIAL SERVICE	179,604	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	660,603	0	0	0	0	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	277,893	18,882	105,758	0	55,105	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,095,765	227,354	1,273,449	243,360	663,528	30.00
31.00	03100	INTENSIVE CARE UNIT	333,459	26,870	150,500	35,990	78,418	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	122,020	12,129	67,933	21,538	35,397	41.00
43.00	04300	NURSERY	182,565	1,771	9,917	0	5,167	43.00
44.00	04400	SKILLED NURSING FACILITY	147,552	28,492	159,585	34,387	83,151	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,017,427	76,145	426,497	87,152	222,225	50.00
51.00	05100	RECOVERY ROOM	75,418	3,889	21,781	0	11,349	51.00
53.00	05300	ANESTHESIOLOGY	31,499	1,645	9,211	0	4,800	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	409,977	49,894	279,461	32,831	145,612	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	124,346	17,446	97,715	7,239	50,914	55.00
60.00	06000	LABORATORY	602,464	20,507	114,865	3,351	59,850	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	127,393	6,041	33,835	15	17,630	65.00
66.00	06600	PHYSICAL THERAPY	337,186	12,318	68,997	2,324	35,951	66.00
69.00	06900	ELECTROCARDIOLOGY	146,531	18,502	103,632	3,674	53,997	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,132	71	400	1,017	208	70.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	563,599	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	464,644	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	535,779	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	32,493	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	4,215	0	0	117	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	43,648	12,779	71,576	47	37,294	90.00
91.00	09100	EMERGENCY	179,045	0	0	28,594	0	91.00
91.01	04950	PARTIAL HOSPITALIZATION	25,625	3,665	20,528	0	10,696	91.01
92.00	09200	OBSERVATION BEDS						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,318,653	748,990	3,765,582	502,446	1,845,858	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	439,172	37,307	208,959	20,167	108,877	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
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)	10,757,825	786,297	3,974,541	522,613	1,954,735	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140224		Period: From 07/01/2012 To 12/31/2012		Worksheet B Part I Date/Time Prepared: 5/24/2013 9:40 am	
Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
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
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING, RECEIVING&STORES					5.03
5.04	00570	ADMINITTING					5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE					5.05
5.06	00591	ADMINISTRATION & GENERAL					5.06
6.00	00600	MAINTENANCE & REPAIRS					6.00
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	1,779,667				10.00
11.00	01100	CAFETERIA	0	103,058			11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	1,473,555	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,442,193	83,516	0	712,255	0
31.00	03100	INTENSIVE CARE UNIT	61,398	3,555	0	90,432	0
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	96,836	5,608	0	42,550	0
43.00	04300	NURSERY	0	0	0	45,171	0
44.00	04400	SKILLED NURSING FACILITY	156,654	9,072	0	49,060	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,493	202	0	214,706	0
51.00	05100	RECOVERY ROOM	0	0	0	21,455	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	106,662	0
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	33,621	0
60.00	06000	LABORATORY	0	0	0	0	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	42,398	0
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	2,215	128	0	43,829	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,631	0
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	373,775
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	312,759
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	16,878	977	0	66,785	0
91.01	04950	PARTIAL HOSPITALIZATION	0	0	0	0	0
92.00	09200	OBSERVATION BEDS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,779,667	103,058	0	1,473,555	686,534
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER	0	0	0	0	0
194.01	07951	LAKESHORE GUEST UNIT	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)	1,779,667	103,058	0	1,473,555	686,534

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140224

Period: From 07/01/2012 To 12/31/2012

Worksheet B Part I Date/Time Prepared: 5/24/2013 9:40 am

Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS	SRVCES-SALARY & FRINGES	
		15.00	16.00	17.00	19.00	21.00		
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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING, RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,051,708					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,166,868				16.00
17.00	01700	SOCIAL SERVICE	0	0	1,385,486			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	0	0	0	0	5,095,965	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	219,300	942,811	0	3,514,120	30.00
31.00	03100	INTENSIVE CARE UNIT	0	25,379	176,659	0	841,914	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	9,285	66,389	0	0	41.00
43.00	04300	NURSERY	0	9,726	97,362	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	6,936	102,265	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	135,831	0	0	203,969	50.00
51.00	05100	RECOVERY ROOM	0	21,659	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	30,784	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	126,589	0	0	110,664	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	10,909	0	0	0	55.00
60.00	06000	LABORATORY	0	132,711	0	0	44,483	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	21,139	0	0	88,423	65.00
66.00	06600	PHYSICAL THERAPY	0	26,628	0	0	88,423	66.00
69.00	06900	ELECTROCARDIOLOGY	0	63,590	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,536	0	0	203,969	70.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	68,567	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	35,840	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,051,708	149,105	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	4,098	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	450	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	4,199	0	0	0	90.00
91.00	09100	EMERGENCY	0	59,520	0	0	0	91.00
91.01	04950	PARTIAL HOSPITALIZATION	0	2,087	0	0	0	91.01
92.00	09200	OBSERVATION BEDS						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,051,708	1,166,868	1,385,486	0	5,095,965	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	0	0	0	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
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)	1,051,708	1,166,868	1,385,486	0	5,095,965	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140224

Period:
From 07/01/2012
To 12/31/2012

Worksheet B
Part I
Date/Time Prepared:
5/24/2013 9:40 am

Cost Center Description	INTERNS & RESIDENTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	SRVCES-OTHER PRGM COSTS					
	22.00					24.00
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	
5.01 00540	NONPATIENT TELEPHONES				5.01	
5.02 00550	DATA PROCESSING				5.02	
5.03 00560	PURCHASING, RECEIVING&STORES				5.03	
5.04 00570	ADMINITTING				5.04	
5.05 00580	CASHIERING/ACCTS RECEIVABLE				5.05	
5.06 00591	ADMINISTRATION & GENERAL				5.06	
6.00 00600	MAINTENANCE & REPAIRS				6.00	
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	
12.00 01200	MAINTENANCE OF PERSONNEL				12.00	
13.00 01300	NURSING ADMINISTRATION				13.00	
14.00 01400	CENTRAL SERVICES & SUPPLY				14.00	
15.00 01500	PHARMACY				15.00	
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00	
17.00 01700	SOCIAL SERVICE				17.00	
19.00 01900	NONPHYSICIAN ANESTHETISTS				19.00	
21.00 02100	I&R SRVCES-SALARY & FRINGES APPRVD				21.00	
22.00 02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	2,323,441			22.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,602,220	27,090,935	-5,116,340	21,974,595	30.00
31.00 03100	INTENSIVE CARE UNIT	383,860	4,447,314	-1,225,774	3,221,540	31.00
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - IRF	0	1,298,940	0	1,298,940	41.00
43.00 04300	NURSERY	0	1,577,443	0	1,577,443	43.00
44.00 04400	SKILLED NURSING FACILITY	0	1,767,834	0	1,767,834	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	92,997	9,311,763	-296,966	9,014,797	50.00
51.00 05100	RECOVERY ROOM	0	661,917	0	661,917	51.00
53.00 05300	ANESTHESIOLOGY	0	289,429	0	289,429	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	50,456	4,064,777	-161,120	3,903,657	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	1,177,060	0	1,177,060	55.00
60.00 06000	LABORATORY	20,281	5,043,521	-64,764	4,978,757	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	40,315	1,232,523	-128,738	1,103,785	65.00
66.00 06600	PHYSICAL THERAPY	40,315	2,876,049	-128,738	2,747,311	66.00
69.00 06900	ELECTROCARDIOLOGY	0	1,419,926	0	1,419,926	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	92,997	368,563	-296,966	71,597	70.00
71.00 07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	4,790,009	0	4,790,009	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	3,932,913	0	3,932,913	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	5,333,874	0	5,333,874	73.00
74.00 07400	RENAL DIALYSIS	0	254,752	0	254,752	74.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00
76.97 07697	CARDIAC REHABILITATION	0	33,079	0	33,079	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	462,599	0	462,599	90.00
91.00 09100	EMERGENCY	0	1,553,927	0	1,553,927	91.00
91.01 04950	PARTIAL HOSPITALIZATION	0	234,649	0	234,649	91.01
92.00 09200	OBSERVATION BEDS	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,323,441	79,223,796	-7,419,406	71,804,390	118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	OTHER	0	3,763,135	0	3,763,135	194.00
194.01 07951	LAKESHORE GUEST UNIT	0	0	0	0	194.01
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	2,323,441	82,986,931	-7,419,406	75,567,525	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140224

Period: From 07/01/2012 To 12/31/2012

Worksheet B Part II Date/Time Prepared: 5/24/2013 9:40 am

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	0	9,754	32,935	42,689	42,689
5.01 00540	NONPATIENT TELEPHONES	0	0	0	0	0
5.02 00550	DATA PROCESSING	0	14,544	49,108	63,652	0
5.03 00560	PURCHASING, RECEIVING&STORES	0	0	0	0	0
5.04 00570	ADMINISTRATIVE	0	0	0	0	0
5.05 00580	CASHIERING/ACCTS RECEIVABLE	0	0	0	0	0
5.06 00591	ADMINISTRATION & GENERAL	0	388,121	1,310,502	1,698,623	2,530
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	299
7.00 00700	OPERATION OF PLANT	0	91,294	308,259	399,553	390
8.00 00800	LAUNDRY & LINEN SERVICE	0	2,539	8,574	11,113	0
9.00 00900	HOUSEKEEPING	0	44,849	151,433	196,282	721
10.00 01000	DIETARY	0	42,799	144,513	187,312	640
11.00 01100	CAFETERIA	0	0	0	0	400
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	0	4,318	14,579	18,897	1,076
14.00 01400	CENTRAL SERVICES & SUPPLY	0	39,508	133,402	172,910	0
15.00 01500	PHARMACY	0	8,271	27,927	36,198	1,333
16.00 01600	MEDICAL RECORDS & LIBRARY	0	17,085	57,689	74,774	520
17.00 01700	SOCIAL SERVICE	0	0	0	0	812
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
21.00 02100	I&R SRVCES-SALARY & FRINGES APPRVD	0	0	0	0	4,079
22.00 02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	22,475	75,886	98,361	2,305
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	270,619	913,756	1,184,375	10,473
31.00 03100	INTENSIVE CARE UNIT	0	31,983	107,990	139,973	1,607
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	0
41.00 04100	SUBPROVIDER - IRF	0	14,436	48,745	63,181	635
43.00 04300	NURSERY	0	2,107	7,116	9,223	1,018
44.00 04400	SKILLED NURSING FACILITY	0	33,913	114,509	148,422	723
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	90,634	306,031	396,665	3,406
51.00 05100	RECOVERY ROOM	0	4,629	15,629	20,258	407
53.00 05300	ANESTHESIOLOGY	0	1,958	6,610	8,568	68
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	59,388	200,525	259,913	1,892
55.00 05500	RADIOLOGY-THERAPEUTIC	0	20,765	70,115	90,880	551
60.00 06000	LABORATORY	0	24,410	82,420	106,830	0
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	0	7,190	24,278	31,468	608
66.00 06600	PHYSICAL THERAPY	0	14,662	49,508	64,170	1,725
69.00 06900	ELECTROCARDIOLOGY	0	22,023	74,360	96,383	855
70.00 07000	ELECTROENCEPHALOGRAPHY	0	85	287	372	47
71.00 07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00 07400	RENAL DIALYSIS	0	0	0	0	0
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	25
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	15,211	51,359	66,570	187
91.00 09100	EMERGENCY	0	0	0	0	1,071
91.01 04950	PARTIAL HOSPITALIZATION	0	4,362	14,730	19,092	138
92.00 09200	OBSERVATION BEDS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,303,932	4,402,775	5,706,707	40,541
NONREIMBURSABLE COST CENTERS						
194.00 07950	OTHER	0	44,406	149,937	194,343	2,148
194.01 07951	LAKESHORE GUEST UNIT	0	0	0	0	0
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	0	1,348,338	4,552,712	5,901,050	42,689

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet B Part II Date/Time Prepared: 5/24/2013 9:40 am		
Cost Center	Description	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING, RECEIVING & STORES	ADMINISTRATIVE	CASHIERING/ACCTS RECEIVABLE
		5.01	5.02	5.03	5.04	5.05
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.01	00540	0				5.01
5.02	00550		63,652			5.02
5.03	00560	0	0	0		5.03
5.04	00570	0	0	0	0	5.04
5.05	00580	0	0	0	0	5.05
5.06	00591	0	63,652	0	0	5.06
6.00	00600	0	0	0	0	6.00
7.00	00700	0	0	0	0	7.00
8.00	00800	0	0	0	0	8.00
9.00	00900	0	0	0	0	9.00
10.00	01000	0	0	0	0	10.00
11.00	01100	0	0	0	0	11.00
12.00	01200	0	0	0	0	12.00
13.00	01300	0	0	0	0	13.00
14.00	01400	0	0	0	0	14.00
15.00	01500	0	0	0	0	15.00
16.00	01600	0	0	0	0	16.00
17.00	01700	0	0	0	0	17.00
19.00	01900	0	0	0	0	19.00
21.00	02100	0	0	0	0	21.00
22.00	02200	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	0	0	0	0	30.00
31.00	03100	0	0	0	0	31.00
40.00	04000	0	0	0	0	40.00
41.00	04100	0	0	0	0	41.00
43.00	04300	0	0	0	0	43.00
44.00	04400	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	0	0	0	0	50.00
51.00	05100	0	0	0	0	51.00
53.00	05300	0	0	0	0	53.00
54.00	05400	0	0	0	0	54.00
55.00	05500	0	0	0	0	55.00
60.00	06000	0	0	0	0	60.00
62.30	06250	0	0	0	0	62.30
65.00	06500	0	0	0	0	65.00
66.00	06600	0	0	0	0	66.00
69.00	06900	0	0	0	0	69.00
70.00	07000	0	0	0	0	70.00
71.00	07100	0	0	0	0	71.00
72.00	07200	0	0	0	0	72.00
73.00	07300	0	0	0	0	73.00
74.00	07400	0	0	0	0	74.00
76.00	03950	0	0	0	0	76.00
76.97	07697	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	0	0	0	0	90.00
91.00	09100	0	0	0	0	91.00
91.01	04950	0	0	0	0	91.01
92.00	09200	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00		0	63,652	0	0	118.00
NONREIMBURSABLE COST CENTERS						
194.00	07950	0	0	0	0	194.00
194.01	07951	0	0	0	0	194.01
200.00						200.00
201.00		0	0	0	0	201.00
202.00		0	63,652	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet B Part II Date/Time Prepared: 5/24/2013 9:40 am				
Cost Center Description		ADM NI STRATI O N & GENERAL	MAI NTENANCE & REPAI RS	OPERATI ON OF PLANT	LAUNDRY & LINEN SERVI CE	HOUSEKEEPING		
		5.06	6.00	7.00	8.00	9.00		
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		
5.01	00540	NONPATIENT TELEPHONES				5.01		
5.02	00550	DATA PROCESSING				5.02		
5.03	00560	PURCHASING, RECEIVING&STORES				5.03		
5.04	00570	ADMITTING				5.04		
5.05	00580	CASHIERING/ACCTS RECEIVABLE				5.05		
5.06	00591	ADMINISTRATION & GENERAL	1,764,805			5.06		
6.00	00600	MAINTENANCE & REPAIRS	16,721	17,020		6.00		
7.00	00700	OPERATION OF PLANT	82,890	1,660	484,493	7.00		
8.00	00800	LAUNDRY & LINEN SERVICE	10,814	46	1,457	23,430	8.00	
9.00	00900	HOUSEKEEPING	36,264	816	25,726	32	259,841	9.00
10.00	01000	DIETARY	30,567	778	24,550	0	13,949	10.00
11.00	01100	CAFETERIA	2,192	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	30,602	79	2,477	0	1,407	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,878	718	22,663	4	12,877	14.00
15.00	01500	PHARMACY	20,959	150	4,744	0	2,696	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,908	311	9,800	0	5,569	16.00
17.00	01700	SOCIAL SERVICE	29,463	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	108,369	0	0	0	0	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	45,587	409	12,892	0	7,325	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	343,832	4,919	155,232	10,909	88,201	30.00
31.00	03100	INTENSIVE CARE UNIT	54,703	582	18,346	1,614	10,424	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	20,017	263	8,281	966	4,705	41.00
43.00	04300	NURSERY	29,949	38	1,209	0	687	43.00
44.00	04400	SKILLED NURSING FACILITY	24,205	617	19,453	1,542	11,053	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	166,905	1,648	51,990	3,907	29,540	50.00
51.00	05100	RECOVERY ROOM	12,372	84	2,655	0	1,509	51.00
53.00	05300	ANESTHESIOLOGY	5,167	36	1,123	0	638	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	67,255	1,080	34,066	1,472	19,356	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	20,398	378	11,911	325	6,768	55.00
60.00	06000	LABORATORY	98,832	444	14,002	150	7,956	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	20,898	131	4,124	1	2,343	65.00
66.00	06600	PHYSICAL THERAPY	55,314	267	8,411	104	4,779	66.00
69.00	06900	ELECTROCARDIOLOGY	24,038	400	12,633	165	7,178	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,334	2	49	46	28	70.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	92,456	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	76,223	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	87,892	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	5,330	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	691	0	0	5	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	7,160	277	8,725	2	4,958	90.00
91.00	09100	EMERGENCY	29,372	0	0	1,282	0	91.00
91.01	04950	PARTIAL HOSPITALIZATION	4,204	79	2,502	0	1,422	91.01
92.00	09200	OBSERVATION BEDS						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,692,761	16,212	459,021	22,526	245,368	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	72,044	808	25,472	904	14,473	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
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)	1,764,805	17,020	484,493	23,430	259,841	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140224		Period: From 07/01/2012 To 12/31/2012		Worksheet B Part II Date/Time Prepared: 5/24/2013 9:40 am	
Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00591						5.06
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	257,796					10.00
11.00	01100	0	2,592				11.00
12.00	01200	0	0	0			12.00
13.00	01300	0	0	0	54,538		13.00
14.00	01400	0	0	0	0	217,050	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	208,911	2,101	0	26,361	0	30.00
31.00	03100	8,894	89	0	3,347	0	31.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	14,027	141	0	1,575	0	41.00
43.00	04300	0	0	0	1,672	0	43.00
44.00	04400	22,692	228	0	1,816	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	506	5	0	7,947	0	50.00
51.00	05100	0	0	0	794	0	51.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	0	3,948	0	54.00
55.00	05500	0	0	0	1,244	0	55.00
60.00	06000	0	0	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	0	0	0	1,569	0	65.00
66.00	06600	0	0	0	0	0	66.00
69.00	06900	321	3	0	1,622	0	69.00
70.00	07000	0	0	0	171	0	70.00
71.00	07100	0	0	0	0	118,171	71.00
72.00	07200	0	0	0	0	98,879	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03950	0	0	0	0	0	76.00
76.97	07697	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	2,445	25	0	2,472	0	91.00
91.01	04950	0	0	0	0	0	91.01
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		257,796	2,592	0	54,538	217,050	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		257,796	2,592	0	54,538	217,050	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet B Part II Date/Time Prepared: 5/24/2013 9:40 am		
Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS SRVCES-SALARY & FRINGES
		15.00	16.00	17.00	19.00	21.00
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
5.01	00540	NONPATIENT TELEPHONES				5.01
5.02	00550	DATA PROCESSING				5.02
5.03	00560	PURCHASING, RECEIVING&STORES				5.03
5.04	00570	ADMITTING				5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE				5.05
5.06	00591	ADMINISTRATION & GENERAL				5.06
6.00	00600	MAINTENANCE & REPAIRS				6.00
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
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY	66,080			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	112,882		16.00
17.00	01700	SOCIAL SERVICE	0	0	30,275	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	0	0	0	112,448
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	21,238	20,601	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,455	3,860	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	898	1,451	41.00
43.00	04300	NURSERY	0	941	2,128	43.00
44.00	04400	SKILLED NURSING FACILITY	0	671	2,235	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	13,137	0	50.00
51.00	05100	RECOVERY ROOM	0	2,095	0	51.00
53.00	05300	ANESTHESIOLOGY	0	2,977	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,243	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,055	0	55.00
60.00	06000	LABORATORY	0	12,835	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	2,045	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,575	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	6,150	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	245	0	70.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	6,631	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,466	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	66,080	14,421	0	73.00
74.00	07400	RENAL DIALYSIS	0	396	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	43	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	406	0	90.00
91.00	09100	EMERGENCY	0	5,757	0	91.00
91.01	04950	PARTIAL HOSPITALIZATION	0	202	0	91.01
92.00	09200	OBSERVATION BEDS				92.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	66,080	112,882	30,275	0
NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	0	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	194.01
200.00		Cross Foot Adjustments				112,448
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	66,080	112,882	30,275	112,448

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140224

Period:
From 07/01/2012
To 12/31/2012

Worksheet B
Part II
Date/Time Prepared:
5/24/2013 9:40 am

Cost Center Description	INTERNS & RESIDENTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	SRVCES-OTHER PRGM COSTS				
	22.00				
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
5.01 00540	NONPATIENT TELEPHONES				5.01
5.02 00550	DATA PROCESSING				5.02
5.03 00560	PURCHASING, RECEIVING&STORES				5.03
5.04 00570	ADMITTING				5.04
5.05 00580	CASHIERING/ACCTS RECEIVABLE				5.05
5.06 00591	ADMINISTRATION & GENERAL				5.06
6.00 00600	MAINTENANCE & REPAIRS				6.00
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
12.00 01200	MAINTENANCE OF PERSONNEL				12.00
13.00 01300	NURSING ADMINISTRATION				13.00
14.00 01400	CENTRAL SERVICES & SUPPLY				14.00
15.00 01500	PHARMACY				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00
17.00 01700	SOCIAL SERVICE				17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS				19.00
21.00 02100	I&R SRVCES-SALARY & FRINGES APPRVD				21.00
22.00 02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	166,879			22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS		2,077,153	0	30.00
31.00 03100	INTENSIVE CARE UNIT		245,894	0	31.00
40.00 04000	SUBPROVIDER - IPF		0	0	40.00
41.00 04100	SUBPROVIDER - IRF		116,140	0	41.00
43.00 04300	NURSERY		46,865	0	43.00
44.00 04400	SKILLED NURSING FACILITY		233,657	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM		675,656	0	50.00
51.00 05100	RECOVERY ROOM		40,174	0	51.00
53.00 05300	ANESTHESIOLOGY		18,577	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC		401,225	0	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC		133,510	0	55.00
60.00 06000	LABORATORY		241,049	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	62.30
65.00 06500	RESPIRATORY THERAPY		63,187	0	65.00
66.00 06600	PHYSICAL THERAPY		137,345	0	66.00
69.00 06900	ELECTROCARDIOLOGY		149,748	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY		2,294	0	70.00
71.00 07100	MEDICAL SUPPLIES CHRGD TO PATIENTS		217,258	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT		178,568	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS		168,393	0	73.00
74.00 07400	RENAL DIALYSIS		5,726	0	74.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS		0	0	76.00
76.97 07697	CARDIAC REHABILITATION		764	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00 09000	CLINIC		88,285	0	90.00
91.00 09100	EMERGENCY		42,424	0	91.00
91.01 04950	PARTIAL HOSPITALIZATION		27,639	0	91.01
92.00 09200	OBSERVATION BEDS		0	0	92.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	5,311,531	0	118.00
NONREIMBURSABLE COST CENTERS					
194.00 07950	OTHER		310,192	0	194.00
194.01 07951	LAKESHORE GUEST UNIT		0	0	194.01
200.00	Cross Foot Adjustments	166,879	279,327	0	200.00
201.00	Negative Cost Centers	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	166,879	5,901,050	0	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140224

Period:
From 07/01/2012
To 12/31/2012

Worksheet B-1
Date/Time Prepared:
5/24/2013 9:40 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (TIME SPENT)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	602,698				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		602,698			2.00
4.00 00400	EMPLOYEE BENEFITS	4,360	4,360	38,049,574		4.00
5.01 00540	NONPATIENT TELEPHONES	0	0	0	1,113	5.01
5.02 00550	DATA PROCESSING	6,501	6,501	0	0	100 5.02
5.03 00560	PURCHASING, RECEIVING&STORES	0	0	0	18	0 5.03
5.04 00570	ADMINISTRATIVE	0	0	0	32	0 5.04
5.05 00580	CASHIERING/ACCTS RECEIVABLE	0	0	0	50	0 5.05
5.06 00591	ADMINISTRATION & GENERAL	173,487	173,487	2,254,714	136	100 5.06
6.00 00600	MAINTENANCE & REPAIRS	0	0	266,478	0	0 6.00
7.00 00700	OPERATION OF PLANT	40,808	40,808	348,038	46	0 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,135	1,135	0	4	0 8.00
9.00 00900	HOUSEKEEPING	20,047	20,047	642,500	6	0 9.00
10.00 01000	DIETARY	19,131	19,131	570,339	8	0 10.00
11.00 01100	CAFETERIA	0	0	356,878	12	0 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	1,930	1,930	958,989	48	0 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	17,660	17,660	0	5	0 14.00
15.00 01500	PHARMACY	3,697	3,697	1,188,014	20	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	7,637	7,637	463,537	38	0 16.00
17.00 01700	SOCIAL SERVICE	0	0	723,576	15	0 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
21.00 02100	I&R SRVCES-SALARY & FRINGES APPRVD	0	0	3,635,668	0	0 21.00
22.00 02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	10,046	10,046	2,054,258	53	0 22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	120,965	120,965	9,334,225	170	0 30.00
31.00 03100	INTENSIVE CARE UNIT	14,296	14,296	1,432,478	39	0 31.00
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	0 40.00
41.00 04100	SUBPROVIDER - IRF	6,453	6,453	566,372	23	0 41.00
43.00 04300	NURSERY	942	942	907,311	8	0 43.00
44.00 04400	SKILLED NURSING FACILITY	15,159	15,159	644,669	12	0 44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	40,513	40,513	3,035,461	82	0 50.00
51.00 05100	RECOVERY ROOM	2,069	2,069	362,852	0	0 51.00
53.00 05300	ANESTHESIOLOGY	875	875	60,739	2	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	26,546	26,546	1,686,304	81	0 54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	9,282	9,282	491,428	0	0 55.00
60.00 06000	LABORATORY	10,911	10,911	0	58	0 60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00 06500	RESPIRATORY THERAPY	3,214	3,214	541,684	14	0 65.00
66.00 06600	PHYSICAL THERAPY	6,554	6,554	1,537,148	28	0 66.00
69.00 06900	ELECTROCARDIOLOGY	9,844	9,844	761,795	16	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	38	38	42,242	13	0 70.00
71.00 07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	0	0	0	6	0 74.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0 76.00
76.97 07697	CARDIAC REHABILITATION	0	0	21,902	3	0 76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	6,799	6,799	167,031	42	0 90.00
91.00 09100	EMERGENCY	0	0	954,788	25	0 91.00
91.01 04950	PARTIAL HOSPITALIZATION	1,950	1,950	123,414	0	0 91.01
92.00 09200	OBSERVATION BEDS					92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	582,849	582,849	36,134,832	1,113	100 118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	OTHER	19,849	19,849	1,914,742	0	0 194.00
194.01 07951	LAKESHORE GUEST UNIT	0	0	0	0	0 194.01
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)	1,348,338	4,552,712	8,411,897	119,188	1,856,983 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	2.237170	7.553886	0.221077	107.087152	18,569.830000 203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			42,689	0	63,652 204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001122	0.000000	636.520000 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140224

Period: From 07/01/2012 To 12/31/2012

Worksheet B-1

Date/Time Prepared: 5/24/2013 9:40 am

Cost Center Description			PURCHASING, RECEIVING & STORES (SUPPLY EXPENSE)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACCTS RECEIVABLE (GROSS REVENUE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			5.03	5.04	5.05	5A.06	5.06	
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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING, RECEIVING & STORES	4,584,521					5.03
5.04	00570	ADMITTING	0	226,041,351				5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	0	351,560,930			5.05
5.06	00591	ADMINISTRATION & GENERAL	106,396	0	0	-10,757,825	72,229,106	5.06
6.00	00600	MAINTENANCE & REPAIRS	480	0	0	0	684,367	6.00
7.00	00700	OPERATION OF PLANT	1,575	0	0	0	3,392,555	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5	0	0	0	442,609	8.00
9.00	00900	HOUSEKEEPING	64,484	0	0	0	1,484,238	9.00
10.00	01000	DIETARY	87,985	0	0	0	1,251,041	10.00
11.00	01100	CAFETERIA	0	0	0	0	89,698	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,487	0	0	0	1,252,479	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	91,708	0	0	0	322,437	14.00
15.00	01500	PHARMACY	23,298	0	0	0	857,799	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,476	0	0	0	896,674	16.00
17.00	01700	SOCIAL SERVICE	1,329	0	0	0	1,205,882	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	0	0	0	0	4,435,362	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	149,859	0	0	0	1,865,803	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	548,463	62,592,565	66,062,799	0	14,071,064	30.00
31.00	03100	INTENSIVE CARE UNIT	135,798	7,646,592	7,646,592	0	2,238,880	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	13,961	2,797,659	2,797,659	0	819,255	41.00
43.00	04300	NURSERY	32,812	2,930,492	2,930,492	0	1,225,764	43.00
44.00	04400	SKILLED NURSING FACILITY	27,196	2,089,785	2,089,785	0	990,680	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,681,860	13,152,850	40,925,284	0	6,831,119	50.00
51.00	05100	RECOVERY ROOM	5,992	2,322,475	6,525,616	0	506,366	51.00
53.00	05300	ANESTHESIOLOGY	88,832	3,481,627	9,275,074	0	211,490	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	80,878	14,497,025	38,140,845	0	2,752,631	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	13,450	273,815	3,286,920	0	834,870	55.00
60.00	06000	LABORATORY	2,010	26,655,302	39,985,290	0	4,045,009	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	42,450	5,973,065	6,369,161	0	855,334	65.00
66.00	06600	PHYSICAL THERAPY	29,041	4,386,704	8,022,793	0	2,263,907	66.00
69.00	06900	ELECTROCARDIOLOGY	165,860	10,974,606	19,159,363	0	983,828	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,661	256,561	764,179	0	54,602	70.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	13,090,195	20,658,811	0	3,784,068	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	6,848,314	10,798,296	0	3,119,670	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	37,675,270	44,924,722	0	3,597,282	73.00
74.00	07400	RENAL DIALYSIS	1,888	1,201,015	1,234,695	0	218,161	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	382	4,929	135,500	0	28,297	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	15,332	92,893	1,265,271	0	293,056	90.00
91.00	09100	EMERGENCY	78,286	7,096,175	17,933,028	0	1,202,128	91.00
91.01	04950	PARTIAL HOSPITALIZATION	3,108	1,437	628,755	0	172,048	91.01
92.00	09200	OBSERVATION BEDS						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,505,342	226,041,351	351,560,930	-10,757,825	69,280,453	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	79,179	0	0	0	2,948,653	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
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)	425,533	676,127	1,863,113		10,757,825	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.092820	0.002991	0.005300		0.148940	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	0		1,764,805	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000000		0.024433	205.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet B-1 Date/Time Prepared: 5/24/2013 9:40 am	
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Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY POUNDS)	HOUSEKEEPING (SQUARE FEET)	DIETARY ((MEALS SERVED))		
		6.00	7.00	8.00	9.00	10.00		
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	
5.01	00540	NONPATIENT TELEPHONES					5.01	
5.02	00550	DATA PROCESSING					5.02	
5.03	00560	PURCHASING, RECEIVING&STORES					5.03	
5.04	00570	ADMITTING					5.04	
5.05	00580	CASHIERING/ACCTS RECEIVABLE					5.05	
5.06	00591	ADMINISTRATION & GENERAL					5.06	
6.00	00600	MAINTENANCE & REPAIRS	418,350				6.00	
7.00	00700	OPERATION OF PLANT	40,808	377,542			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	1,135	1,135	858,402		8.00	
9.00	00900	HOUSEKEEPING	20,047	20,047	1,171	356,360	9.00	
10.00	01000	DIETARY	19,131	19,131	0	19,131	224,177	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,930	1,930	0	1,930	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	17,660	17,660	159	17,660	0	14.00
15.00	01500	PHARMACY	3,697	3,697	0	3,697	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,637	7,637	0	7,637	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SRVCES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	10,046	10,046	0	10,046	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	120,965	120,965	399,725	120,965	181,667	30.00
31.00	03100	INTENSIVE CARE UNIT	14,296	14,296	59,114	14,296	7,734	31.00
40.00	04000	SUBPROVIDER - I/PF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I/RF	6,453	6,453	35,376	6,453	12,198	41.00
43.00	04300	NURSERY	942	942	0	942	0	43.00
44.00	04400	SKILLED NURSING FACILITY	15,159	15,159	56,482	15,159	19,733	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	40,513	40,513	143,148	40,513	440	50.00
51.00	05100	RECOVERY ROOM	2,069	2,069	0	2,069	0	51.00
53.00	05300	ANESTHESIOLOGY	875	875	0	875	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,546	26,546	53,926	26,546	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	9,282	9,282	11,890	9,282	0	55.00
60.00	06000	LABORATORY	10,911	10,911	5,504	10,911	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,214	3,214	24	3,214	0	65.00
66.00	06600	PHYSICAL THERAPY	6,554	6,554	3,818	6,554	0	66.00
69.00	06900	ELECTROCARDIOLOGY	9,844	9,844	6,034	9,844	279	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	38	38	1,670	38	0	70.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	192	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	6,799	6,799	78	6,799	0	90.00
91.00	09100	EMERGENCY	0	0	46,966	0	2,126	91.00
91.01	04950	PARTIAL HOSPITALIZATION	1,950	1,950	0	1,950	0	91.01
92.00	09200	OBSERVATION BEDS						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	398,501	357,693	825,277	336,511	224,177	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	OTHER	19,849	19,849	33,125	19,849	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
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)	786,297	3,974,541	522,613	1,954,735	1,779,667	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.879520	10.527414	0.608821	5.485282	7.938669	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	17,020	484,493	23,430	259,841	257,796	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.040684	1.283282	0.027295	0.729153	1.149966	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140224

Period:
From 07/01/2012
To 12/31/2012

Worksheet B-1
Date/Time Prepared:
5/24/2013 9:40 am

Cost Center Description		CAFETERIA ((MEALS SERVED))	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION ((DIRECT NRSNG HRS))	CENTRAL SERVICES & SUPPLY (SUPPLY EXPENSE)	PHARMACY ((COSTED REQUIS))	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00591						5.06
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	224,177					11.00
12.00	01200		0	0			12.00
13.00	01300			631,256			13.00
14.00	01400				6,677,379		14.00
15.00	01500					3,246,494	15.00
16.00	01600						16.00
17.00	01700						17.00
19.00	01900						19.00
21.00	02100						21.00
22.00	02200						22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	181,667	0	305,122	0	0	30.00
31.00	03100	7,734	0	38,740	0	0	31.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	12,198	0	18,228	0	0	41.00
43.00	04300	0	0	19,351	0	0	43.00
44.00	04400	19,733	0	21,017	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	440	0	91,978	0	0	50.00
51.00	05100	0	0	9,191	0	0	51.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	45,693	0	0	54.00
55.00	05500	0	0	14,403	0	0	55.00
60.00	06000	0	0	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	0	0	18,163	0	0	65.00
66.00	06600	0	0	0	0	0	66.00
69.00	06900	279	0	18,776	0	0	69.00
70.00	07000	0	0	1,984	0	0	70.00
71.00	07100	0	0	0	3,635,423	0	71.00
72.00	07200	0	0	0	3,041,956	0	72.00
73.00	07300	0	0	0	0	3,246,494	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03950	0	0	0	0	0	76.00
76.97	07697	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	2,126	0	28,610	0	0	91.00
91.01	04950	0	0	0	0	0	91.01
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		224,177	0	631,256	6,677,379	3,246,494	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		103,058	0	1,473,555	686,534	1,051,708	202.00
203.00		0.459717	0.000000	2.334322	0.102815	0.323952	203.00
204.00		2,592	0	54,538	217,050	66,080	204.00
205.00		0.011562	0.000000	0.086396	0.032505	0.020354	205.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet B-1 Date/Time Prepared: 5/24/2013 9:40 am
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Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	INTERNS & RESIDENTS			
				SRVCES-SALARY & FRINGES ((ASSIGNED TIME))	SRVCES-OTHER PRGM COSTS ((ASSIGNED TIME))		
	16.00	17.00	19.00	21.00	22.00		
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	
5.01 00540 NONPATIENT TELEPHONES						5.01	
5.02 00550 DATA PROCESSING						5.02	
5.03 00560 PURCHASING, RECEIVING&STORES						5.03	
5.04 00570 ADMITTING						5.04	
5.05 00580 CASHIERING/ACCTS RECEIVABLE						5.05	
5.06 00591 ADMINISTRATION & GENERAL						5.06	
6.00 00600 MAINTENANCE & REPAIRS						6.00	
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	
12.00 01200 MAINTENANCE OF PERSONNEL						12.00	
13.00 01300 NURSING ADMINISTRATION						13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00	
15.00 01500 PHARMACY						15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	351,560,930					16.00	
17.00 01700 SOCIAL SERVICE	0	33,057				17.00	
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0			19.00	
21.00 02100 I&R SRVCES-SALARY & FRINGES APPRVD	0	0		9,394		21.00	
22.00 02200 I&R SRVCES-OTHER PRGM COSTS APPRVD	0	0			9,394	22.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	66,062,799	22,495		6,478	6,478	30.00	
31.00 03100 INTENSIVE CARE UNIT	7,646,592	4,215		1,552	1,552	31.00	
40.00 04000 SUBPROVIDER - IPF	0	0		0	0	40.00	
41.00 04100 SUBPROVIDER - IRF	2,797,659	1,584		0	0	41.00	
43.00 04300 NURSERY	2,930,492	2,323		0	0	43.00	
44.00 04400 SKILLED NURSING FACILITY	2,089,785	2,440		0	0	44.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	40,925,284	0	0	376	376	50.00	
51.00 05100 RECOVERY ROOM	6,525,616	0	0	0	0	51.00	
53.00 05300 ANESTHESIOLOGY	9,275,074	0	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	38,140,845	0	0	204	204	54.00	
55.00 05500 RADIOLOGY-THERAPEUTIC	3,286,920	0	0	0	0	55.00	
60.00 06000 LABORATORY	39,985,290	0	0	82	82	60.00	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30	
65.00 06500 RESPIRATORY THERAPY	6,369,161	0	0	163	163	65.00	
66.00 06600 PHYSICAL THERAPY	8,022,793	0	0	163	163	66.00	
69.00 06900 ELECTROCARDIOLOGY	19,159,363	0	0	0	0	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	764,179	0	0	376	376	70.00	
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	20,658,811	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	10,798,296	0	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	44,924,722	0	0	0	0	73.00	
74.00 07400 RENAL DIALYSIS	1,234,695	0	0	0	0	74.00	
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00	
76.97 07697 CARDIAC REHABILITATION	135,500	0	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	1,265,271	0	0	0	0	90.00	
91.00 09100 EMERGENCY	17,933,028	0	0	0	0	91.00	
91.01 04950 PARTIAL HOSPITALIZATION	628,755	0	0	0	0	91.01	
92.00 09200 OBSERVATION BEDS						92.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	351,560,930	33,057	0	9,394	9,394	118.00
NONREIMBURSABLE COST CENTERS							
194.00 07950 OTHER	0	0	0	0	0	194.00	
194.01 07951 LAKESHORE GUEST UNIT	0	0	0	0	0	194.01	
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)	1,166,868	1,385,486	0	5,095,965	2,323,441	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.003319	41.912031	0.000000	542.470194	247.332446	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	112,882	30,275	0	112,448	166,879	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000321	0.915842	0.000000	11.970194	17.764424	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet C Part I Date/Time Prepared: 5/24/2013 9:40 am
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Cost Center Description	Therapy Limit Adj.	Costs			Charges	
		Total Costs	RCE Disallowance	Total Costs	Inpatient	
		1.00	2.00	3.00	4.00	5.00

INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	21,974,595		21,974,595	10,607	21,985,202	61,844,748	30.00
31.00	03100	INTENSIVE CARE UNIT	3,221,540		3,221,540	0	3,221,540	7,646,592	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	1,298,940		1,298,940	0	1,298,940	2,797,659	41.00
43.00	04300	NURSERY	1,577,443		1,577,443	0	1,577,443	2,930,492	43.00
44.00	04400	SKILLED NURSING FACILITY	1,767,834		1,767,834	0	1,767,834	2,089,785	44.00

ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	9,014,797		9,014,797	0	9,014,797	13,152,850	50.00
51.00	05100	RECOVERY ROOM	661,917		661,917	0	661,917	2,322,475	51.00
53.00	05300	ANESTHESIOLOGY	289,429		289,429	0	289,429	3,481,627	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,903,657		3,903,657	0	3,903,657	14,497,025	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,177,060		1,177,060	0	1,177,060	273,815	55.00
60.00	06000	LABORATORY	4,978,757		4,978,757	0	4,978,757	26,655,302	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,103,785	0	1,103,785	0	1,103,785	5,973,065	65.00
66.00	06600	PHYSICAL THERAPY	2,747,311	0	2,747,311	0	2,747,311	4,386,704	66.00
69.00	06900	ELECTROCARDIOLOGY	1,419,926		1,419,926	0	1,419,926	10,974,606	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	71,597		71,597	0	71,597	256,561	70.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	4,790,009		4,790,009	0	4,790,009	13,090,195	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,932,913		3,932,913	0	3,932,913	6,848,314	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,333,874		5,333,874	0	5,333,874	37,675,270	73.00
74.00	07400	RENAL DIALYSIS	254,752		254,752	0	254,752	1,201,015	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	33,079		33,079	0	33,079	4,929	76.97

OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	462,599		462,599	0	462,599	92,893	90.00
91.00	09100	EMERGENCY	1,553,927		1,553,927	0	1,553,927	7,096,175	91.00
91.01	04950	PARTIAL HOSPITALIZATION	234,649		234,649	0	234,649	1,437	91.01
92.00	09200	OBSERVATION BEDS	1,852,609		1,852,609	0	1,852,609	747,817	92.00
200.00		Subtotal (see instructions)	73,656,999	0	73,656,999	10,607	73,667,606	226,041,351	200.00
201.00		Less Observation Beds	1,852,609		1,852,609		1,852,609		201.00
202.00		Total (see instructions)	71,804,390	0	71,804,390	10,607	71,814,997	226,041,351	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		61,844,748					30.00
31.00	03100	INTENSIVE CARE UNIT		7,646,592					31.00
40.00	04000	SUBPROVIDER - IPF		0					40.00
41.00	04100	SUBPROVIDER - IRF		2,797,659					41.00
43.00	04300	NURSERY		2,930,492					43.00
44.00	04400	SKILLED NURSING FACILITY		2,089,785					44.00

ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	27,772,434	40,925,284	0.220275	0.000000	0.220275		50.00
51.00	05100	RECOVERY ROOM	4,203,141	6,525,616	0.101434	0.000000	0.101434		51.00
53.00	05300	ANESTHESIOLOGY	5,793,447	9,275,074	0.031205	0.000000	0.031205		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,643,820	38,140,845	0.102348	0.000000	0.102348		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,013,105	3,286,920	0.358104	0.000000	0.358104		55.00
60.00	06000	LABORATORY	13,329,988	39,985,290	0.124515	0.000000	0.124515		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	396,096	6,369,161	0.173301	0.000000	0.173301		65.00
66.00	06600	PHYSICAL THERAPY	3,636,089	8,022,793	0.342438	0.000000	0.342438		66.00
69.00	06900	ELECTROCARDIOLOGY	8,184,757	19,159,363	0.074111	0.000000	0.074111		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	507,618	764,179	0.093691	0.000000	0.093691		70.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	7,568,616	20,658,811	0.231863	0.000000	0.231863		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,949,982	10,798,296	0.364216	0.000000	0.364216		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,249,452	44,924,722	0.118729	0.000000	0.118729		73.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140224

Period:
From 07/01/2012
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		
74.00	07400	RENAL DIALYSIS	33,680	1,234,695	0.206328	0.000000	0.206328		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	130,571	135,500	0.244125	0.000000	0.244125		76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	1,172,378	1,265,271	0.365613	0.000000	0.365613		90.00
91.00	09100	EMERGENCY	10,836,853	17,933,028	0.086652	0.000000	0.086652		91.00
91.01	04950	PARTIAL HOSPITALIZATION	627,318	628,755	0.373196	0.000000	0.373196		91.01
92.00	09200	OBSERVATION BEDS	3,470,234	4,218,051	0.439210	0.000000	0.439210		92.00
200.00		Subtotal (see instructions)	125,519,579	351,560,930					200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	125,519,579	351,560,930					202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140224

Period:
From 07/01/2012
To 12/31/2012

Worksheet C
Part I
Date/Time Prepared:
5/24/2013 9:40 am

			Title XIX		Hospital		Cost		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			
			Total Costs	RCE Disallowance	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	21,974,595		21,974,595	0	0	61,844,748	30.00
31.00	03100	INTENSIVE CARE UNIT	3,221,540		3,221,540	0	0	7,646,592	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	1,298,940		1,298,940	0	0	2,797,659	41.00
43.00	04300	NURSERY	1,577,443		1,577,443	0	0	2,930,492	43.00
44.00	04400	SKILLED NURSING FACILITY	1,767,834		1,767,834	0	0	2,089,785	44.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	9,014,797		9,014,797	0	0	13,152,850	50.00
51.00	05100	RECOVERY ROOM	661,917		661,917	0	0	2,322,475	51.00
53.00	05300	ANESTHESIOLOGY	289,429		289,429	0	0	3,481,627	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,903,657		3,903,657	0	0	14,497,025	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,177,060		1,177,060	0	0	273,815	55.00
60.00	06000	LABORATORY	4,978,757		4,978,757	0	0	26,655,302	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,103,785	0	1,103,785	0	0	5,973,065	65.00
66.00	06600	PHYSICAL THERAPY	2,747,311	0	2,747,311	0	0	4,386,704	66.00
69.00	06900	ELECTROCARDIOLOGY	1,419,926		1,419,926	0	0	10,974,606	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	71,597		71,597	0	0	256,561	70.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	4,790,009		4,790,009	0	0	13,090,195	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,932,913		3,932,913	0	0	6,848,314	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,333,874		5,333,874	0	0	37,675,270	73.00
74.00	07400	RENAL DIALYSIS	254,752		254,752	0	0	1,201,015	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	33,079		33,079	0	0	4,929	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	462,599		462,599	0	0	92,893	90.00
91.00	09100	EMERGENCY	1,553,927		1,553,927	0	0	7,096,175	91.00
91.01	04950	PARTIAL HOSPITALIZATION	234,649		234,649	0	0	1,437	91.01
92.00	09200	OBSERVATION BEDS	1,852,609		1,852,609	0	0	747,817	92.00
200.00		Subtotal (see instructions)	73,656,999	0	73,656,999	0	0	226,041,351	200.00
201.00		Less Observation Beds	1,852,609		1,852,609	0	0	0	201.00
202.00		Total (see instructions)	71,804,390	0	71,804,390	0	0	226,041,351	202.00
Charges									
Cost Center Description		Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio			
		7.00	8.00	9.00	10.00	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS		61,844,748				30.00	
31.00	03100	INTENSIVE CARE UNIT		7,646,592				31.00	
40.00	04000	SUBPROVIDER - IPF		0				40.00	
41.00	04100	SUBPROVIDER - IRF		2,797,659				41.00	
43.00	04300	NURSERY		2,930,492				43.00	
44.00	04400	SKILLED NURSING FACILITY		2,089,785				44.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	27,772,434	40,925,284	0.220275	0.000000	0.000000	50.00	
51.00	05100	RECOVERY ROOM	4,203,141	6,525,616	0.101434	0.000000	0.000000	51.00	
53.00	05300	ANESTHESIOLOGY	5,793,447	9,275,074	0.031205	0.000000	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,643,820	38,140,845	0.102348	0.000000	0.000000	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	3,013,105	3,286,920	0.358104	0.000000	0.000000	55.00	
60.00	06000	LABORATORY	13,329,988	39,985,290	0.124515	0.000000	0.000000	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0.000000	62.30	
65.00	06500	RESPIRATORY THERAPY	396,096	6,369,161	0.173301	0.000000	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	3,636,089	8,022,793	0.342438	0.000000	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	8,184,757	19,159,363	0.074111	0.000000	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	507,618	764,179	0.093691	0.000000	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	7,568,616	20,658,811	0.231863	0.000000	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,949,982	10,798,296	0.364216	0.000000	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	7,249,452	44,924,722	0.118729	0.000000	0.000000	73.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140224

Period:
From 07/01/2012
To 12/31/2012

Worksheet C
Part I
Date/Time Prepared:
5/24/2013 9:40 am

Cost Center Description			Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	Cost
			Outpatient	Total (col. 6 + col. 7)				
7.00			7.00	8.00	9.00	10.00	11.00	
74.00	07400	RENAL DIALYSIS	33,680	1,234,695	0.206328	0.000000	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	130,571	135,500	0.244125	0.000000	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,172,378	1,265,271	0.365613	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	10,836,853	17,933,028	0.086652	0.000000	0.000000	91.00
91.01	04950	PARTIAL HOSPITALIZATION	627,318	628,755	0.373196	0.000000	0.000000	91.01
92.00	09200	OBSERVATION BEDS	3,470,234	4,218,051	0.439210	0.000000	0.000000	92.00
200.00		Subtotal (see instructions)	125,519,579	351,560,930				200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	125,519,579	351,560,930				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part I Date/Time Prepared: 5/24/2013 9:40 am
		Title XVIII	Hospital	PPS

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)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	2,077,153	0	2,077,153	24,565	84.56	30.00	
31.00	INTENSIVE CARE UNIT	245,894		245,894	4,215	58.34	31.00	
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00	
41.00	SUBPROVIDER - IRF	116,140	0	116,140	1,584	73.32	41.00	
43.00	NURSERY	46,865		46,865	2,323	20.17	43.00	
44.00	SKILLED NURSING FACILITY	233,657		233,657	2,440	95.76	44.00	
200.00	Total (lines 30-199)	2,719,709		2,719,709	35,127		200.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	9,960	842,218					30.00
31.00	INTENSIVE CARE UNIT	1,194	69,658					31.00
40.00	SUBPROVIDER - IPF	0	0					40.00
41.00	SUBPROVIDER - IRF	1,222	89,597					41.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	1,911	182,997					44.00
200.00	Total (lines 30-199)	14,287	1,184,470					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part II Date/Time Prepared: 5/24/2013 9:40 am
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Cost Center Description		Capital Related Cost (from Wkst. C, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	675,656	40,925,284	0.016510	6,064,411	100,123	50.00
51.00	05100 RECOVERY ROOM	40,174	6,525,616	0.006156	1,058,205	6,514	51.00
53.00	05300 ANESTHESIOLOGY	18,577	9,275,074	0.002003	1,291,097	2,586	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	401,225	38,140,845	0.010520	6,450,442	67,859	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	133,510	3,286,920	0.040619	148,301	6,024	55.00
60.00	06000 LABORATORY	241,049	39,985,290	0.006028	12,652,785	76,271	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	63,187	6,369,161	0.009921	3,142,042	31,172	65.00
66.00	06600 PHYSICAL THERAPY	137,345	8,022,793	0.017119	1,014,759	17,372	66.00
69.00	06900 ELECTROCARDIOLOGY	149,748	19,159,363	0.007816	5,370,743	41,978	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	2,294	764,179	0.003002	152,304	457	70.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	217,258	20,658,811	0.010516	6,314,666	66,405	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	178,568	10,798,296	0.016537	3,441,797	56,917	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	168,393	44,924,722	0.003748	15,946,315	59,767	73.00
74.00	07400 RENAL DIALYSIS	5,726	1,234,695	0.004638	791,515	3,671	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	764	135,500	0.005638	1,699	10	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	88,285	1,265,271	0.069776	39,780	2,776	90.00
91.00	09100 EMERGENCY	42,424	17,933,028	0.002366	3,890,600	9,205	91.00
91.01	04950 PARTIAL HOSPITALIZATION	27,639	628,755	0.043958	0	0	91.01
92.00	09200 OBSERVATION BEDS	175,034	4,218,051	0.041496	510,442	21,181	92.00
200.00	Total (lines 50-199)	2,766,856	274,251,654		68,281,903	570,288	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part III Date/Time Prepared: 5/24/2013 9:40 am
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Cost Center Description	Title XVIII				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	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
200.00		Total (lines 30-199)	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	24,565	0.00	9,960	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,215	0.00	1,194	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0.00	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	1,584	0.00	1,222	0	41.00
43.00	04300	NURSERY	2,323	0.00	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,440	0.00	1,911	0	44.00
200.00		Total (lines 30-199)	35,127		14,287	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/24/2013 9:40 am
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Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		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	
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00	
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0	0	0	0	0	91.00	
91.01	04950	PARTIAL HOSPITALIZATION	0	0	0	0	0	91.01	
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: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/24/2013 9:40 am
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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 Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	PPS
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	40,925,284	0.000000	0.000000	6,064,411	50.00
51.00	05100 RECOVERY ROOM	0	6,525,616	0.000000	0.000000	1,058,205	51.00
53.00	05300 ANESTHESIOLOGY	0	9,275,074	0.000000	0.000000	1,291,097	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	38,140,845	0.000000	0.000000	6,450,442	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	3,286,920	0.000000	0.000000	148,301	55.00
60.00	06000 LABORATORY	0	39,985,290	0.000000	0.000000	12,652,785	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	6,369,161	0.000000	0.000000	3,142,042	65.00
66.00	06600 PHYSICAL THERAPY	0	8,022,793	0.000000	0.000000	1,014,759	66.00
69.00	06900 ELECTROCARDIOLOGY	0	19,159,363	0.000000	0.000000	5,370,743	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	764,179	0.000000	0.000000	152,304	70.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	20,658,811	0.000000	0.000000	6,314,666	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	10,798,296	0.000000	0.000000	3,441,797	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	44,924,722	0.000000	0.000000	15,946,315	73.00
74.00	07400 RENAL DIALYSIS	0	1,234,695	0.000000	0.000000	791,515	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	135,500	0.000000	0.000000	1,699	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	1,265,271	0.000000	0.000000	39,780	90.00
91.00	09100 EMERGENCY	0	17,933,028	0.000000	0.000000	3,890,600	91.00
91.01	04950 PARTIAL HOSPITALIZATION	0	628,755	0.000000	0.000000	0	91.01
92.00	09200 OBSERVATION BEDS	0	4,218,051	0.000000	0.000000	510,442	92.00
200.00	Total (lines 50-199)	0	274,251,654			68,281,903	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/24/2013 9:40 am
	Title XVIII	Hospital	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	5,699,516	0	50.00
51.00	05100 RECOVERY ROOM	0	584,000	0	51.00
53.00	05300 ANESTHESIOLOGY	0	1,170,220	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	6,710,383	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	1,681,094	0	55.00
60.00	06000 LABORATORY	0	818,380	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	145,266	0	65.00
66.00	06600 PHYSICAL THERAPY	0	151,209	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	3,248,123	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	172,829	0	70.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	1,811,390	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	1,162,995	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,989,401	0	73.00
74.00	07400 RENAL DIALYSIS	0	21,748	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	58,050	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	208,256	0	90.00
91.00	09100 EMERGENCY	0	2,364,170	0	91.00
91.01	04950 PARTIAL HOSPITALIZATION	0	57,456	0	91.01
92.00	09200 OBSERVATION BEDS	0	1,314,428	0	92.00
200.00	Total (lines 50-199)	0	30,368,914	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/24/2013 9:40 am
	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	0.220275	5,699,516	0	0	1,255,461	50.00	
51.00 05100 RECOVERY ROOM	0.101434	584,000	0	0	59,237	51.00	
53.00 05300 ANESTHESIOLOGY	0.031205	1,170,220	0	0	36,517	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.102348	6,710,383	14	0	686,794	54.00	
55.00 05500 RADIOLOGY-THERAPEUTIC	0.358104	1,681,094	0	0	602,006	55.00	
60.00 06000 LABORATORY	0.124515	818,380	0	0	101,901	60.00	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
65.00 06500 RESPIRATORY THERAPY	0.173301	145,266	0	0	25,175	65.00	
66.00 06600 PHYSICAL THERAPY	0.342438	151,209	1	0	51,780	66.00	
69.00 06900 ELECTROCARDIOLOGY	0.074111	3,248,123	10	0	240,722	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0.093691	172,829	0	0	16,193	70.00	
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0.231863	1,811,390	4,363	0	419,994	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.364216	1,162,995	11,250	0	423,581	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0.118729	2,989,401	0	13,050	354,929	73.00	
74.00 07400 RENAL DIALYSIS	0.206328	21,748	0	0	4,487	74.00	
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00	
76.97 07697 CARDIAC REHABILITATION	0.244125	58,050	0	0	14,171	76.97	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0.365613	208,256	6	0	76,141	90.00	
91.00 09100 EMERGENCY	0.086652	2,364,170	0	0	204,860	91.00	
91.01 04950 PARTIAL HOSPITALIZATION	0.373196	57,456	0	0	21,442	91.01	
92.00 09200 OBSERVATION BEDS	0.439210	1,314,428	0	0	577,310	92.00	
200.00		Subtotal (see instructions)	30,368,914	15,644	13,050	5,172,701	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0	0		201.00
202.00		Net Charges (Line 200 +/- Line 201)	30,368,914	15,644	13,050	5,172,701	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/24/2013 9:40 am
		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
51.00 05100	RECOVERY ROOM	0	0	51.00
53.00 05300	ANESTHESIOLOGY	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1	0	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00 06000	LABORATORY	0	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	66.00
69.00 06900	ELECTROCARDIOLOGY	1	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	1,012	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	4,097	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	1,549	73.00
74.00 07400	RENAL DIALYSIS	0	0	74.00
76.00 03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.97 07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00 09000	CLINIC	2	0	90.00
91.00 09100	EMERGENCY	0	0	91.00
91.01 04950	PARTIAL HOSPITALIZATION	0	0	91.01
92.00 09200	OBSERVATION BEDS	0	0	92.00
200.00	Subtotal (see instructions)	5,113	1,549	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	5,113	1,549	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part II Date/Time Prepared: 5/24/2013 9:40 am
		Component CCN: 14T224	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	675,656	40,925,284	0.016510	1,088	18	50.00
51.00	05100 RECOVERY ROOM	40,174	6,525,616	0.006156	2,205	14	51.00
53.00	05300 ANESTHESIOLOGY	18,577	9,275,074	0.002003	3,690	7	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	401,225	38,140,845	0.010520	90,998	957	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	133,510	3,286,920	0.040619	0	0	55.00
60.00	06000 LABORATORY	241,049	39,985,290	0.006028	372,503	2,245	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	63,187	6,369,161	0.009921	190,086	1,886	65.00
66.00	06600 PHYSICAL THERAPY	137,345	8,022,793	0.017119	1,214,111	20,784	66.00
69.00	06900 ELECTROCARDIOLOGY	149,748	19,159,363	0.007816	21,347	167	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	2,294	764,179	0.003002	1,784	5	70.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	217,258	20,658,811	0.010516	144,532	1,520	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	178,568	10,798,296	0.016537	785	13	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	168,393	44,924,722	0.003748	783,524	2,937	73.00
74.00	07400 RENAL DIALYSIS	5,726	1,234,695	0.004638	70,256	326	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	764	135,500	0.005638	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	88,285	1,265,271	0.069776	0	0	90.00
91.00	09100 EMERGENCY	42,424	17,933,028	0.002366	5,085	12	91.00
91.01	04950 PARTIAL HOSPITALIZATION	27,639	628,755	0.043958	0	0	91.01
92.00	09200 OBSERVATION BEDS	0	4,218,051	0.000000	0	0	92.00
200.00	Total (lines 50-199)	2,591,822	274,251,654		2,901,994	30,891	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140224 Component CCN: 14T224	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/24/2013 9:40 am
Title XVIII		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	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
91.01	04950 PARTIAL HOSPITALIZATION	0	0	0	0	0	91.01
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: 140224 Component CCN: 14T224	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/24/2013 9:40 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient	
	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)	Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	40,925,284	0.000000	0.000000	1,088	50.00
51.00 05100 RECOVERY ROOM	0	6,525,616	0.000000	0.000000	2,205	51.00
53.00 05300 ANESTHESIOLOGY	0	9,275,074	0.000000	0.000000	3,690	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	38,140,845	0.000000	0.000000	90,998	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	3,286,920	0.000000	0.000000	0	55.00
60.00 06000 LABORATORY	0	39,985,290	0.000000	0.000000	372,503	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00 06500 RESPIRATORY THERAPY	0	6,369,161	0.000000	0.000000	190,086	65.00
66.00 06600 PHYSICAL THERAPY	0	8,022,793	0.000000	0.000000	1,214,111	66.00
69.00 06900 ELECTROCARDIOLOGY	0	19,159,363	0.000000	0.000000	21,347	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	764,179	0.000000	0.000000	1,784	70.00
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	20,658,811	0.000000	0.000000	144,532	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	10,798,296	0.000000	0.000000	785	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	44,924,722	0.000000	0.000000	783,524	73.00
74.00 07400 RENAL DIALYSIS	0	1,234,695	0.000000	0.000000	70,256	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	135,500	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	1,265,271	0.000000	0.000000	0	90.00
91.00 09100 EMERGENCY	0	17,933,028	0.000000	0.000000	5,085	91.00
91.01 04950 PARTIAL HOSPITALIZATION	0	628,755	0.000000	0.000000	0	91.01
92.00 09200 OBSERVATION BEDS	0	4,218,051	0.000000	0.000000	0	92.00
200.00 Total (lines 50-199)	0	274,251,654			2,901,994	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140224 Component CCN: 14T224	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/24/2013 9:40 am
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
51.00 05100 RECOVERY ROOM	0	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	8,068	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
60.00 06000 LABORATORY	0	666	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	966	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	4,975	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	91.00
91.01 04950 PARTIAL HOSPITALIZATION	0	0	0	91.01
92.00 09200 OBSERVATION BEDS	0	0	0	92.00
200.00 Total (lines 50-199)	0	14,675	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140224 Component CCN: 14T224	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/24/2013 9:40 am
	Title XVIIII	Subprovider - IRF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)
		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	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.220275	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.101434	0	0	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0.031205	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.102348	8,068	0	0	826	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0.358104	0	0	0	0	55.00
60.00 06000 LABORATORY	0.124515	666	0	0	83	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	0.173301	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.342438	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0.074111	966	0	0	72	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.093691	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0.231863	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.364216	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.118729	4,975	0	0	591	73.00
74.00 07400 RENAL DIALYSIS	0.206328	0	0	0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0.244125	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.365613	0	0	0	0	90.00
91.00 09100 EMERGENCY	0.086652	0	0	0	0	91.00
91.01 04950 PARTIAL HOSPITALIZATION	0.373196	0	0	0	0	91.01
92.00 09200 OBSERVATION BEDS	0.439210	0	0	0	0	92.00
200.00	Subtotal (see instructions)		14,675	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		14,675	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140224 Component CCN: 14T224	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/24/2013 9:40 am
	Title XVII I	Subprovider - IRF	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
51.00 05100 RECOVERY ROOM	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00 06000 LABORATORY	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
91.00 09100 EMERGENCY	0	0	91.00
91.01 04950 PARTIAL HOSPITALIZATION	0	0	91.01
92.00 09200 OBSERVATION BEDS	0	0	92.00
200.00 Subtotal (see instructions)	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140224 Component CCN: 145568	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/24/2013 9:40 am
Title XVIII		Skilled Nursing Facility	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	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
91.01	04950 PARTIAL HOSPITALIZATION	0	0	0	0	0	91.01
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: 140224 Component CCN: 145568	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/24/2013 9:40 am
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient	
	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)	Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	40,925,284	0.000000	0.000000	16,910	50.00
51.00 05100 RECOVERY ROOM	0	6,525,616	0.000000	0.000000	0	51.00
53.00 05300 ANESTHESIOLOGY	0	9,275,074	0.000000	0.000000	4,036	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	38,140,845	0.000000	0.000000	101,104	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	3,286,920	0.000000	0.000000	8,081	55.00
60.00 06000 LABORATORY	0	39,985,290	0.000000	0.000000	455,394	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00 06500 RESPIRATORY THERAPY	0	6,369,161	0.000000	0.000000	118,000	65.00
66.00 06600 PHYSICAL THERAPY	0	8,022,793	0.000000	0.000000	962,992	66.00
69.00 06900 ELECTROCARDIOLOGY	0	19,159,363	0.000000	0.000000	20,286	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	764,179	0.000000	0.000000	0	70.00
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	20,658,811	0.000000	0.000000	434,295	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	10,798,296	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	44,924,722	0.000000	0.000000	1,240,583	73.00
74.00 07400 RENAL DIALYSIS	0	1,234,695	0.000000	0.000000	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	135,500	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	1,265,271	0.000000	0.000000	0	90.00
91.00 09100 EMERGENCY	0	17,933,028	0.000000	0.000000	463	91.00
91.01 04950 PARTIAL HOSPITALIZATION	0	628,755	0.000000	0.000000	0	91.01
92.00 09200 OBSERVATION BEDS	0	4,218,051	0.000000	0.000000	0	92.00
200.00 Total (lines 50-199)	0	274,251,654			3,362,144	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/24/2013 9:40 am
	Component CCN: 145568	Title XVIII	Skilled Nursing Facility 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
51.00 05100 RECOVERY ROOM	0	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
60.00 06000 LABORATORY	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	91.00
91.01 04950 PARTIAL HOSPITALIZATION	0	0	0	91.01
92.00 09200 OBSERVATION BEDS	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140224 Component CCN: 145568	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/24/2013 9:40 am
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)
		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	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.220275	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.101434	0	0	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0.031205	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.102348	0	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0.358104	0	0	0	0	55.00
60.00 06000 LABORATORY	0.124515	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	0.173301	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.342438	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0.074111	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.093691	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0.231863	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.364216	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.118729	0	0	16	0	73.00
74.00 07400 RENAL DIALYSIS	0.206328	0	0	0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0.244125	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.365613	0	0	0	0	90.00
91.00 09100 EMERGENCY	0.086652	0	0	0	0	91.00
91.01 04950 PARTIAL HOSPITALIZATION	0.373196	0	0	0	0	91.01
92.00 09200 OBSERVATION BEDS	0.439210	0	0	0	0	92.00
200.00	Subtotal (see instructions)	0	0	16	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	16	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140224 Component CCN: 145568	Period: From 07/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/24/2013 9:40 am
	Title XVIII	Skilled Nursing Facility	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
51.00 05100 RECOVERY ROOM	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00 06000 LABORATORY	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
91.00 09100 EMERGENCY	0	0	91.00
91.01 04950 PARTIAL HOSPITALIZATION	0	0	91.01
92.00 09200 OBSERVATION BEDS	0	0	92.00
200.00 Subtotal (see instructions)	0	2	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	2	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/24/2013 9:40 am
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)		24,565	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		24,565	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)		22,495	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)		9,960	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)		21,985,202	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)		21,985,202	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		69,929,045	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		69,929,045	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.314393	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)		3,108.65	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)		21,985,202	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)		894.98	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		8,914,001	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)		8,914,001	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140224		Period: From 07/01/2012 To 12/31/2012		Worksheet D-1		
		Title XVIII		Hospital		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	42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	3,221,540	4,215	764.30	1,194	912,574	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)						10,427,111	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						20,253,686	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)						911,876	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						570,288	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						1,482,164	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						18,771,522	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)						2,070	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						894.98	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						1,852,609	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140224		Period: From 07/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/24/2013 9:40 am	
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	2,077,153	21,985,202	0.094480	1,852,609	175,034	90.00
91.00	Nursing School cost	0	21,985,202	0.000000	1,852,609	0	91.00
92.00	Allied health cost	0	21,985,202	0.000000	1,852,609	0	92.00
93.00	All other Medical Education	0	21,985,202	0.000000	1,852,609	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet D-1
		Component CCN: 14T224		Date/Time Prepared: 5/24/2013 9:40 am
		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)		1,584	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,584	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)		1,584	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)		1,222	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)		1,298,940	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)		1,298,940	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,825,192	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,825,192	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.459771	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)		1,783.58	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)		1,298,940	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)		820.04	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,002,089	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)		1,002,089	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140224		Period: From 07/01/2012 To 12/31/2012		Worksheet D-1	
		Component CCN: 14T224				Date/Time Prepared: 5/24/2013 9:40 am	
		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)					648,485		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,650,574		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)					89,597		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					30,891		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					120,488		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					1,530,086		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: 140224 Component CCN: 14T224		Period: From 07/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/24/2013 9:40 am	
		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	116,140	1,298,940	0.089411	0	0	90.00
91.00	Nursing School cost	0	1,298,940	0.000000	0	0	91.00
92.00	Allied health cost	0	1,298,940	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,298,940	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet D-1
		Component CCN: 145568		Date/Time Prepared: 5/24/2013 9:40 am
		Title XVIII	Skilled Nursing Facility	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)		2,440	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,440	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)		2,440	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)		1,911	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)		1,767,834	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)		1,767,834	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,138,420	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,138,420	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.826701	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)		876.40	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)		1,767,834	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)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet D-1	
		Component CCN: 145568		Date/Time Prepared: 5/24/2013 9:40 am	
		Title XVIII	Skilled Nursing Facility	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)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				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)				48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				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)				50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)				53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				54.00
55.00	Target amount per discharge				55.00
56.00	Target amount (line 54 x line 55)				56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				57.00
58.00	Bonus payment (see instructions)				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				59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				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)				61.00
62.00	Relief payment (see instructions)				62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				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)				64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				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)				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)				68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				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)			1,767,834	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)			724.52	71.00
72.00	Program routine service cost (line 9 x line 71)			1,384,558	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)			0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)			1,384,558	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)			0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)			0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)			0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)			0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)			0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)			0	80.00
81.00	Inpatient routine service cost per diem limitation			0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)			0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)			1,384,558	83.00
84.00	Program inpatient ancillary services (see instructions)			673,544	84.00
85.00	Utilization review - physician compensation (see instructions)			0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)			2,058,102	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: 140224 Component CCN: 145568		Period: From 07/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/24/2013 9:40 am	
		Title XVIII		Skilled Nursing Facility		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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/24/2013 9:40 am	
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		20,956,383	30.00
31.00	03100	INTENSIVE CARE UNIT		4,443,960	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.220275	6,064,411	50.00
51.00	05100	RECOVERY ROOM	0.101434	1,058,205	51.00
53.00	05300	ANESTHESIOLOGY	0.031205	1,291,097	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102348	6,450,442	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.358104	148,301	55.00
60.00	06000	LABORATORY	0.124515	12,652,785	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.173301	3,142,042	65.00
66.00	06600	PHYSICAL THERAPY	0.342438	1,014,759	66.00
69.00	06900	ELECTROCARDIOLOGY	0.074111	5,370,743	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.093691	152,304	70.00
71.00	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	0.231863	6,314,666	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.364216	3,441,797	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.118729	15,946,315	73.00
74.00	07400	RENAL DIALYSIS	0.206328	791,515	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.244125	1,699	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.365613	39,780	90.00
91.00	09100	EMERGENCY	0.086652	3,890,600	91.00
91.01	04950	PARTIAL HOSPITALIZATION	0.373196	0	91.01
92.00	09200	OBSERVATION BEDS	0.439210	510,442	92.00
200.00		Total (sum of lines 50-94 and 96-98)		68,281,903	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)		68,281,903	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140224 Component CCN: 14T224	Period: From 07/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/24/2013 9:40 am	
		Title XVIIII	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
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		2,149,589		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.220275	1,088	240	50.00
51.00	05100 RECOVERY ROOM	0.101434	2,205	224	51.00
53.00	05300 ANESTHESIOLOGY	0.031205	3,690	115	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.102348	90,998	9,313	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.358104	0	0	55.00
60.00	06000 LABORATORY	0.124515	372,503	46,382	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.173301	190,086	32,942	65.00
66.00	06600 PHYSICAL THERAPY	0.342438	1,214,111	415,758	66.00
69.00	06900 ELECTROCARDIOLOGY	0.074111	21,347	1,582	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.093691	1,784	167	70.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0.231863	144,532	33,512	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.364216	785	286	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.118729	783,524	93,027	73.00
74.00	07400 RENAL DIALYSIS	0.206328	70,256	14,496	74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.244125	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.365613	0	0	90.00
91.00	09100 EMERGENCY	0.086652	5,085	441	91.00
91.01	04950 PARTIAL HOSPITALIZATION	0.373196	0	0	91.01
92.00	09200 OBSERVATION BEDS	0.439210	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		2,901,994	648,485	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)		2,901,994		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140224 Component CCN: 145568	Period: From 07/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/24/2013 9:40 am
		Title XVIII	Skilled Nursing Facility	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
40.00	04000 SUBPROVIDER - IPF		0	40.00
41.00	04100 SUBPROVIDER - IRF		0	41.00
43.00	04300 NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.220275	16,910	3,725 50.00
51.00	05100 RECOVERY ROOM	0.101434	0	0 51.00
53.00	05300 ANESTHESIOLOGY	0.031205	4,036	126 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.102348	101,104	10,348 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.358104	8,081	2,894 55.00
60.00	06000 LABORATORY	0.124515	455,394	56,703 60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0 62.30
65.00	06500 RESPIRATORY THERAPY	0.173301	118,000	20,450 65.00
66.00	06600 PHYSICAL THERAPY	0.342438	962,992	329,765 66.00
69.00	06900 ELECTROCARDIOLOGY	0.074111	20,286	1,503 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.093691	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHRGD TO PATIENTS	0.231863	434,295	100,697 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.364216	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.118729	1,240,583	147,293 73.00
74.00	07400 RENAL DIALYSIS	0.206328	0	0 74.00
76.00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0 76.00
76.97	07697 CARDIAC REHABILITATION	0.244125	0	0 76.97
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.365613	0	0 90.00
91.00	09100 EMERGENCY	0.086652	463	40 91.00
91.01	04950 PARTIAL HOSPITALIZATION	0.373196	0	0 91.01
92.00	09200 OBSERVATION BEDS	0.439210	0	0 92.00
200.00	Total (sum of lines 50-94 and 96-98)		3,362,144	673,544 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net Charges (line 200 minus line 201)		3,362,144	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/24/2013 9:40 am
		Title XVII I	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		15,729,072	1.00
2.00	Outlier payments for discharges. (see instructions)		428,980	2.00
2.01	Outlier reconciliation amount		0	2.01
3.00	Managed Care Simulated Payments		939,938	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		278.75	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)		139.15	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)		22.76	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.		0.64	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.		-1.89	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.		3.50	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)		3.50	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)		120.86	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		109.81	10.00
11.00	FTE count for residents in dental and podiatric programs.		13.93	11.00
12.00	Current year allowable FTE (see instructions)		123.74	12.00
13.00	Total allowable FTE count for the prior year.		125.76	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.		133.40	14.00
15.00	Sum of lines 12 through 14 divided by 3.		127.63	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		127.63	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.457865	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.510866	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.457865	21.00
22.00	IME payment adjustment (see instructions)		3,711,788	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)		3,711,788	29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		7.13	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		19.18	31.00
32.00	Sum of lines 30 and 31		26.31	32.00
33.00	Allowable disproportionate share percentage (see instructions)		10.92	33.00
34.00	Disproportionate share adjustment (see instructions)		1,717,615	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)		21,587,455	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)		21,587,455	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		1,706,458	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).		2,880,154	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: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/24/2013 9:40 am
		Title XVII	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)			26,174,067 59.00
60.00	Primary payer payments			24,123 60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			26,149,944 61.00
62.00	Deductibles billed to program beneficiaries			1,453,092 62.00
63.00	Coinurance billed to program beneficiaries			197,676 63.00
64.00	Allowable bad debts (see instructions)			801,386 64.00
65.00	Adjusted reimbursable bad debts (see instructions)			560,970 65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			416,040 66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			25,060,146 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)			21,228 70.93
70.94	Hospital readmissions reduction adjustment (see instructions)			-15,459 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)			25,065,915 71.00
72.00	Interim payments			24,713,058 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)			352,857 74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2			18,498 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: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/24/2013 9:40 am
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		6,662	1.00
2.00	Medical and other services reimbursed under OPPI (see instructions)		5,172,701	2.00
3.00	PPS payments		4,831,139	3.00
4.00	Outlier payment (see instructions)		61,736	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)		6,662	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		28,694	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)		28,694	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)		28,694	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		22,032	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)		6,662	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)		4,892,875	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		3,123	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,131,155	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)		3,765,259	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		620,174	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)		4,385,433	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		4,385,433	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)		397,188	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		278,032	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		234,616	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		4,663,465	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)		4,663,465	40.00
41.00	Interim payments		4,374,732	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)		288,733	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, 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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140224 Component CCN: 14T224	Period: From 07/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/24/2013 9:40 am
		Title XVII	Subprovider - IRF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			0 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			1,572 2.00
3.00	PPS payments			1,292 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)			0 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 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)			0 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)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 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)			0 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)			1,292 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)			387 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)			905 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)			905 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			905 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)			0 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			0 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			905 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)			905 40.00
41.00	Interim payments			905 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)			0 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, 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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140224 Component CCN: 145568	Period: From 07/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/24/2013 9:40 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			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)		2	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		16	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)		16	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)		16	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		14	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)		2	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)		0	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)			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)		2	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)		2	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		2	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)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		2	37.00
38.00	MSP-LCC reconciliation amount from PS&R			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)		2	40.00
41.00	Interim payments		4	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)		-2	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 140224		Period: From 07/01/2012 To 12/31/2012		Worksheet E-1 Part I Date/Time Prepared: 5/24/2013 9:40 am	
		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		25,391,203		4,540,826	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	01/25/2013	678,145	01/25/2013	166,094	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)		-678,145		-166,094	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)		24,713,058		4,374,732	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		352,857		288,733	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		25,065,915		4,663,465	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: 140224
Component CCN: 14T224

Period:
From 07/01/2012
To 12/31/2012

Worksheet E-1
Part I
Date/Time Prepared:
5/24/2013 9:40 am

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				905	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		1,946,056		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	01/25/2013	30,660		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)		30,660		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)		1,976,716		905	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		20,393		0	6.02
7.00	Total Medicare program liability (see instructions)		1,956,323		905	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: 140224
Component CCN: 145568

Period:
From 07/01/2012
To 12/31/2012

Worksheet E-1
Part I
Date/Time Prepared:
5/24/2013 9:40 am

Title XVIII

Skilled Nursing
Facility

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					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		778,331		4	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)		778,331		4	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		0		2	6.02
7.00	Total Medicare program liability (see instructions)		778,331		2	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: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet E-1 Part II Date/Time Prepared: 5/24/2013 9:40 am
		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			0 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			0 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6 line 2			0 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			0 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			0 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			0 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: 140224 Component CCN: 14T224	Period: From 07/01/2012 To 12/31/2012	Worksheet E-3 Part III Date/Time Prepared: 5/24/2013 9:40 am
		Title XVIIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			1,863,166 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0535 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			127,169 3.00
4.00	Outlier Payments			800 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)			8.608696 10.00
11.00	Medical Education Adjustment Factor $\{((1 + (\text{line 9}/\text{line 10})) \text{ raised to the power of } .6876 - 1)\}$.			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)			1,991,135 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)			1,991,135 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			1,991,135 19.00
20.00	Deductibles			21,964 20.00
21.00	Subtotal (line 19 minus line 20)			1,969,171 21.00
22.00	Coinurance			14,450 22.00
23.00	Subtotal (line 21 minus line 22)			1,954,721 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			2,288 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			1,602 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			2,288 26.00
27.00	Subtotal (sum of lines 23 and 25)			1,956,323 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)			1,956,323 32.00
33.00	Interim payments			1,976,716 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)			-20,393 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			177,354 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4			800 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: 140224 Component CCN: 145568	Period: From 07/01/2012 To 12/31/2012	Worksheet E-3 Part VI Date/Time Prepared: 5/24/2013 9:40 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		796,104	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		796,104	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		17,773	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Allowable reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)		778,331	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14)		778,331	15.00
16.00	Interim payments		778,331	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus the sum of lines 16 and 17)		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2		0	19.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet E-4 Date/Time Prepared: 5/24/2013 9:40 am	
		Title XVII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			142.44	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			23.61	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			1.79	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			-2.82	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			7.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 plus line 4.02 plus applicable subscripts)			121.22	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			109.98	6.00
7.00	Enter the lesser of line 5 or line 6			109.98	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	97.10	12.40	109.50	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	97.10	12.40	109.50	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		5.74		10.00
11.00	Total weighted FTE count	97.10	18.14		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	98.26	24.88		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	95.45	19.96		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	96.94	20.99		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	96.94	20.99		17.00
18.00	Per resident amount	65,064.22	62,714.68		18.00
19.00	Approved amount for resident costs	6,307,325	1,316,381	7,623,706	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			7,623,706	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days	12,376	716		26.00
27.00	Total Inpatient Days (see instructions)	28,294	28,294		27.00
28.00	Ratio of inpatient days to total inpatient days	0.437407	0.025306		28.00
29.00	Program direct GME amount	3,334,662	192,926		29.00
30.00	Reduction for direct GME payments for Medicare managed care		27,260		30.00
31.00	Net Program direct GME amount			3,500,328	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet E-4 Date/Time Prepared: 5/24/2013 9:40 am
		Title XVIII	Hospital	PPS
				1.00
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Worksheet C, Part I, column 8, sum of lines 74 and 94)		1,234,695	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		24,084,922	37.00
38.00	Organ acquisition costs (Worksheet D-4, Part III, column 1, line 69)		0	38.00
39.00	Cost of teaching physicians (Worksheet D-5, Part II, column 3, line 20)		0	39.00
40.00	Primary payer payments (see instructions)		24,123	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		24,060,799	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		5,180,937	42.00
43.00	Primary payer payments (see instructions)		0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		5,180,937	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		29,241,736	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.822824	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.177176	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		3,500,328	48.00
49.00	Part A Medicare GME payment (line 46 x 48)(Title XVIII only)(see instructions)		2,880,154	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		620,174	50.00

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

Provider CCN: 140224

Period:
From 07/01/2012
To 12/31/2012

Worksheet G

Date/Time Prepared:
5/24/2013 9:40 am

		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	46,538	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	80,170,891	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-51,769,891	0	0	0	6.00
7.00	Inventory	4,103,454	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,052,000	0	0	0	9.00
10.00	Due from other funds	18,651,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	52,253,992	0	0	0	11.00
FIXED ASSETS						
12.00	Land	7,327,666	0	0	0	12.00
13.00	Land improvements	11,980,239	0	0	0	13.00
14.00	Accumulated depreciation	-3,082,131	0	0	0	14.00
15.00	Buildings	57,482,110	0	0	0	15.00
16.00	Accumulated depreciation	-21,413,678	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	0	0	0	0	19.00
20.00	Accumulated depreciation	0	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	49,013,214	0	0	0	23.00
24.00	Accumulated depreciation	-37,548,585	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)	63,758,835	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	2,468,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,468,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	118,480,827	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	399,000	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)	0	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	38,971,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	39,370,000	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	19,499,291	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	19,499,291	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	58,869,291	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	59,611,536	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	59,611,536	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	118,480,827	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140224

Period:
From 07/01/2012
To 12/31/2012

Worksheet G-1

Date/Time Prepared:
5/24/2013 9:40 am

		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		42,148,409			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		17,280,175				2.00
3.00	Total (sum of line 1 and line 2)		59,428,584			0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00	TRANSFER FROM AFFILIATE	182,952		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)		182,952			0	10.00
11.00	Subtotal (line 3 plus line 10)		59,611,536			0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		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)		59,611,536			0	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			0				5.00
6.00	TRANSFER FROM AFFILIATE		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			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: 140224

Period:
From 07/01/2012
To 12/31/2012

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/24/2013 9:40 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	69,929,045		69,929,045	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	2,825,192		2,825,192	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	2,138,420		2,138,420	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)	74,892,657		74,892,657	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	7,947,700		7,947,700	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)	7,947,700		7,947,700	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	82,840,357		82,840,357	17.00
18.00	Ancillary services	146,945,193	126,987,823	273,933,016	18.00
19.00	Outpatient services	93,349	1,251,481	1,344,830	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
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN REVENUE	0	17,068	17,068	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	229,878,899	128,256,372	358,135,271	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		87,722,643		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	RECONCILING ITEM	16			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		16		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		87,722,627		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140224

Period:
From 07/01/2012
To 12/31/2012

Worksheet G-3

Date/Time Prepared:
5/24/2013 9:40 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	358,135,271	1.00
2.00	Less contractual allowances and discounts on patients' accounts	258,539,100	2.00
3.00	Net patient revenues (line 1 minus line 2)	99,596,171	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	87,722,627	4.00
5.00	Net income from service to patients (line 3 minus line 4)	11,873,544	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	31,580	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	0	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	0	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	0	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	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	REVENUE FROM OTHER SOURCES	5,351,026	24.00
24.01	NET ASSETS RELEASED FROM RESTRICTION	24,025	24.01
25.00	Total other income (sum of lines 6-24)	5,406,631	25.00
26.00	Total (line 5 plus line 25)	17,280,175	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)	17,280,175	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140224	Period: From 07/01/2012 To 12/31/2012	Worksheet L Parts I-III Date/Time Prepared: 5/24/2013 9:40 am
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,261,595	1.00
2.00	Capital DRG outlier payments		20,589	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		145.16	3.00
4.00	Number of interns & residents (see instructions)		127.63	4.00
5.00	Indirect medical education percentage (see instructions)		28.16	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		355,265	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		7.13	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		19.18	8.00
9.00	Sum of lines 7 and 8		26.31	9.00
10.00	Allowable disproportionate share percentage (see instructions)		5.47	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		69,009	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		1,706,458	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

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