

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: 144009	Period: From 01/01/2012 To 12/31/2012	Worksheet S Parts I-III Date/Time Prepared: 4/9/2013 1:21 pm
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**PART I - COST REPORT STATUS**

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

**PART II - CERTIFICATION**

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RIVEREDGE HOSPITAL ( 144009 ) for the cost reporting period beginning 01/01/2012 and ending 12/31/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) \_\_\_\_\_  
Officer or Administrator of Provider(s)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-27,335	0	0	-5,300,293	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	-27,335	0	0	-5,300,293	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: 144009		Period: From 01/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 4/9/2013 1:20 pm					
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 Zip Code: 60130		4.00 County: COOK					
1.00	Street: 8311 WEST ROOSEVELT RD	State: IL		Zip Code: 60130		County: COOK			1.00		
2.00	City: FOREST PARK	State: IL		Zip Code: 60130		County: COOK			2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
		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	RIVEREDGE HOSPITAL		144009	16974	4	07/01/1967	N	P	O	3.00
4.00	Subprovider - IPF	RIVEREDGE HOSPITAL RTC		144009	16974	4	07/01/1967	N	N	O	4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2012	12/31/2012		20.00	
21.00	Type of Control (see instructions)						4			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.						N		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.						3		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 days	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.	0	0	0	0	0	0		24.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0		25.00		
							Urban/Rural S	Date of Geogr			
							1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						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: 144009	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 4/9/2013 1:20 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.					39.00
		V 1.00	XVIII 2.00	XIX 3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					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.					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
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
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
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
<b>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.</b>						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00		0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 144009

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

Worksheet S-2  
Part I  
Date/Time Prepared:  
4/9/2013 1:20 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	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)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	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.			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 144009	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 4/9/2013 1:20 pm		
		1.00	2.00	3.00		
<b>Inpatient Psychiatric Facility PPS</b>						
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.	Y				70.00
71.00	If line 70 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		71.00
<b>Inpatient Rehabilitation Facility PPS</b>						
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.	N				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		
<b>Long Term Care Hospital PPS</b>						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
<b>TEFRA Providers</b>						
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	
<b>Title V and XIX Services</b>						
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		Y		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
<b>Rural Providers</b>						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)					107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00
				1.00	2.00	3.00
<b>Miscellaneous Cost Reporting Information</b>						
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.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00

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		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	177,970	250,667	0
			1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N	
119.00	DO NOT USE THIS LINE			
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N	
<b>Transplant Center Information</b>				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			
<b>All Providers</b>				
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	399001
		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: HIGMARK HEALTH SERVICES	Contractor's Name: HIGMARK HEALTH SERVICES	Contractor's Number: 12901	
142.00	Street: 120 FIFTH AVENUE	PO Box:		
143.00	City: PITTSBURGH	State: PA	Zip Code: 15222-3099	
			1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		Y	
			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	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N	
		Part A	Part B	Title V
		1.00	2.00	3.00
				Title XIX
				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
156.00	Subprovider - IPF	N	N	N
157.00	Subprovider - IRF	N	N	N
158.00	SUBPROVIDER			
159.00	SNF	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N
161.00	CMHC		N	N

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 144009	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 4/9/2013 1:20 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			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.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	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.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			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			
		Description	Y/N	Date	
		0	1.00	2.00	
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	02/29/2012		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			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			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			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			20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 144009	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 4/9/2013 1:20 pm
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		Part A			
		Description	Y/N	Date	
		0	1.00	2.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		N		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.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		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		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		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.		N		33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		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.		N		35.00
			Y/N	Date	
			1.00	2.00	
<b>Home Office Costs</b>					
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
<b>Cost Report Preparer Contact Information</b>					
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.	KEVIN		SMI TH	41.00
42.00	Enter the employer/company name of the cost report preparer.	UHS, INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-312-5742		KEVIN.SMI TH@UHSI NC.COM	43.00

		Part B		
		Y/N	Date	
		3.00	4.00	
<b>PS&amp;R Data</b>				
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	02/29/2012	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		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		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		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		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
		3.00		
<b>Cost Report Preparer Contact Information</b>				
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.	REIMBURSEMENT MANAGER		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: 144009

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
4/9/2013 1:20 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours		
	Line Number					
	1.00	2.00	3.00	4.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	196	71,736	0.00		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						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		196	71,736	0.00		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)		196	71,736	0.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	40.00	14	5,124			16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		210				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 AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 144009

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
4/9/2013 1:20 pm

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	13,097	16,044	44,451		1.00
2.00 HMO		0	0			2.00
3.00 HMO IPF Subprovider		0	0			3.00
4.00 HMO IRF Subprovider		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0	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)	0	13,097	16,044	44,451		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	13,097	16,044	44,451		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF	0	0	0	4,806		16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	0		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 144009

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
4/9/2013 1:20 pm

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	1,035	1.00
2.00 HMO					0	2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	241.08	0.00	0	1,035	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	16.78	0.00	0	0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
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	257.86	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 AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 144009

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
4/9/2013 1:20 pm

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	1,188	3,287		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				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)	1,188	3,287		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF	0	7		16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				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



RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 144009

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

Worksheet A

Date/Time Prepared:  
4/9/2013 1:20 pm

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		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100		1,084,960	1,084,960	0	1,084,960	1.00	
2.00	00200		38,923	38,923	31,788	70,711	2.00	
4.00	00400	102,692	2,159,968	2,262,660	0	2,262,660	4.00	
5.00	00500	1,764,132	4,410,483	6,174,615	-13,009	6,161,606	5.00	
7.00	00700	53,877	1,001,331	1,055,208	-15,000	1,040,208	7.00	
8.00	00800	0	186,842	186,842	0	186,842	8.00	
9.00	00900	0	443,755	443,755	0	443,755	9.00	
10.00	01000	289,203	605,827	895,030	-688	894,342	10.00	
13.00	01300	1,184,181	32,372	1,216,553	-3,052	1,213,501	13.00	
16.00	01600	237,185	212,530	449,715	0	449,715	16.00	
17.00	01700	980,497	74,395	1,054,892	0	1,054,892	17.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	6,119,927	1,231,644	7,351,571	-39	7,351,532	30.00	
40.00	04000	728,925	48,967	777,892	0	777,892	40.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
60.00	06000	0	240,165	240,165	0	240,165	60.00	
69.00	06900	0	0	0	0	0	69.00	
70.00	07000	0	24,546	24,546	0	24,546	70.00	
73.00	07300	0	947,879	947,879	0	947,879	73.00	
76.00	03020	0	0	0	0	0	76.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	305,279	6,344	311,623	0	311,623	90.00	
91.00	09100	0	0	0	0	0	91.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>								
98.00	05950	0	0	0	0	0	98.00	
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	0	0	0	0	0	113.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)		11,765,898	12,750,931	24,516,829	0	24,516,829	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
192.00	19200	0	0	0	0	0	192.00	
194.00	07950	0	0	0	0	0	194.00	
194.01	07951	0	0	0	0	0	194.01	
194.02	07953	303,024	60,988	364,012	0	364,012	194.02	
194.03	07952	184,435	13,134	197,569	0	197,569	194.03	
200.00	TOTAL (SUM OF LINES 118-199)		12,253,357	12,825,053	25,078,410	0	25,078,410	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 144009

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

Worksheet A  
Date/Time Prepared:  
4/9/2013 1:20 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,426,471	3,511,431	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	175,303	246,014	2.00
4.00	00400	EMPLOYEE BENEFITS	-19,724	2,242,936	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,262,834	3,898,772	5.00
7.00	00700	OPERATION OF PLANT	0	1,040,208	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	186,842	8.00
9.00	00900	HOUSEKEEPING	0	443,755	9.00
10.00	01000	DIETARY	-27,144	867,198	10.00
13.00	01300	NURSING ADMINISTRATION	0	1,213,501	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-11,917	437,798	16.00
17.00	01700	SOCIAL SERVICE	0	1,054,892	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-824,178	6,527,354	30.00
40.00	04000	SUBPROVIDER - I PF	0	777,892	40.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
60.00	06000	LABORATORY	0	240,165	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	24,546	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	947,879	73.00
76.00	03020	RECREATION THERAPY	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	311,623	90.00
91.00	09100	EMERGENCY	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-544,023	23,972,806	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	PHP MEALS	0	0	194.01
194.02	07953	COMMUNITY RELATIONS	-20,237	343,775	194.02
194.03	07952	EDUCATION	0	197,569	194.03
200.00		TOTAL (SUM OF LINES 118-199)	-564,260	24,514,150	200.00

Provider CCN: 144009

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

Worksheet A-6  
Date/Time Prepared:  
4/9/2013 1:20 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - RENT LEASE					
1.00		0.00	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	31,788	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	31,788	
500.00	Grand Total: Increases		0	31,788	500.00

Provider CCN: 144009

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

Worksheet A-6  
Date/Time Prepared:  
4/9/2013 1:20 pm

Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - RENT LEASE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	13,009	10	1.00	
2.00	OPERATION OF PLANT	7.00	0	15,000	10	2.00	
3.00	DIETARY	10.00	0	688	10	3.00	
4.00	NURSING ADMINISTRATION	13.00	0	3,052	10	4.00	
5.00	ADULTS & PEDIATRICS	30.00	0	39	10	5.00	
	TOTALS		0	31,788			
500.00	Grand Total: Decreases		0	31,788		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144009

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
4/9/2013 1:20 pm

	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
	1.00	2.00	3.00	4.00	5.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	0	0	0	0	1.00	
2.00	Land Improvements	0	0	0	0	2.00	
3.00	Buildings and Fixtures	3,597,655	0	0	0	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	1,283,211	0	0	0	6.00	
7.00	HIT designated Assets	15,775	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	4,896,641	0	0	0	8.00	
9.00	Reconciling Items	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	4,896,641	0	0	0	10.00	
<b>SUMMARY OF CAPITAL</b>							
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)		
	9.00	10.00	11.00	12.00	13.00		
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	CAP REL COSTS-BLDG & FIXT	502,535	0	0	41,900	540,525	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	25,222	0	4,479	9,222	0	2.00
3.00	Total (sum of lines 1-2)	527,757	0	4,479	51,122	540,525	3.00
<b>COMPUTATION OF RATIOS</b>							
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144009

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
4/9/2013 1:20 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	0	0		1.00		
2.00	Land Improvements	0	0		2.00		
3.00	Buildings and Fixtures	3,597,655	0		3.00		
4.00	Building Improvements	0	0		4.00		
5.00	Fixed Equipment	0	0		5.00		
6.00	Movable Equipment	1,283,211	0		6.00		
7.00	HIT designated Assets	15,775	0		7.00		
8.00	Subtotal (sum of lines 1-7)	4,896,641	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	4,896,641	0		10.00		
<b>SUMMARY OF CAPITAL</b>							
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	CAP REL COSTS-BLDG & FIXT	0	1,084,960		1.00		
2.00	CAP REL COSTS-MVBLE EQUIP	0	38,923		2.00		
3.00	Total (sum of lines 1-2)	0	1,123,883		3.00		
<b>ALLOCATION OF OTHER CAPITAL</b>							
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,929,006	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	200,525	31,788	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,129,531	31,788	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144009

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
4/9/2013 1:20 pm

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	41,900	540,525	0	3,511,431	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,479	9,222	0	0	246,014	2.00
3.00	Total (sum of lines 1-2)	4,479	51,122	540,525	0	3,757,445	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 144009

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

Worksheet A-8

Date/Time Prepared:  
4/9/2013 1:20 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center		Line #	
			1.00	2.00	3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			OCAP REL COSTS-BLDG & FIXT		1.00	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			OCAP REL COSTS-MVBLE EQUIP		2.00	2.00
3.00 Investment income - other (chapter 2)		0			0.00	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00	4.00
5.00 Refunds and rebates of expenses (chapter 8)	B	-85,789	ADMINISTRATIVE & GENERAL		5.00	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00	7.00
8.00 Television and radio service (chapter 21)		0			0.00	8.00
9.00 Parking lot (chapter 21)		0			0.00	9.00
10.00 Provider-based physician adjustment	A-8-2	-824,178				10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	479,265				12.00
13.00 Laundry and linen service		0			0.00	13.00
14.00 Cafeteria-employees and guests	B	-27,144	DIETARY		10.00	14.00
15.00 Rental of quarters to employee and others		0			0.00	15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	16.00
17.00 Sale of drugs to other than patients		0			0.00	17.00
18.00 Sale of medical records and abstracts	B	-11,917	MEDICAL RECORDS & LIBRARY		16.00	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00	19.00
20.00 Vending machines		0			0.00	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***		65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***		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	A	168,593	CAP REL COSTS-BLDG & FIXT		1.00	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	175,303	CAP REL COSTS-MVBLE EQUIP		2.00	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***		19.00	28.00
29.00 Physicians' assistant		0			0.00	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	32.00
33.00 ADMIN NON ALLOWABLE MISC	A	-60	ADMINISTRATIVE & GENERAL		5.00	33.00
33.01 MISC ADMIN REVENUE	B	-6,298	ADMINISTRATIVE & GENERAL		5.00	33.01
33.02 LOBBYING	A	-9,146	ADMINISTRATIVE & GENERAL		5.00	33.02
33.03 DONATIONS	A	-5,068	ADMINISTRATIVE & GENERAL		5.00	33.03
33.04 BAD DEBT	A	-947,966	ADMINISTRATIVE & GENERAL		5.00	33.04
33.05 MARKETING	A	-20,237	COMMUNITY RELATIONS		194.02	33.05
33.06 PATIENT TRANSPORTATION	A	-110,664	ADMINISTRATIVE & GENERAL		5.00	33.06
33.07 REBATES	B	85,789	ADMINISTRATIVE & GENERAL		5.00	33.07
33.08 RELATED PARTY CAPITAL COST	A	2,257,878	CAP REL COSTS-BLDG & FIXT		1.00	33.08
33.09 RELATED PARTY RENT EXP	A	-1,657,836	ADMINISTRATIVE & GENERAL		5.00	33.09
33.10 PHYSICIAN BILLING COST	A	-24,785	ADMINISTRATIVE & GENERAL		5.00	33.10
33.11		0			0.00	33.11
33.12		0			0.00	33.12
33.13		0			0.00	33.13
33.14		0			0.00	33.14
33.15		0			0.00	33.15
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-564,260				50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 144009

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

Worksheet A-8

Date/Time Prepared:  
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Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	9	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	ADMIN NON ALLOWABLE MISC	0	33.00
33.01	MISC ADMIN REVENUE	0	33.01
33.02	LOBBYING	0	33.02
33.03	DONATIONS	0	33.03
33.04	BAD DEBT	0	33.04
33.05	MARKETING	0	33.05
33.06	PATIENT TRANSPORTATION	0	33.06
33.07	REBATES	0	33.07
33.08	RELATED PARTY CAPITAL COST	9	33.08
33.09	RELATED PARTY RENT EXP	0	33.09
33.10	PHYSICIAN BILLING COST	0	33.10
33.11		0	33.11
33.12		0	33.12
33.13		0	33.13
33.14		0	33.14
33.15		0	33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

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

Provider CCN: 144009

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

Worksheet A-8-1

Date/Time Prepared:  
4/9/2013 1:20 pm

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	0.00			1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE COST	2.00
3.00	4.00	EMPLOYEE BENEFITS	WORKERS COMP INSURANCE	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE INSURANCE	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5.00

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

	Symbol (1)	Name	Percentage of Ownership	
	1.00	2.00	3.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

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

6.00	B		0.00	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			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: 144009

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

Worksheet A-8-1

Date/Time Prepared:  
4/9/2013 1:20 pm

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	0	0	0	0	1.00
2.00	1,171,132	744,840	426,292	0	2.00
3.00	115,489	135,213	-19,724	0	3.00
4.00	250,667	177,970	72,697	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	1,537,288	1,058,023	479,265	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			
Name	Percentage of Ownership	Type of Business	
	4.00	5.00	6.00
<b>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>			

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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00		UNI VERSAL HEALT	100.00	HEALTHCARE	6.00
7.00			0.00		7.00
8.00			0.00		8.00
9.00			0.00		9.00
10.00			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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 144009

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

Worksheet A-8-2

Date/Time Prepared:  
4/9/2013 1:20 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	977,160	670,778	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
200.00			977,160	670,778	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 144009

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

Worksheet A-8-2

Date/Time Prepared:  
4/9/2013 1:20 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	306,382	142,500	2,233	152,982	7,649	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	306,382		2,233	152,982	7,649	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 144009

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

Worksheet A-8-2

Date/Time Prepared:  
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	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 16.00	
1.00	0	0	0	0	152,982	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	0	0	0	0	152,982	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 144009

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

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	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	153,400	824,178	1.00
2.00	0	0	2.00
3.00	0	0	3.00
4.00	0	0	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	153,400	824,178	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144009

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

Worksheet B  
Part I  
Date/Time Prepared:  
4/9/2013 1:20 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	3,511,431	3,511,431			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	246,014		246,014		2.00
4.00 00400	EMPLOYEE BENEFITS	2,242,936	21,231	1,550	2,265,717	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,898,772	558,377	40,763	328,956	4,826,868
7.00 00700	OPERATION OF PLANT	1,040,208	208,375	15,212	10,046	1,273,841
8.00 00800	LAUNDRY & LINEN SERVICE	186,842	40,393	2,949	0	230,184
9.00 00900	HOUSEKEEPING	443,755	43,245	3,157	0	490,157
10.00 01000	DIETARY	867,198	205,800	15,024	53,927	1,141,949
13.00 01300	NURSING ADMINISTRATION	1,213,501	197,419	14,412	220,813	1,646,145
16.00 01600	MEDICAL RECORDS & LIBRARY	437,798	38,625	2,820	44,228	523,471
17.00 01700	SOCIAL SERVICE	1,054,892	0	0	182,832	1,237,724
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	6,527,354	1,753,622	128,020	1,141,172	9,550,168
40.00 04000	SUBPROVIDER - IPF	777,892	168,866	12,328	135,922	1,095,008
<b>ANCILLARY SERVICE COST CENTERS</b>						
60.00 06000	LABORATORY	240,165	10,578	772	0	251,515
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00 07000	ELECTROENCEPHALOGRAPHY	24,546	0	0	0	24,546
73.00 07300	DRUGS CHARGED TO PATIENTS	947,879	30,143	2,201	0	980,223
76.00 03020	RECREATION THERAPY	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	311,623	21,686	1,583	56,925	391,817
91.00 09100	EMERGENCY	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
98.00 05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	23,972,806	3,298,360	240,791	2,174,821	23,663,616
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	141,526	0	0	141,526
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01 07951	PHP MEALS	0	0	0	0	0
194.02 07953	COMMUNITY RELATIONS	343,775	25,245	1,843	56,505	427,368
194.03 07952	EDUCATION	197,569	46,300	3,380	34,391	281,640
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	24,514,150	3,511,431	246,014	2,265,717	24,514,150

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144009

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

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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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
5.00	00500	ADMINISTRATIVE & GENERAL	4,826,868				5.00
7.00	00700	OPERATION OF PLANT	312,317	1,586,158			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	56,436	23,525	310,145		8.00
9.00	00900	HOUSEKEEPING	120,175	25,186	0	635,518	9.00
10.00	01000	DIETARY	279,980	119,860	0	49,545	1,591,334
13.00	01300	NURSING ADMINISTRATION	403,597	114,978	0	47,527	0
16.00	01600	MEDICAL RECORDS & LIBRARY	128,343	22,496	0	9,299	0
17.00	01700	SOCIAL SERVICE	303,461	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	2,341,479	1,021,322	279,884	422,173	1,336,231
40.00	04000	SUBPROVIDER - I/PF	268,471	98,349	30,261	40,654	155,380
<b>ANCILLARY SERVICE COST CENTERS</b>							
60.00	06000	LABORATORY	61,666	6,161	0	2,547	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	6,018	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	240,328	17,556	0	7,257	0
76.00	03020	RECREATION THERAPY	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	96,065	12,630	0	5,221	99,723
91.00	09100	EMERGENCY	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,618,336	1,462,063	310,145	584,223	1,591,334
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	34,699	82,426	0	34,071	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01	07951	PHP MEALS	0	0	0	0	0
194.02	07953	COMMUNITY RELATIONS	104,781	14,703	0	6,078	0
194.03	07952	EDUCATION	69,052	26,966	0	11,146	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	4,826,868	1,586,158	310,145	635,518	1,591,334

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144009

Period:  
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To 12/31/2012

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Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	16.00	17.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
13.00	01300	2,212,247					13.00
16.00	01600	0	683,609				16.00
17.00	01700	0	0	1,541,185			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	1,839,262	564,440	1,390,812	18,745,771	0	30.00
40.00	04000	262,531	17,458	150,373	2,118,485	0	40.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
60.00	06000	0	9,426	0	331,315	0	60.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	2,759	0	33,323	0	70.00
73.00	07300	0	44,454	0	1,289,818	0	73.00
76.00	03020	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	110,454	45,072	0	760,982	0	90.00
91.00	09100	0	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	05950	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		2,212,247	683,609	1,541,185	23,279,694	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	0	0	0	292,722	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07953	0	0	0	552,930	0	194.02
194.03	07952	0	0	0	388,804	0	194.03
200.00					0		200.00
201.00		0	0	0	0	0	201.00
202.00		2,212,247	683,609	1,541,185	24,514,150	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144009

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

Worksheet B  
Part I  
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Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
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
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
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
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
40.00	04000	SUBPROVIDER - IPF	40.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
60.00	06000	LABORATORY	60.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03020	RECREATION THERAPY	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
98.00	05950	OTHER REIMBURSABLE COST CENTERS	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	194.00
194.01	07951	PHP MEALS	194.01
194.02	07953	COMMUNITY RELATIONS	194.02
194.03	07952	EDUCATION	194.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144009

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

Worksheet B  
Part II  
Date/Time Prepared:  
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
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	21,231	1,550	22,781	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	23,831	558,377	40,763	622,971	5.00
7.00 00700	OPERATION OF PLANT	0	208,375	15,212	223,587	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	40,393	2,949	43,342	8.00
9.00 00900	HOUSEKEEPING	0	43,245	3,157	46,402	9.00
10.00 01000	DIETARY	0	205,800	15,024	220,824	10.00
13.00 01300	NURSING ADMINISTRATION	0	197,419	14,412	211,831	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	38,625	2,820	41,445	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	1,753,622	128,020	1,881,642	30.00
40.00 04000	SUBPROVIDER - IPF	0	168,866	12,328	181,194	40.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
60.00 06000	LABORATORY	0	10,578	772	11,350	60.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	30,143	2,201	32,344	73.00
76.00 03020	RECREATION THERAPY	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	21,686	1,583	23,269	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
98.00 05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	23,831	3,298,360	240,791	3,562,982	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	141,526	0	141,526	192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01 07951	PHP MEALS	0	0	0	0	194.01
194.02 07953	COMMUNITY RELATIONS	0	25,245	1,843	27,088	194.02
194.03 07952	EDUCATION	0	46,300	3,380	49,680	194.03
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	23,831	3,511,431	246,014	3,781,276	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144009

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

Worksheet B  
Part II  
Date/Time Prepared:  
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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
5.00	00500	ADMINISTRATIVE & GENERAL	626,279				5.00
7.00	00700	OPERATION OF PLANT	40,522	264,210			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,322	3,919	54,583		8.00
9.00	00900	HOUSEKEEPING	15,592	4,195	0	66,189	9.00
10.00	01000	DIETARY	36,327	19,965	0	5,160	282,818
13.00	01300	NURSING ADMINISTRATION	52,366	19,152	0	4,950	0
16.00	01600	MEDICAL RECORDS & LIBRARY	16,652	3,747	0	968	0
17.00	01700	SOCIAL SERVICE	39,373	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	303,808	170,125	49,257	43,969	237,480
40.00	04000	SUBPROVIDER - I/PF	34,833	16,382	5,326	4,234	27,615
<b>ANCILLARY SERVICE COST CENTERS</b>							
60.00	06000	LABORATORY	8,001	1,026	0	265	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	781	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	31,182	2,924	0	756	0
76.00	03020	RECREATION THERAPY	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	12,464	2,104	0	544	17,723
91.00	09100	EMERGENCY	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	599,223	243,539	54,583	60,846	282,818
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,502	13,730	0	3,549	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01	07951	PHP MEALS	0	0	0	0	0
194.02	07953	COMMUNITY RELATIONS	13,595	2,449	0	633	0
194.03	07952	EDUCATION	8,959	4,492	0	1,161	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	626,279	264,210	54,583	66,189	282,818

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144009

Period:  
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To 12/31/2012

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Part II  
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Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	16.00	17.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
13.00	01300	290,519					13.00
16.00	01600	0	63,257				16.00
17.00	01700	0	0	41,211			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	241,538	52,226	37,190	3,028,709	0	30.00
40.00	04000	34,476	1,616	4,021	311,064	0	40.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
60.00	06000	0	873	0	21,515	0	60.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	255	0	1,036	0	70.00
73.00	07300	0	4,115	0	71,321	0	73.00
76.00	03020	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	14,505	4,172	0	75,353	0	90.00
91.00	09100	0	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	05950	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		290,519	63,257	41,211	3,508,998	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	0	0	0	163,307	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07953	0	0	0	44,333	0	194.02
194.03	07952	0	0	0	64,638	0	194.03
200.00					0		200.00
201.00		0	0	0	0	0	201.00
202.00		290,519	63,257	41,211	3,781,276	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144009

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

Worksheet B  
Part II  
Date/Time Prepared:  
4/9/2013 1:20 pm

Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
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
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
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
13.00	01300	NURSING ADMINISTRATION	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
40.00	04000	SUBPROVIDER - IPF	40.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
60.00	06000	LABORATORY	60.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03020	RECREATION THERAPY	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
98.00	05950	OTHER REIMBURSABLE COST CENTERS	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	194.00
194.01	07951	PHP MEALS	194.01
194.02	07953	COMMUNITY RELATIONS	194.02
194.03	07952	EDUCATION	194.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144009

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

Worksheet B-1

Date/Time Prepared:  
4/9/2013 1:20 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (PHYS SQ FT)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	139,092				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		133,486			2.00
4.00 00400	EMPLOYEE BENEFITS	841	841	12,150,665		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	22,118	22,118	1,764,132	-4,826,868	5.00
7.00 00700	OPERATION OF PLANT	8,254	8,254	53,877	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,600	1,600	0	0	8.00
9.00 00900	HOUSEKEEPING	1,713	1,713	0	0	9.00
10.00 01000	DIETARY	8,152	8,152	289,203	0	10.00
13.00 01300	NURSING ADMINISTRATION	7,820	7,820	1,184,181	0	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,530	1,530	237,185	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	980,497	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	69,463	69,463	6,119,927	0	30.00
40.00 04000	SUBPROVIDER - IPF	6,689	6,689	728,925	0	40.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
60.00 06000	LABORATORY	419	419	0	0	60.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,194	1,194	0	0	73.00
76.00 03020	RECREATION THERAPY	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	859	859	305,279	0	90.00
91.00 09100	EMERGENCY	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
98.00 05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	130,652	130,652	11,663,206	-4,826,868	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	5,606	0	0	0	192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01 07951	PHP MEALS	0	0	0	0	194.01
194.02 07953	COMMUNITY RELATIONS	1,000	1,000	303,024	0	194.02
194.03 07952	EDUCATION	1,834	1,834	184,435	0	194.03
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)	3,511,431	246,014	2,265,717	4,826,868	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	25.245384	1.842995	0.186469	0.245177	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			22,781	626,279	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001875	0.031811	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144009

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

Worksheet B-1

Date/Time Prepared:  
4/9/2013 1:20 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (NURSING MANHOURS)	
		7.00	8.00	9.00	10.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700	107,879					7.00
8.00	00800	1,600	49,257				8.00
9.00	00900	1,713	0	104,566			9.00
10.00	01000	8,152	0	8,152	142,931		10.00
13.00	01300	7,820	0	7,820	0	295,243	13.00
16.00	01600	1,530	0	1,530	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	69,463	44,451	69,463	120,018	245,465	30.00
40.00	04000	6,689	4,806	6,689	13,956	35,037	40.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
60.00	06000	419	0	419	0	0	60.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
73.00	07300	1,194	0	1,194	0	0	73.00
76.00	03020	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	859	0	859	8,957	14,741	90.00
91.00	09100	0	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	05950	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		99,439	49,257	96,126	142,931	295,243	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	5,606	0	5,606	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07953	1,000	0	1,000	0	0	194.02
194.03	07952	1,834	0	1,834	0	0	194.03
200.00							200.00
201.00							201.00
202.00		1,586,158	310,145	635,518	1,591,334	2,212,247	202.00
203.00		14,703,121	6,296,465	6,077,673	11,133,582	7,492,970	203.00
204.00		264,210	54,583	66,189	282,818	290,519	204.00
205.00		2,449,133	1,108,127	0,632,988	1,978,703	0,984,000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144009

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

Worksheet B-1

Date/Time Prepared:  
4/9/2013 1:20 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	
		16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>				
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
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
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
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	62,713,762	16.00
17.00	01700	SOCIAL SERVICE	0 49,257	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	51,780,876	30.00
40.00	04000	SUBPROVIDER - I PF	1,601,681 4,806	40.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
60.00	06000	LABORATORY	864,783 0	60.00
69.00	06900	ELECTROCARDIOLOGY	0 0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	253,076 0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,078,346 0	73.00
76.00	03020	RECREATION THERAPY	0 0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000	CLINIC	4,135,000 0	90.00
91.00	09100	EMERGENCY	0 0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0 0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	62,713,762 49,257	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0 0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0 0	194.00
194.01	07951	PHP MEALS	0 0	194.01
194.02	07953	COMMUNITY RELATIONS	0 0	194.02
194.03	07952	EDUCATION	0 0	194.03
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)	683,609 1,541,185	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.010900 31.288649	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	63,257 41,211	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001009 0.836653	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144009

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

Worksheet C  
Part I  
Date/Time Prepared:  
4/9/2013 1:20 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
1.00	2.00	3.00	4.00	5.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	18,745,771		18,745,771	153,400	18,899,171	30.00
40.00	04000 SUBPROVIDER - IPF	2,118,485		2,118,485	0	2,118,485	40.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000 LABORATORY	331,315		331,315	0	331,315	60.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	33,323		33,323	0	33,323	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,289,818		1,289,818	0	1,289,818	73.00
76.00	03020 RECREATION THERAPY	0		0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	760,982		760,982	0	760,982	90.00
91.00	09100 EMERGENCY	0		0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	23,279,694	0	23,279,694	153,400	23,433,094	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	23,279,694	0	23,279,694	153,400	23,433,094	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144009

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

Worksheet C  
Part I  
Date/Time Prepared:  
4/9/2013 1:20 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	51,780,876		51,780,876		30.00
40.00	04000	SUBPROVIDER - I/PF	1,601,681		1,601,681		40.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	864,783	0	864,783	0.383119	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	253,076	0	253,076	0.131672	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,078,346	0	4,078,346	0.316260	73.00
76.00	03020	RECREATION THERAPY	0	0	0	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	4,135,000	4,135,000	0.184034	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	58,578,762	4,135,000	62,713,762		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	58,578,762	4,135,000	62,713,762		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 144009	Period: From 01/01/2012 To 12/31/2012	Worksheet C Part I Date/Time Prepared: 4/9/2013 1:20 pm
		Title XVIII	Hospital	PPS
Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
40.00	04000 SUBPROVIDER - I/PF			40.00
ANCILLARY SERVICE COST CENTERS				
60.00	06000 LABORATORY	0.383119		60.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.131672		70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.316260		73.00
76.00	03020 RECREATION THERAPY	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.184034		90.00
91.00	09100 EMERGENCY	0.000000		91.00
OTHER REIMBURSABLE COST CENTERS				
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144009

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

Worksheet C  
Part I  
Date/Time Prepared:  
4/9/2013 1:20 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX Hospital Cost			
				Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	18,745,771		18,745,771	0	0	30.00
40.00	04000 SUBPROVIDER - IPF	2,118,485		2,118,485	0	0	40.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
60.00	06000 LABORATORY	331,315		331,315	0	0	60.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	33,323		33,323	0	0	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,289,818		1,289,818	0	0	73.00
76.00	03020 RECREATION THERAPY	0		0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	760,982		760,982	0	0	90.00
91.00	09100 EMERGENCY	0		0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	23,279,694	0	23,279,694	0	0	200.00
201.00	Less Observation Beds	0		0			201.00
202.00	Total (see instructions)	23,279,694	0	23,279,694	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144009

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

Worksheet C  
Part I  
Date/Time Prepared:  
4/9/2013 1:20 pm

Cost Center Description		Title XIX			Hospital	Cost		
		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	51,780,876		51,780,876			30.00
40.00	04000	SUBPROVIDER - I/PF	1,601,681		1,601,681			40.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	864,783	0	864,783	0.383119	0.000000	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	253,076	0	253,076	0.131672	0.000000	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,078,346	0	4,078,346	0.316260	0.000000	73.00
76.00	03020	RECREATION THERAPY	0	0	0	0.000000	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	4,135,000	4,135,000	0.184034	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
OTHER REIMBURSABLE COST CENTERS								
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	58,578,762	4,135,000	62,713,762			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	58,578,762	4,135,000	62,713,762			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144009

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

Worksheet C  
Part I  
Date/Time Prepared:  
4/9/2013 1:20 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
40.00	04000 SUBPROVIDER - I/PF				40.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000 LABORATORY	0.000000			60.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03020 RECREATION THERAPY	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
OTHER REIMBURSABLE COST CENTERS					
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0.000000			98.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

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

Provider CCN: 144009

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

Worksheet C  
Part II  
Date/Time Prepared:  
4/9/2013 1:20 pm

Cost Center Description		Title XIX Hospital Cost						
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
60.00	06000	LABORATORY	331,315	21,515	309,800	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	33,323	1,036	32,287	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,289,818	71,321	1,218,497	0	0	73.00
76.00	03020	RECREATION THERAPY	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	760,982	75,353	685,629	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	2,415,438	169,225	2,246,213	0	0	200.00
201.00		Less Observation Beds	0	0	0	0	0	201.00
202.00		Total (line 200 minus line 201)	2,415,438	169,225	2,246,213	0	0	202.00

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

Provider CCN: 144009

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

Worksheet C Part II Date/Time Prepared: 4/9/2013 1:20 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital Cost
		6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS					
60.00	06000 LABORATORY	331,315	864,783	0.383119	60.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	33,323	253,076	0.131672	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,289,818	4,078,346	0.316260	73.00
76.00	03020 RECREATION THERAPY	0	0	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	760,982	4,135,000	0.184034	90.00
91.00	09100 EMERGENCY	0	0	0.000000	91.00
OTHER REIMBURSABLE COST CENTERS					
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	98.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (sum of lines 50 thru 199)	2,415,438	9,331,205		200.00
201.00	Less Observation Beds	0	0		201.00
202.00	Total (line 200 minus line 201)	2,415,438	9,331,205		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Provider CCN: 144009		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part I Date/Time Prepared: 4/9/2013 1:20 pm	
Cost Center Description			Title XVIII		Hospital		PPS	
			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	03000	ADULTS & PEDIATRICS	3,028,709	0	3,028,709	44,451	68.14	30.00
40.00	04000	SUBPROVIDER - IPF	311,064	0	311,064	4,806	64.72	40.00
200.00		Total (lines 30-199)	3,339,773		3,339,773	49,257		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Provider CCN: 144009	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part I Date/Time Prepared: 4/9/2013 1:20 pm
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
			6.00	7.00	
Title XVIII Hospital PPS					
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	13,097	892,430	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
200.00		Total (lines 30-199)	13,097	892,430	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 144009		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part II Date/Time Prepared: 4/9/2013 1:20 pm		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	PPS	
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	21,515	864,783	0.024879	216,087	5,376	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,036	253,076	0.004094	67,423	276	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	71,321	4,078,346	0.017488	2,053,191	35,906	73.00
76.00	03020	RECREATION THERAPY	0	0	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	75,353	4,135,000	0.018223	0	0	90.00
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
OTHER REIMBURSABLE COST CENTERS								
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (lines 50-199)	169,225	9,331,205		2,336,701	41,558	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 144009		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part III Date/Time Prepared: 4/9/2013 1:20 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 144009		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part III Date/Time Prepared: 4/9/2013 1:20 pm	
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)	PPS	
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	44,451	0.00	13,097	0		30.00
40.00	04000	SUBPROVIDER - IPF	4,806	0.00	0	0		40.00
200.00		Total (lines 30-199)	49,257		13,097	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144009

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

Worksheet D  
Part IV  
Date/Time Prepared:  
4/9/2013 1:20 pm

Cost Center Description		Title XVIII			Hospital		PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
60.00	06000	LABORATORY	0	0	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	RECREATION THERAPY	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144009

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

Worksheet D  
Part IV  
Date/Time Prepared:  
4/9/2013 1:20 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	0	864,783	0.000000	0.000000	216,087	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	253,076	0.000000	0.000000	67,423	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,078,346	0.000000	0.000000	2,053,191	73.00
76.00	03020	RECREATION THERAPY	0	0	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	4,135,000	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	0	0.000000	0.000000	0	91.00
OTHER REIMBURSABLE COST CENTERS								
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00		Total (lines 50-199)	0	9,331,205			2,336,701	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 144009	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 4/9/2013 1:20 pm
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)		
ANCILLARY SERVICE COST CENTERS		11.00	12.00	13.00		
60.00	06000 LABORATORY	0	0	0		60.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020 RECREATION THERAPY	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
OTHER REIMBURSABLE COST CENTERS						
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 144009

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

Worksheet D  
Part V  
Date/Time Prepared:  
4/9/2013 1:20 pm

		Title XVIII		Hospital		PPS	
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	0.383119	0	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.131672	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.316260	0	0	0	73.00
76.00	03020	RECREATION THERAPY	0.000000	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.184034	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	98.00
200.00		Subtotal (see instructions)		0	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)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 144009	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 4/9/2013 1:20 pm
Title XVIII		Hospital	PPS

Cost Center Description	Costs					
	PPS Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		5.00	6.00			7.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
60.00	06000	LABORATORY	0	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00	03020	RECREATION THERAPY	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	91.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	98.00
200.00		Subtotal (see instructions)	0	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	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Provider CCN: 144009		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part I Date/Time Prepared: 4/9/2013 1:20 pm	
Cost Center Description			Title XIX		Hospital		Cost	
			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	03000	ADULTS & PEDIATRICS	3,028,709	0	3,028,709	44,451	68.14	30.00
40.00	04000	SUBPROVIDER - IPF	311,064	0	311,064	4,806	64.72	40.00
200.00		Total (lines 30-199)	3,339,773		3,339,773	49,257		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Provider CCN: 144009		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part I Date/Time Prepared: 4/9/2013 1:20 pm	
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Title XIX		Hospital Cost	
			6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	16,044	1,093,238			30.00	
40.00	04000	SUBPROVIDER - IPF	0	0			40.00	
200.00		Total (lines 30-199)	16,044	1,093,238			200.00	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 144009

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

Worksheet D  
Part II  
Date/Time Prepared:  
4/9/2013 1:20 pm

Cost Center Description		Title XIX			Hospital		Capital Costs (column 3 x column 4)	
		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	Cost		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	21,515	864,783	0.024879	374,430	9,315	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,036	253,076	0.004094	114,548	469	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	71,321	4,078,346	0.017488	1,044,829	18,272	73.00
76.00	03020	RECREATION THERAPY	0	0	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	75,353	4,135,000	0.018223	0	0	90.00
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
OTHER REIMBURSABLE COST CENTERS								
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (lines 50-199)	169,225	9,331,205		1,533,807	28,056	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 144009		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part III Date/Time Prepared: 4/9/2013 1:20 pm	
Cost Center Description		Title XIX			Hospital		Cost
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0 30.00
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	0 40.00
200.00		Total (lines 30-199)	0	0	0		0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 144009		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part III Date/Time Prepared: 4/9/2013 1:20 pm	
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)	Cost	
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	44,451	0.00	16,044	0	30.00	
40.00	04000	SUBPROVIDER - IPF	4,806	0.00	0	0	40.00	
200.00		Total (lines 30-199)	49,257		16,044	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144009

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

Worksheet D  
Part IV  
Date/Time Prepared:  
4/9/2013 1:20 pm

Cost Center Description		Title XIX				Hospital		Total Cost (sum of col 1 through col . 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost			
		1.00	2.00	3.00	4.00	5.00			
<b>ANCILLARY SERVICE COST CENTERS</b>									
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
76.00	03020	RECREATION THERAPY	0	0	0	0	0	76.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>									
90.00	09000	CLINIC	0	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0	0	0	0	0	91.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>									
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00	
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: 144009

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

Worksheet D  
Part IV  
Date/Time Prepared:  
4/9/2013 1:20 pm

Cost Center Description		Title XIX			Hospital		Inpatient Program Charges	
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Cost		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	0	864,783	0.000000	0.000000	374,430	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	253,076	0.000000	0.000000	114,548	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,078,346	0.000000	0.000000	1,044,829	73.00
76.00	03020	RECREATION THERAPY	0	0	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	4,135,000	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	0	0.000000	0.000000	0	91.00
OTHER REIMBURSABLE COST CENTERS								
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00		Total (lines 50-199)	0	9,331,205			1,533,807	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 144009	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 4/9/2013 1:20 pm
		Title XIX	Hospital
		Cost	

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)		
ANCILLARY SERVICE COST CENTERS		11.00	12.00	13.00		
60.00	06000 LABORATORY	0	0	0		60.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020 RECREATION THERAPY	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
OTHER REIMBURSABLE COST CENTERS						
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
200.00	Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 144009	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 4/9/2013 1:20 pm
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		44,451	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		44,451	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)		44,451	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)		13,097	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
<b>SWING BED ADJUSTMENT</b>				
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)		18,899,171	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)		18,899,171	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		51,780,876	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		51,780,876	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.364984	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)		1,164.90	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)		18,899,171	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		425.17	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,568,451	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)		5,568,451	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 144009	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 4/9/2013 1:20 pm	
Cost Center Description			Title XVIII	Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)				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)				741,007	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				6,309,458	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)				892,430	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				41,558	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				933,988	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				5,375,470	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: 144009		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 4/9/2013 1:20 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,028,709	18,899,171	0.160256	0	0	90.00
91.00	Nursing School cost	0	18,899,171	0.000000	0	0	91.00
92.00	Allied health cost	0	18,899,171	0.000000	0	0	92.00
93.00	All other Medical Education	0	18,899,171	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 144009	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 4/9/2013 1:20 pm
		Title XIX	Hospital	Cost
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		44,451	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		44,451	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)		44,451	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)		16,044	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
<b>SWING BED ADJUSTMENT</b>				
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)		18,745,771	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)		18,745,771	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		51,780,876	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		51,780,876	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.362021	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)		1,164.90	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)		18,745,771	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		421.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,766,076	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)		6,766,076	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 144009	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 4/9/2013 1:20 pm	
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)
NURSERY (title V & XIX only)		1.00	2.00	3.00	4.00	5.00
42.00	Intensive Care Type Inpatient Hospital Units					42.00
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)					488,972 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					7,255,048 49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>						
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>						
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>						
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
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: 144009		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 4/9/2013 1:20 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	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: 144009	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 4/9/2013 1:20 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		17,096,960	30.00
40.00	04000	SUBPROVIDER - I/PF		0	40.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000	LABORATORY	0.383119	216,087	60.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.131672	67,423	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.316260	2,053,191	73.00
76.00	03020	RECREATION THERAPY	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.184034	0	90.00
91.00	09100	EMERGENCY	0.000000	0	91.00
OTHER REIMBURSABLE COST CENTERS					
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	98.00
200.00		Total (sum of lines 50-94 and 96-98)		2,336,701	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)		2,336,701	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 144009	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 4/9/2013 1:20 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		20,947,410	30.00
40.00	04000	SUBPROVIDER - I/PF		0	40.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000	LABORATORY	0.383119	374,430	60.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.131672	114,548	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.316260	1,044,829	73.00
76.00	03020	RECREATION THERAPY	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.184034	0	90.00
91.00	09100	EMERGENCY	0.000000	0	91.00
OTHER REIMBURSABLE COST CENTERS					
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	98.00
200.00		Total (sum of lines 50-94 and 96-98)		1,533,807	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		1,533,807	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 144009	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 4/9/2013 1:20 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	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
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
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
<b>Customary charges</b>				
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)		0	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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)		0	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)		0	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)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
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)		0	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)		0	40.00
41.00	Interim payments		0	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-II, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 144009

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
4/9/2013 1:20 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		9,196,528		0		1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		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	12/31/2012	25,250		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)		-25,250		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)		9,171,278		0		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0		6.01
6.02	SETTLEMENT TO PROGRAM		27,335		0		6.02
7.00	Total Medicare program liability (see instructions)		9,143,943		0		7.00
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 144009	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part II Date/Time Prepared: 4/9/2013 1:20 pm
		Title XVII	Hospital	PPS
		1.00		
<b>PART II - MEDICARE PART A SERVICES - IPF PPS</b>				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		10,072,945	1.00
2.00	Net IPF PPS Outlier Payments		0	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	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	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	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	6.00
7.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		121.450820	9.00
10.00	Medical Education Adjustment Factor $\{((1 + (\text{line } 8/\text{line } 9))) \text{ raised to the power of } .5150 - 1\}$ .		0.000000	10.00
11.00	Medical Education Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		10,072,945	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition		0	14.00
15.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	15.00
16.00	Subtotal (see instructions)		10,072,945	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		10,072,945	18.00
19.00	Deductibles		560,826	19.00
20.00	Subtotal (line 18 minus line 19)		9,512,119	20.00
21.00	Coinsurance		412,981	21.00
22.00	Subtotal (line 20 minus line 21)		9,099,138	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		64,007	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		44,805	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		3,396	25.00
26.00	Subtotal (sum of lines 22 and 24)		9,143,943	26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.99	Recovery of Accelerated Depreciation		0	30.99
31.00	Total amount payable to the provider (see instructions)		9,143,943	31.00
32.00	Interim payments		9,171,278	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus the sum lines 32 and 33)		-27,335	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		181,814	35.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		0	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: 144009	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part VII Date/Time Prepared: 4/9/2013 1:20 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		7,255,048		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		7,255,048	0	4.00
5.00	Inpatient primary payer payments		331,899		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		6,923,149	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		20,947,410		8.00
9.00	Ancillary service charges		1,533,807	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		22,481,217	0	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		22,481,217	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		15,226,169	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		7,255,048	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		7,255,048	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		6,923,149	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		6,923,149	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		6,923,149	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		6,923,149	0	40.00
41.00	Interim payments		12,223,442	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		-5,300,293	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 144009 Component CCN: 144009	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part VII Date/Time Prepared: 4/9/2013 1:20 pm
		Title XIX	Subprovider - IPF	Cost
		Inpatient 1.00	Outpatient 2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>				
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable Charges</b>				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
<b>CUSTOMARY CHARGES</b>				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	0	43.00

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

Provider CCN: 144009

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

Worksheet G

Date/Time Prepared:  
4/9/2013 1:20 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	-236,876	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	11,964,695	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	124,639	0	0	0	7.00
8.00	Prepaid expenses	16,671	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	11,869,129	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	3,639,655	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	1,191,376	0	0	0	15.00
16.00	Accumulated depreciation	-650,025	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	112,228	0	0	0	23.00
24.00	Accumulated depreciation	-448,986	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)	3,844,248	0	0	0	30.00
<b>OTHER ASSETS</b>						
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	53,699,174	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	53,699,174	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	69,412,551	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	21,630	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,793,163	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	49,212,067	0	0	0	43.00
44.00	Other current liabilities	448,819	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	51,475,679	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	51,475,679	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	17,936,872				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	17,936,872	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	69,412,551	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 144009

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

Worksheet G-1

Date/Time Prepared:  
4/9/2013 1:20 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
1.00	Fund balances at beginning of period		2,169,163		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		9,374,294			2.00
3.00	Total (sum of line 1 and line 2)		11,543,457		0	3.00
4.00	CONSOLIDATING ENTRIES	6,393,415		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		6,393,415		0	10.00
11.00	Subtotal (line 3 plus line 10)		17,936,872		0	11.00
12.00		0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		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)		17,936,872		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 144009

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

Worksheet G-1

Date/Time Prepared:  
4/9/2013 1:20 pm

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
1.00			0		0	1.00
2.00						2.00
3.00			0		0	3.00
4.00	0			0		4.00
5.00	0			0		5.00
6.00	0			0		6.00
7.00	0			0		7.00
8.00	0			0		8.00
9.00	0			0		9.00
10.00			0		0	10.00
11.00			0		0	11.00
12.00	0			0		12.00
13.00	0			0		13.00
14.00	0			0		14.00
15.00	0			0		15.00
16.00	0			0		16.00
17.00	0			0		17.00
18.00			0		0	18.00
19.00			0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 144009

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
4/9/2013 1:20 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	51,734,425		51,734,425	1.00
2.00	SUBPROVIDER - IPF	1,601,681		1,601,681	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	53,336,106		53,336,106	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	53,336,106		53,336,106	17.00
18.00	Ancillary services	5,242,656	0	5,242,656	18.00
19.00	Outpatient services	0	4,135,000	4,135,000	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	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	58,578,762	4,135,000	62,713,762	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		25,078,410		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	PHYSICIAN REVENUE	1,329,649			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		1,329,649		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		23,748,761		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 144009

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

Worksheet G-3

Date/Time Prepared:  
4/9/2013 1:20 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	62,713,762	1.00
2.00	Less contractual allowances and discounts on patients' accounts	30,020,555	2.00
3.00	Net patient revenues (line 1 minus line 2)	32,693,207	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	23,748,761	4.00
5.00	Net income from service to patients (line 3 minus line 4)	8,944,446	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	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	OTHER INCOME	429,848	24.00
25.00	Total other income (sum of lines 6-24)	429,848	25.00
26.00	Total (line 5 plus line 25)	9,374,294	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)	9,374,294	29.00