

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: 140125

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

Worksheet S Parts I-III Date/Time Prepared: 5/31/2013 11:35 am

**PART I - COST REPORT STATUS**

Provider use only

1.  Electronically filed cost report Date: 5/31/2013 Time: 11:35 am

2.  Manually submitted cost report

3.  If this is an amended report enter the number of times the provider resubmitted this cost report

4.  Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5.  Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended

6. Date Received: Contractor No.

7.  Initial Report for this Provider CCN

8.  Final Report for this Provider CCN

9.  Final Report for this Provider CCN

10. NPR Date:

11. Contractor's Vendor Code: 4

12.  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 GATEWAY REGIONAL ( 140125 ) 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	518,914	39,191	-162,580	0	1.00
2.00 Subprovider - IPF	0	1,956	0		0	2.00
3.00 Subprovider - IRF	0	29,784	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	727	0		0	7.00
8.00 NURSING FACILITY	0				0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00 CMHC I	0		0		0	12.00
200.00 Total	0	551,381	39,191	-162,580	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet S Parts I-III Date/Time Prepared: 5/31/2013 11:35 am
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**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/31/2013 Time: 11:35 am
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**

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Encryption Information  
ECR: Date: 5/31/2013 Time: 11:35 am  
23g7oHe7i Nvi aoP: EJ6TI i t3Ri vqNO  
E9Qh40vWrCfJ4TI uTi QfKO: eo. Sf4h  
Kj j p1F9CQ906U5xg  
PI: Date: 5/31/2013 Time: 11:35 am  
Kg. GM9PYt74o7hQ8. L9I J9T2g7wOFO  
OPh7A0QbBH9yANI tVbkMb8vZvi EV97  
nMj 20YvmOE0Eql NG

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

	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	518,914	39,191	-162,580	0	1.00
2.00 Subprovider - IPF	0	1,956	0		0	2.00
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4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	727	0		0	7.00
8.00 NURSING FACILITY	0				0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00 CMHC I	0		0		0	12.00
200.00 Total	0	551,381	39,191	-162,580	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140125		Period: From 01/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 5/30/2013 4:00 pm				
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 Zip Code: 62040		4.00 County: MADISON				
1.00	Street: 2100 MADISON AVE	State: IL		Zip Code: 62040		County: MADISON			1.00	
2.00	City: GRANITE CITY								2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	GATEWAY REGIONAL	140125	41180	1	07/01/1969	N	P	P	3.00
4.00	Subprovider - IPF	PSYCH DPU	14S125	41180	4	01/01/1984	N	P	P	4.00
5.00	Subprovider - IRF	REHAB DPU	14T125	41180	5	12/31/2001	N	P	P	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	HOSPITAL BASED SNF	145562	41180		05/23/1986	N	P	P	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.					Y		N		22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					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	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.	5,490	5,927	204	71	670	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.	141	58	17	0	8	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: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/30/2013 4:00 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	Y	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
<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.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)		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		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 140125

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

Worksheet S-2  
Part I  
Date/Time Prepared:  
5/30/2013 4:00 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

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		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 report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N		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.	Y					75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N	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		N			91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N			92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N			93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N			94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00			0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N			96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00			0.00	97.00
<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)	N					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)	N					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	
		1.00		2.00		3.00	
						Respiratory	
						4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N		N	109.00
		1.00			2.00		
					3.00		
<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.	N					117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1					118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/30/2013 4:00 pm	
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	166,161	1,532,345		0
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
<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		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
<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	449008	140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: COMMUNITY HEALTH SYSTEMS, INC.	Contractor's Name: WPS		Contractor's Number: 10301	
142.00	Street: 4000 MERIDIAN BOULEVARD	PO Box: 52280			
143.00	City: FRANKLIN	State: 49		Zip Code: 37067	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.			Y	145.00
			1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140125			Period: From 01/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 5/30/2013 4:00 pm	
							1.00	
<b>Multi campus</b>								
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	
<b>Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act</b>								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							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)						1.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/30/2013 4:00 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	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.			Y	15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/04/2013	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/30/2013 4:00 pm	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
<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	12/31/2012
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.	DAWN		GI BSON	41.00
42.00	Enter the employer/company name of the cost report preparer.	CHS			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615 465 3460		DAWN_GI BSON@CHS.NET	43.00

		Part B		
		Date		
		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)	04/04/2013		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
<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.	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

HFS Supplemental Information		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part IX Date/Time Prepared: 5/30/2013 4:00 pm	
			Title V	Title XIX	
			1.00	2.00	
<b>TITLES V AND/OR XIX FOLLOWING MEDICARE</b>					
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	3.00
			Inpatient	Outpatient	
			1.00	2.00	
<b>CRITICAL ACCESS HOSPITALS</b>					
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.		N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.		N	N	5.00
			Title V	Title XIX	
			1.00	2.00	
<b>RCE DISALLOWANCE</b>					
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	6.00
<b>PASS THROUGH COST</b>					
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140125

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/30/2013 4:00 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Visi ts / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	297	108,702	0.00	0	1.00
2.00 HMO						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		297	108,702	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,392	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		309	113,094	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	17	6,222		0	16.00
17.00 SUBPROVIDER - IRF	41.00	14	5,124		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	19	6,954		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPI CE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		359				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00
Component	I/P Days / O/P Visi ts / Tri ps			Full Time Equival ents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payrol l	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	9,141	10,295	29,794			1.00
2.00 HMO	2,110	1,276				2.00
3.00 HMO IPF Subprovider	149	0				3.00
4.00 HMO IRF Subprovider	34	47				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	9,141	10,295	29,794			7.00
8.00 INTENSIVE CARE UNIT	815	260	1,677			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		531	624			13.00
14.00 Total (see instructions)	9,956	11,086	32,095	0.00	556.81	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	2,639	529	3,943	0.00	15.10	16.00
17.00 SUBPROVIDER - IRF	832	177	1,274	0.00	9.57	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	1,899	0	2,913	0.00	13.53	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 HOSPI CE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140125

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/30/2013 4:00 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents							
	Title VIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll						
	6.00	7.00	8.00	9.00	10.00						
27.00	Total (sum of lines 14-26)					0.00	595.01	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			
Component	Full Time Equivalents	Discharges									
	Nonpaid Workers	Title V	Title VIII	Title XIX	Total All Patients						
	11.00	12.00	13.00	14.00	15.00						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)							1.00			
2.00	HMO						434	2.00			
3.00	HMO IPF Subprovider							3.00			
4.00	HMO IRF Subprovider							4.00			
5.00	Hospital Adults & Peds. Swing Bed SNF							5.00			
6.00	Hospital Adults & Peds. Swing Bed NF							6.00			
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)							7.00			
8.00	INTENSIVE CARE UNIT							8.00			
9.00	CORONARY CARE UNIT							9.00			
10.00	BURN INTENSIVE CARE UNIT							10.00			
11.00	SURGICAL INTENSIVE CARE UNIT							11.00			
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00			
13.00	NURSERY							13.00			
14.00	Total (see instructions)					0.00	0	2,097	1,999	6,922	14.00
15.00	CAH visits										15.00
16.00	SUBPROVIDER - IPF					0.00	0	312	66	501	16.00
17.00	SUBPROVIDER - IRF					0.00	0	78	15	116	17.00
18.00	SUBPROVIDER										18.00
19.00	SKILLED NURSING FACILITY					0.00					19.00
20.00	NURSING FACILITY										20.00
21.00	OTHER LONG TERM CARE										21.00
22.00	HOME HEALTH AGENCY										22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)										23.00
24.00	HOSPICE										24.00
25.00	CMHC - CMHC										25.00
26.00	RURAL HEALTH CLINIC					0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER										26.25
27.00	Total (sum of lines 14-26)					0.00					27.00
28.00	Observation Bed Days										28.00
29.00	Ambulance Trips										29.00
30.00	Employee discount days (see instruction)										30.00
31.00	Employee discount days - IRF										31.00
32.00	Labor & delivery days (see instructions)										32.00
33.00	LTCH non-covered days										33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140125

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/30/2013 4:00 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	31,817,183	0	31,817,183	1,237,625.00	25.71
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	661,299	0	661,299	28,138.00	23.50
10.00	Excluded area salaries (see instructions)		1,392,874	158,545	1,551,419	62,458.00	24.84
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract labor (see instructions)		405,743	0	405,743	7,792.75	52.07
12.00	Contract management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		106,638	0	106,638	129.00	826.65
14.00	Home office salaries & wage-related costs		1,987,684	0	1,987,684	29,444.00	67.51
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		7,006,887	0	7,006,887		
18.00	Wage-related costs (other) Wkst S-3, Part IV line 25		0	0	0		
19.00	Excluded areas		371,433	0	371,433		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FOHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits	4.00	191,337	0	191,337	6,861.00	27.89
27.00	Administrative & General	5.00	4,139,311	141,059	4,280,370	182,285.00	23.48
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	821,192	0	821,192	36,775.00	22.33
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	0	0	0	0.00	0.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	1,682,294	0	1,682,294	48,657.00	34.57
39.00	Central Services and Supply	14.00	274,226	0	274,226	18,388.00	14.91
40.00	Pharmacy	15.00	1,469,368	0	1,469,368	42,053.00	34.94
41.00	Medical Records & Medical Records Library	16.00	696,756	0	696,756	42,258.00	16.49

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140125

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/30/2013 4:00 pm

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

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140125

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/30/2013 4:00 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	31,817,183	0	31,817,183	1,237,625.00	25.71	1.00
2.00	Excluded area salaries (see instructions)	2,054,173	158,545	2,212,718	90,596.00	24.42	2.00
3.00	Subtotal salaries (line 1 minus line 2)	29,763,010	-158,545	29,604,465	1,147,029.00	25.81	3.00
4.00	Subtotal other wages & related costs (see inst.)	2,500,065	0	2,500,065	37,365.75	66.91	4.00
5.00	Subtotal wage-related costs (see inst.)	7,006,887	0	7,006,887	0.00	23.67	5.00
6.00	Total (sum of lines 3 thru 5)	39,269,962	-158,545	39,111,417	1,184,394.75	33.02	6.00
7.00	Total overhead cost (see instructions)	9,274,484	141,059	9,415,543	377,277.00	24.96	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet S-3 Part IV Date/Time Prepared: 5/30/2013 4:00 pm
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions			731,316 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration Fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)			3,209,904 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			43,664 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			38,849 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			-852 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			29,706 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			346,046 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			0 16.00
<b>TAXES</b>				
17.00	FICA-Employers Portion Only			1,894,887 17.00
18.00	Medicare Taxes - Employers Portion Only			443,159 18.00
19.00	Unemployment Insurance			0 19.00
20.00	State or Federal Unemployment Taxes			427,007 20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			0 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			7,163,686 24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			214,633 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet S-3 Part V Date/Time Prepared: 5/30/2013 4:00 pm
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	405,743	0	1.00
2.00	Hospital	405,743	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140125

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

Worksheet S-7

Date/Time Prepared:  
5/30/2013 4:00 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N		2.00

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1.00	2.00	3.00	4.00	
3.00	RUX	0	0	0	3.00
4.00	RUL	0	0	0	4.00
5.00	RVX	0	0	0	5.00
6.00	RVL	14	0	14	6.00
7.00	RHX	19	0	19	7.00
8.00	RHL	53	0	53	8.00
9.00	RMX	17	0	17	9.00
10.00	RML	120	0	120	10.00
11.00	RLX	0	0	0	11.00
12.00	RUC	0	0	0	12.00
13.00	RUB	10	0	10	13.00
14.00	RUA	0	0	0	14.00
15.00	RVC	11	0	11	15.00
16.00	RVB	145	0	145	16.00
17.00	RVA	19	0	19	17.00
18.00	RHC	107	0	107	18.00
19.00	RHB	380	0	380	19.00
20.00	RHA	109	0	109	20.00
21.00	RMC	115	0	115	21.00
22.00	RMB	368	0	368	22.00
23.00	RMA	148	0	148	23.00
24.00	RLB	0	0	0	24.00
25.00	RLA	0	0	0	25.00
26.00	ES3	0	0	0	26.00
27.00	ES2	0	0	0	27.00
28.00	ES1	10	0	10	28.00
29.00	HE2	0	0	0	29.00
30.00	HE1	0	0	0	30.00
31.00	HD2	0	0	0	31.00
32.00	HD1	7	0	7	32.00
33.00	HC2	0	0	0	33.00
34.00	HC1	5	0	5	34.00
35.00	HB2	0	0	0	35.00
36.00	HB1	89	0	89	36.00
37.00	LE2	0	0	0	37.00
38.00	LE1	2	0	2	38.00
39.00	LD2	0	0	0	39.00
40.00	LD1	0	0	0	40.00
41.00	LC2	0	0	0	41.00
42.00	LC1	3	0	3	42.00
43.00	LB2	0	0	0	43.00
44.00	LB1	17	0	17	44.00
45.00	CE2	0	0	0	45.00
46.00	CE1	0	0	0	46.00
47.00	CD2	0	0	0	47.00
48.00	CD1	21	0	21	48.00
49.00	CC2	0	0	0	49.00
50.00	CC1	37	0	37	50.00
51.00	CB2	0	0	0	51.00
52.00	CB1	15	0	15	52.00
53.00	CA2	0	0	0	53.00
54.00	CA1	51	0	51	54.00
55.00	SE3	0	0	0	55.00
56.00	SE2	0	0	0	56.00
57.00	SE1	0	0	0	57.00
58.00	SSC	0	0	0	58.00
59.00	SSB	0	0	0	59.00
60.00	SSA	0	0	0	60.00
61.00	IB2	0	0	0	61.00
62.00	IB1	0	0	0	62.00
63.00	IA2	0	0	0	63.00
64.00	IA1	0	0	0	64.00
65.00	BB2	0	0	0	65.00
66.00	BB1	0	0	0	66.00
67.00	BA2	0	0	0	67.00
68.00	BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 140125

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

Worksheet S-7

Date/Time Prepared:  
5/30/2013 4:00 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	4	0	4	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	3	0	3	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		1,899	0	1,899	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
SNF SERVICES						
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).			41180	41180	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing			0	0.00	202.00
203.00	Recruitment			0	0.00	203.00
204.00	Retention of employees			0	0.00	204.00
205.00	Training			0	0.00	205.00
206.00	OTHER (SPECIFY)			0	0.00	206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)			6,154,857		207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet S-10 Date/Time Prepared: 5/30/2013 4:00 pm
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				1.00	
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.110860		1.00
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid		16,879,918		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		1,747,319		5.00
6.00	Medicaid charges		167,133,491		6.00
7.00	Medicaid cost (line 1 times line 6)		18,528,419		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0		8.00
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>					
9.00	Net revenue from stand-alone SCHIP		347,943		9.00
10.00	Stand-alone SCHIP charges		360,502		10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		39,965		11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00
<b>Other state or local government indigent care program (see instructions for each line)</b>					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00
<b>Uncompensated care (see instructions for each line)</b>					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	25,878,433	4,058,912	29,937,345	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	2,868,883	449,971	3,318,854	21.00
22.00	Partial payment by patients approved for charity care	6,385	109	6,494	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,862,498	449,862	3,312,360	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		7,447,181		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		1,417,252		27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		6,029,929		28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		668,478		29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		3,980,838		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,980,838		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140125

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

Worksheet A  
Date/Time Prepared:  
5/30/2013 4:00 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT		2,637,450	2,637,450	1,258,159	3,895,609 1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		3,499,288	3,499,288	1,111,439	4,610,727 2.00
4.00 00400	EMPLOYEE BENEFITS	191,337	255,177	446,514	4,569,403	5,015,917 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	4,139,311	51,177,553	55,316,864	-6,056,434	49,260,430 5.00
7.00 00700	OPERATION OF PLANT	821,192	3,059,789	3,880,981	-632	3,880,349 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	328,153	328,153	0	328,153 8.00
9.00 00900	HOUSEKEEPING	0	2,182,982	2,182,982	0	2,182,982 9.00
10.00 01000	DIETARY	0	1,637,674	1,637,674	-10,650	1,627,024 10.00
11.00 01100	CAFETERIA	0	0	0	10,650	10,650 11.00
13.00 01300	NURSING ADMINISTRATION	1,682,294	527,330	2,209,624	-133,671	2,075,953 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	274,226	45,481	319,707	192,981	512,688 14.00
15.00 01500	PHARMACY	1,469,368	2,172,145	3,641,513	-1,917,744	1,723,769 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	696,756	410,163	1,106,919	0	1,106,919 16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	7,140,658	3,328,303	10,468,961	41,290	10,510,251 30.00
31.00 03100	INTENSIVE CARE UNIT	967,985	316,859	1,284,844	0	1,284,844 31.00
40.00 04000	SUBPROVIDER - I/PF	847,298	440,439	1,287,737	0	1,287,737 40.00
41.00 04100	SUBPROVIDER - I/RF	495,699	161,121	656,820	0	656,820 41.00
43.00 04300	NURSERY	221,568	67,202	288,770	-102,408	186,362 43.00
44.00 04400	SKILLED NURSING FACILITY	661,299	238,208	899,507	0	899,507 44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	2,139,282	5,145,668	7,284,950	-2,841,409	4,443,541 50.00
51.00 05100	RECOVERY ROOM	256,506	51,454	307,960	0	307,960 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	407,284	86,782	494,066	61,118	555,184 52.00
53.00 05300	ANESTHESIOLOGY	0	2,203,308	2,203,308	0	2,203,308 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	885,635	843,537	1,729,172	688,614	2,417,786 54.00
54.01 05401	ULTRA-SOUND	88,104	37,823	125,927	-125,927	0 54.01
56.00 05600	RADIOISOTOPE	73,095	101,167	174,262	-174,262	0 56.00
57.00 05700	CT SCAN	246,998	239,895	486,893	-486,893	0 57.00
58.00 05800	MRI	102,330	9,405	111,735	-111,735	0 58.00
60.00 06000	LABORATORY	2,032,406	1,844,184	3,876,590	-1,077,642	2,798,948 60.00
65.00 06500	RESPIRATORY THERAPY	741,988	320,694	1,062,682	-90,720	971,962 65.00
66.00 06600	PHYSICAL THERAPY	881,278	123,968	1,005,246	275,845	1,281,091 66.00
67.00 06700	OCCUPATIONAL THERAPY	215,660	18,628	234,288	-234,288	0 67.00
68.00 06800	SPEECH PATHOLOGY	96,432	8,028	104,460	-104,460	0 68.00
69.00 06900	ELECTROCARDIOLOGY	1,079,597	1,022,052	2,101,649	-427,590	1,674,059 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,244,227	1,244,227 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,489,968	1,489,968 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,750,177	1,750,177 73.00
74.00 07400	RENAL DIALYSIS	0	206,478	206,478	0	206,478 74.00
76.00 03020	ACUPUNCTURE	0	0	0	0	0 76.00
76.01 03021	SLEEP LAB	193,824	47,220	241,044	-2,376	238,668 76.01
76.02 03022	PSYCH SERVICES	365,015	343,770	708,785	-335,564	373,221 76.02
76.03 03023	WOUND CARE	130,921	491,431	622,352	-173	622,179 76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	330,904	45,235	376,139	-376,139	0 88.00
90.00 09000	CLINIC	0	0	0	1,304,815	1,304,815 90.00
91.00 09100	EMERGENCY	1,891,056	1,520,765	3,411,821	-2,606	3,409,215 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0 96.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	31,767,306	87,196,809	118,964,115	-614,637	118,349,478 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	268,315	268,315	-3,427	264,888 192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.00
194.01 07951	OTHER NONREIMB - MARKETING	0	0	0	519,706	519,706 194.01
194.02 07952	OTHER NONREIMB - SENIOR CIRCLE	49,877	25,961	75,838	98,358	174,196 194.02
194.03 07953	VNA	0	0	0	0	0 194.03
194.04 07954	OTHER NONREIMB. - MARKETING	0	0	0	0	0 194.04
194.05 07958	FREE STANDING HHA	0	158	158	0	158 194.05
194.06 07955	OTHER NONREIMB - TRI-LAB	0	0	0	0	0 194.06
194.07 07956	OTHER NONREIMB - CONVENT	0	0	0	0	0 194.07
194.08 07957	OTHER NONREIMB - UNOCCUPIED SPACE	0	0	0	0	0 194.08
200.00	TOTAL (SUM OF LINES 118-199)	31,817,183	87,491,243	119,308,426	0	119,308,426 200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140125

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

Worksheet A  
Date/Time Prepared:  
5/30/2013 4:00 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	603,867	4,499,476	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-265,614	4,345,113	2.00
4.00	00400	EMPLOYEE BENEFITS	-1,707	5,014,210	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-38,855,230	10,405,200	5.00
7.00	00700	OPERATION OF PLANT	-364,347	3,516,002	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	328,153	8.00
9.00	00900	HOUSEKEEPING	0	2,182,982	9.00
10.00	01000	DIETARY	0	1,627,024	10.00
11.00	01100	CAFETERIA	0	10,650	11.00
13.00	01300	NURSING ADMINISTRATION	-50	2,075,903	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	512,688	14.00
15.00	01500	PHARMACY	-103,900	1,619,869	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,037	1,103,882	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-1,157,355	9,352,896	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,284,844	31.00
40.00	04000	SUBPROVIDER - I PF	-186,164	1,101,573	40.00
41.00	04100	SUBPROVIDER - I RF	-27,852	628,968	41.00
43.00	04300	NURSERY	0	186,362	43.00
44.00	04400	SKILLED NURSING FACILITY	0	899,507	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	4,443,541	50.00
51.00	05100	RECOVERY ROOM	0	307,960	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	555,184	52.00
53.00	05300	ANESTHESIOLOGY	-2,106,710	96,598	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,317	2,414,469	54.00
54.01	05401	ULTRA-SOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	2,798,948	60.00
65.00	06500	RESPIRATORY THERAPY	0	971,962	65.00
66.00	06600	PHYSICAL THERAPY	0	1,281,091	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,674,059	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,244,227	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,489,968	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,750,177	73.00
74.00	07400	RENAL DIALYSIS	0	206,478	74.00
76.00	03020	ACUPUNCTURE	0	0	76.00
76.01	03021	SLEEP LAB	0	238,668	76.01
76.02	03022	PSYCH SERVICES	-239,706	133,515	76.02
76.03	03023	WOUND CARE	0	622,179	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	1,304,815	90.00
91.00	09100	EMERGENCY	-551,649	2,857,566	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-43,262,771	75,086,707	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	264,888	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	0	519,706	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	0	174,196	194.02
194.03	07953	VNA	0	0	194.03
194.04	07954	OTHER NONREIMB. - MARKETING	0	0	194.04
194.05	07958	FREE STANDING HHA	0	158	194.05
194.06	07955	OTHER NONREIMB - TRI-LAB	0	0	194.06
194.07	07956	OTHER NONREIMB - CONVENT	0	0	194.07
194.08	07957	OTHER NONREIMB - UNOCCUPIED SPACE	0	0	194.08
200.00		TOTAL (SUM OF LINES 118-199)	-43,262,771	76,045,655	200.00

COST CENTERS USED IN COST REPORT		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet Non-CMS W Date/Time Prepared: 5/30/2013 4:00 pm
Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
40.00	SUBPROVIDER - IPF	04000		40.00
41.00	SUBPROVIDER - IRF	04100		41.00
43.00	NURSERY	04300		43.00
44.00	SKILLED NURSING FACILITY	04400		44.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
54.01	ULTRA-SOUND	05401		54.01
56.00	RADIOISOTOPE	05600		56.00
57.00	CT SCAN	05700		57.00
58.00	MRI	05800		58.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
74.00	RENAL DIALYSIS	07400		74.00
76.00	ACUPUNCTURE	03020		76.00
76.01	SLEEP LAB	03021		76.01
76.02	PSYCH SERVICES	03022		76.02
76.03	WOUND CARE	03023		76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	RURAL HEALTH CLINIC	08800		88.00
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00	DURABLE MEDICAL EQUIP-RENTED	09600		96.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
193.00	NONPAID WORKERS	19300		193.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	07950		194.00
194.01	OTHER NONREIMB - MARKETING	07951		194.01
194.02	OTHER NONREIMB - SENIOR CIRCLE	07952		194.02
194.03	VNA	07953		194.03
194.04	OTHER NONREIMB. - MARKETING	07954		194.04
194.05	FREE STANDING HHA	07958		194.05
194.06	OTHER NONREIMB - TRI-LAB	07955		194.06
194.07	OTHER NONREIMB - CONVENT	07956		194.07
194.08	OTHER NONREIMB - UNOCCUPIED SPACE	07957		194.08
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 140125

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

Worksheet A-6  
Date/Time Prepared:  
5/30/2013 4:00 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - RECLASS OF EMPLOYEE BENEFITS</b>					
1.00	EMPLOYEE BENEFITS	4.00	0	4,569,403	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
	TOTALS		0	4,569,403	
<b>B - RECLASS OF OXYGEN COSTS</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	57,729	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
	TOTALS		0	57,729	
<b>C - RECLASS OF RENTAL AND LEASE EXPENSES</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	26,647	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,099,664	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
	TOTALS		0	1,126,311	
<b>D - RECLASS OF OTHER CAPITAL COSTS</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	193,484	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,038,028	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	11,775	3.00
	TOTALS		0	1,243,287	
<b>E - RECLASS OF MARKETING DEPARTMENTS</b>					
1.00	OTHER NONREIMB - MARKETING	194.01	87,683	432,023	1.00
	TOTALS		87,683	432,023	
<b>F - RECLASS OF MEDICAL SUPPLIES</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,186,498	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,489,968	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	226,443	3.00
	TOTALS		0	2,902,909	
<b>G - RECLASS OF COST OF DRUGS/IV SOLUTION</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,750,177	1.00
	TOTALS		0	1,750,177	
<b>H - RECLASS OF PT, OT, AND SP COSTS</b>					
1.00	PHYSICAL THERAPY	66.00	312,092	26,656	1.00
2.00		0.00	0	0	2.00
	TOTALS		312,092	26,656	
<b>I - RECLASS OF MISC DEPARTMENTS</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	228,742	71,367	1.00
2.00	OTHER NONREIMB - SENIOR CIRCLE	194.02	70,862	27,496	2.00
	TOTALS		299,604	98,863	
<b>J - RECLASS OF OTHER RADIOLOGY COSTS</b>					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	510,527	388,290	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
	TOTALS		510,527	388,290	
<b>K - RECLASS OF A PORTION OF DIETARY COST</b>					
1.00	CAFETERIA	11.00	0	10,650	1.00
	TOTALS		0	10,650	
<b>L - RECLASS OF CLINIC COSTS</b>					
1.00	CLINIC	90.00	956,859	347,956	1.00
2.00		0.00	0	0	2.00
	TOTALS		956,859	347,956	
<b>M - OB/GYN COSTS</b>					
1.00	ADULTS & PEDIATRICS	30.00	29,494	11,796	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	42,512	18,606	2.00
	TOTALS		72,006	30,402	
500.00	Grand Total: Increases		2,238,771	12,984,656	500.00

RECLASSIFICATIONS

Provider CCN: 140125

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

Worksheet A-6  
Date/Time Prepared:  
5/30/2013 4:00 pm

Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
<b>A - RECLASS OF EMPLOYEE BENEFITS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,427,621	0		1.00
2.00	OPERATION OF PLANT	7.00	0	464	0		2.00
3.00	NURSING ADMINISTRATION	13.00	0	133,671	0		3.00
4.00	OPERATING ROOM	50.00	0	5,771	0		4.00
5.00	LABORATORY	60.00	0	1,325	0		5.00
6.00	EMERGENCY	91.00	0	551	0		6.00
	<b>TOTALS</b>		0	4,569,403			
<b>B - RECLASS OF OXYGEN COSTS</b>							
1.00	OPERATION OF PLANT	7.00	0	97	0		1.00
2.00	OPERATING ROOM	50.00	0	144	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	55,433	0		3.00
4.00	EMERGENCY	91.00	0	2,055	0		4.00
	<b>TOTALS</b>		0	57,729			
<b>C - RECLASS OF RENTAL AND LEASE EXPENSES</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	165,929	9		1.00
2.00	OPERATION OF PLANT	7.00	0	71	9		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	33,462	0		3.00
4.00	PHARMACY	15.00	0	167,567	0		4.00
5.00	OPERATING ROOM	50.00	0	354,475	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	210,203	0		6.00
7.00	LABORATORY	60.00	0	147,641	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	35,287	0		8.00
9.00	ELECTROCARDIOLOGY	69.00	0	5,700	0		9.00
10.00	SLEEP LAB	76.01	0	2,376	0		10.00
11.00	WOUND CARE	76.03	0	173	0		11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3,427	0		12.00
	<b>TOTALS</b>		0	1,126,311			
<b>D - RECLASS OF OTHER CAPITAL COSTS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,243,287	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	<b>TOTALS</b>		0	1,243,287			
<b>E - RECLASS OF MARKETING DEPARTMENTS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	87,683	432,023	0		1.00
	<b>TOTALS</b>		87,683	432,023			
<b>F - RECLASS OF MEDICAL SUPPLIES</b>							
1.00	OPERATING ROOM	50.00	0	2,481,019	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	421,890	0		2.00
3.00		0.00	0	0	0		3.00
	<b>TOTALS</b>		0	2,902,909			
<b>G - RECLASS OF COST OF DRUGS/IV SOLUTION</b>							
1.00	PHARMACY	15.00	0	1,750,177	0		1.00
	<b>TOTALS</b>		0	1,750,177			
<b>H - RECLASS OF PT, OT, AND SP COSTS</b>							
1.00	OCCUPATIONAL THERAPY	67.00	215,660	18,628	0		1.00
2.00	SPEECH PATHOLOGY	68.00	96,432	8,028	0		2.00
	<b>TOTALS</b>		312,092	26,656			
<b>I - RECLASS OF MISC DEPARTMENTS</b>							
1.00	PSYCH SERVICES	76.02	242,460	93,104	0		1.00
2.00	PHYSICAL THERAPY	66.00	57,144	5,759	0		2.00
	<b>TOTALS</b>		299,604	98,863			
<b>J - RECLASS OF OTHER RADIOLOGY COSTS</b>							
1.00	ULTRA-SOUND	54.01	88,104	37,823	0		1.00
2.00	RADIOISOTOPE	56.00	73,095	101,167	0		2.00
3.00	CT SCAN	57.00	246,998	239,895	0		3.00
4.00	MRI	58.00	102,330	9,405	0		4.00
	<b>TOTALS</b>		510,527	388,290			
<b>K - RECLASS OF A PORTION OF DIETARY COST</b>							
1.00	DIETARY	10.00	0	10,650	0		1.00
	<b>TOTALS</b>		0	10,650			
<b>L - RECLASS OF CLINIC COSTS</b>							
1.00	RURAL HEALTH CLINIC	88.00	330,904	45,235	0		1.00
2.00	LABORATORY	60.00	625,955	302,721	0		2.00
	<b>TOTALS</b>		956,859	347,956			
<b>M - OB/GYN COSTS</b>							
1.00	NURSERY	43.00	72,006	30,402	0		1.00
2.00		0.00	0	0	0		2.00
	<b>TOTALS</b>		72,006	30,402			
500.00	<b>Grand Total: Decreases</b>		2,238,771	12,984,656			500.00

RECLASSIFICATIONS

Provider CCN: 140125

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

Worksheet A-6  
Non-CMS Worksheet  
Date/Time Prepared:  
5/30/2013 4:00 pm

Increases			Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary	
2.00	3.00	4.00	6.00	7.00	8.00	
<b>A - RECLASS OF EMPLOYEE BENEFITS</b>						
1.00	EMPLOYEE BENEFITS	4.00	ADMINISTRATIVE & GENERAL	5.00	0	1.00
2.00		0.00	OPERATION OF PLANT	7.00	0	2.00
3.00		0.00	NURSING ADMINISTRATION	13.00	0	3.00
4.00		0.00	OPERATING ROOM	50.00	0	4.00
5.00		0.00	LABORATORY	60.00	0	5.00
6.00		0.00	EMERGENCY	91.00	0	6.00
	TOTALS		TOTALS		0	
<b>B - RECLASS OF OXYGEN COSTS</b>						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	OPERATION OF PLANT	7.00	0	1.00
2.00		0.00	OPERATING ROOM	50.00	0	2.00
3.00		0.00	RESPIRATORY THERAPY	65.00	0	3.00
4.00		0.00	EMERGENCY	91.00	0	4.00
	TOTALS		TOTALS		0	
<b>C - RECLASS OF RENTAL AND LEASE EXPENSES</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	ADMINISTRATIVE & GENERAL	5.00	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	OPERATION OF PLANT	7.00	0	2.00
3.00		0.00	CENTRAL SERVICES & SUPPLY	14.00	0	3.00
4.00		0.00	PHARMACY	15.00	0	4.00
5.00		0.00	OPERATING ROOM	50.00	0	5.00
6.00		0.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6.00
7.00		0.00	LABORATORY	60.00	0	7.00
8.00		0.00	RESPIRATORY THERAPY	65.00	0	8.00
9.00		0.00	ELECTROCARDIOLOGY	69.00	0	9.00
10.00		0.00	SLEEP LAB	76.01	0	10.00
11.00		0.00	WOUND CARE	76.03	0	11.00
12.00		0.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	12.00
	TOTALS		TOTALS		0	
<b>D - RECLASS OF OTHER CAPITAL COSTS</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	ADMINISTRATIVE & GENERAL	5.00	0	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00		0.00	0	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00		0.00	0	3.00
	TOTALS		TOTALS		0	
<b>E - RECLASS OF MARKETING DEPARTMENTS</b>						
1.00	OTHER NONREIMB - MARKETING	194.01	ADMINISTRATIVE & GENERAL	5.00	87,683	1.00
	TOTALS		TOTALS		87,683	
<b>F - RECLASS OF MEDICAL SUPPLIES</b>						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	OPERATING ROOM	50.00	0	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	ELECTROCARDIOLOGY	69.00	0	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00		0.00	0	3.00
	TOTALS		TOTALS		0	
<b>G - RECLASS OF COST OF DRUGS/IV SOLUTION</b>						
1.00	DRUGS CHARGED TO PATIENTS	73.00	PHARMACY	15.00	0	1.00
	TOTALS		TOTALS		0	
<b>H - RECLASS OF PT, OT, AND SP COSTS</b>						
1.00	PHYSICAL THERAPY	66.00	OCCUPATIONAL THERAPY	67.00	215,660	1.00
2.00		0.00	SPEECH PATHOLOGY	68.00	96,432	2.00
	TOTALS		TOTALS		312,092	
<b>I - RECLASS OF MISC DEPARTMENTS</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	PSYCH SERVICES	76.02	242,460	1.00
2.00	OTHER NONREIMB - SENIOR CIRCLE	194.02	PHYSICAL THERAPY	66.00	57,144	2.00
	TOTALS		TOTALS		299,604	
<b>J - RECLASS OF OTHER RADIOLOGY COSTS</b>						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	ULTRA-SOUND	54.01	88,104	1.00
2.00		0.00	RADIOISOTOPE	56.00	73,095	2.00
3.00		0.00	CT SCAN	57.00	246,998	3.00
4.00		0.00	MRI	58.00	102,330	4.00
	TOTALS		TOTALS		510,527	
<b>K - RECLASS OF A PORTION OF DIETARY COST</b>						
1.00	CAFETERIA	11.00	DIETARY	10.00	0	1.00
	TOTALS		TOTALS		0	
<b>L - RECLASS OF CLINIC COSTS</b>						
1.00	CLINIC	90.00	RURAL HEALTH CLINIC	88.00	330,904	1.00
2.00		0.00	LABORATORY	60.00	625,955	2.00
	TOTALS		TOTALS		956,859	
<b>M - OB/GYN COSTS</b>						
1.00	ADULTS & PEDIATRICS	30.00	NURSERY	43.00	72,006	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00		0.00	0	2.00
	TOTALS		TOTALS		72,006	
500.00	Grand Total: Increases		Grand Total: Decreases			500.00
		2,238,771			2,238,771	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140125

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/30/2013 4:00 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	4,314,217	631,615	0	631,615	663,230	1.00
2.00	Land Improvements	2,267,345	606,081	0	606,081	1,350	2.00
3.00	Buildings and Fixtures	2,451,207	25,330	0	25,330	5,906	3.00
4.00	Building Improvements	90,504,065	2,954,911	0	2,954,911	241,034	4.00
5.00	Fixed Equipment	6,728,276	359,749	0	359,749	13,057	5.00
6.00	Movable Equipment	44,554,157	2,702,989	0	2,702,989	1,184,762	6.00
7.00	HIT designated Assets	1,889,345	1,437,256	0	1,437,256	33,446	7.00
8.00	Subtotal (sum of lines 1-7)	152,708,612	8,717,931	0	8,717,931	2,142,785	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	152,708,612	8,717,931	0	8,717,931	2,142,785	10.00
	Ending Balance		Fully Depreciated Assets				
	6.00		7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	4,282,602	0				1.00
2.00	Land Improvements	2,872,076	0				2.00
3.00	Buildings and Fixtures	2,470,631	0				3.00
4.00	Building Improvements	93,217,942	0				4.00
5.00	Fixed Equipment	7,074,968	0				5.00
6.00	Movable Equipment	46,072,384	0				6.00
7.00	HIT designated Assets	3,293,155	0				7.00
8.00	Subtotal (sum of lines 1-7)	159,283,758	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	159,283,758	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140125

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/30/2013 4:00 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	2,637,450	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,499,288	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	6,136,738	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	2,637,450				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,499,288				2.00
3.00	Total (sum of lines 1-2)	0	6,136,738				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140125

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/30/2013 4:00 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	102,843,251	0	102,843,251	0.645661	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	56,440,507	0	56,440,507	0.354339	0	2.00
3.00	Total (sum of lines 1-2)	159,283,758	0	159,283,758	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,267,964	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	4,333,338	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	7,601,302	0	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	193,484	1,038,028	0	4,499,476	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	11,775	0	0	4,345,113	2.00
3.00	Total (sum of lines 1-2)	0	205,259	1,038,028	0	8,844,589	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140125

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

Worksheet A-8

Date/Time Prepared:  
5/30/2013 4:00 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted					
			Cost Center	Line #	Wkst.	A-7 Ref.		
			3.00	4.00	5.00			
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)			0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)	B	-491,822		CAP REL COSTS-BLDG & FIXT	1.00		9	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-33,788		ADMINISTRATIVE & GENERAL	5.00		0	7.00
8.00 Television and radio service (chapter 21)	A	-16,161		ADMINISTRATIVE & GENERAL	5.00		0	8.00
9.00 Parking lot (chapter 21)			0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-4,317,791					0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	B	-3,317		RADIOLOGY-DIAGNOSTIC	54.00		0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-12,693,405					0	12.00
13.00 Laundry and linen service			0		0.00		0	13.00
14.00 Cafeteria-employees and guests			0		0.00		0	14.00
15.00 Rental of quarters to employee and others			0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00		0	16.00
17.00 Sale of drugs to other than patients			0		0.00		0	17.00
18.00 Sale of medical records and abstracts	B	-3,037		MEDICAL RECORDS & LIBRARY	16.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00		0	19.00
20.00 Vending machines	B	-19,492		ADMINISTRATIVE & GENERAL	5.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3			RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3			PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	A	425,823		CAP REL COSTS-BLDG & FIXT	1.00		9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-499,753		CAP REL COSTS-MVBLE EQUIP	2.00		9	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant			0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3			OCCUPATIONAL THERAPY	67.00			30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3			SPEECH PATHOLOGY	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00		0	32.00
33.00 PHOTO COMMISSION	B	-2,447		ADMINISTRATIVE & GENERAL	5.00		0	33.00
33.01 ASSISTED LIVING REVENUE	B	-13,665		ADMINISTRATIVE & GENERAL	5.00		0	33.01
33.02 PENALTIES	A	-6,337		ADMINISTRATIVE & GENERAL	5.00		0	33.02
33.03 OTHER MISC REVENUE	B	-101,818		ADMINISTRATIVE & GENERAL	5.00		0	33.03

Provider CCN: 140125      Period: From 01/01/2012 To 12/31/2012      Worksheet A-8  
 Date/Time Prepared: 5/30/2013 4:00 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
33.04 HOSPITAL BAD DEBT	A	-17,211,842	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05 PATIENT PHONES WAGE COST	A	-7,360	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06 PATIENT PHONES BENEFIT COST	A	-1,707	EMPLOYEE BENEFITS	4.00	0	33.06
33.07 PATIENT PHONES DEPRECIATION EXPENSE	A	-17,570	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.07
33.08 PATIENT TELEVISION DEPRECIATION	A	-6,848	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.08
33.09 MARKETING EXPENSE	A	-314,280	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10 HAIL DAMAGE INSURANCE	B	-364,347	OPERATION OF PLANT	7.00	0	33.10
33.11 PHYSICIAN RECRUITING	A	-171,125	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12 LOBBYING EXPENSES	A	-19,813	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13 CHARITABLE CONTRIBUTIONS	A	-30,259	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14 PATIENT TRANSPORTATION	A	-10,955	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15 ILLINOIS PROVIDER TAX	A	-7,225,755	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16 SALE OF PHARMACY RECORDS	B	-103,900	PHARMACY	15.00	0	33.16
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-43,262,771				50.00

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

Provider CCN: 140125

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

Worksheet A-8-1

Date/Time Prepared: 5/30/2013 4:00 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	DIRECT ALLOC - CAP RELATED INTEREST	607,160	0
2.00	5.00	ADMINISTRATIVE & GENERAL	DIRECT ALLOC - OPERATING INTEREST	139,820	0
3.00	5.00	ADMINISTRATIVE & GENERAL	PASI OPERATING COSTS	353,929	0
3.01	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS	9,856	0
4.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS	19,743	0
4.01	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL BLDG AND FIXTURES	42,963	0
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPMENT	248,701	0
4.03	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL HOME OFFICE COSTS	2,045,356	0
4.04	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	0	8,636,881
4.05	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	4,211,835
4.06	5.00	ADMINISTRATIVE & GENERAL	401K FEES	0	3,398
4.07	5.00	ADMINISTRATIVE & GENERAL	AUDIT FEES	0	67,383
4.08	5.00	ADMINISTRATIVE & GENERAL	MIS FEES	0	681,838
4.09	5.00	ADMINISTRATIVE & GENERAL	MANAGED CARE	0	21,653
4.10	5.00	ADMINISTRATIVE & GENERAL	CASE MANAGEMENT	0	129,703
4.11	5.00	ADMINISTRATIVE & GENERAL	PURCHASE AND ANCILLARY	0	11,442
4.12	5.00	ADMINISTRATIVE & GENERAL	EMERGENCY ROOM	0	62,358
4.13	5.00	ADMINISTRATIVE & GENERAL	PPSI FEES	0	16,600
4.14	5.00	ADMINISTRATIVE & GENERAL	COMPLIANCE/HIM/CCA FEES	0	37,076
4.15	5.00	ADMINISTRATIVE & GENERAL	SENIOR CIRCLE	0	26,510
4.16	5.00	ADMINISTRATIVE & GENERAL	PASI COLLECTION FEES	0	488,832
4.17	5.00	ADMINISTRATIVE & GENERAL	EBOS FEES	0	50,092
4.18	5.00	ADMINISTRATIVE & GENERAL	PASI LIEN UNIT COLLECTION FEES	0	82,170
4.19	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	0	1,633,162
5.00	0			3,467,528	16,160,933

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

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
<b>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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

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

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

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



PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140125

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

Worksheet A-8-2

Date/Time Prepared:  
5/30/2013 4:00 pm

Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00 ADMINISTRATIVE & GENERAL	50,350	0	50,350	177,200	24	1.00
2.00	13.00 NURSING ADMINISTRATION	50	50	0	0	0	2.00
3.00	30.00 ADULTS & PEDIATRICS	1,161,870	1,153,912	7,958	177,200	53	3.00
4.00	40.00 SUBPROVIDER - IPF	190,679	182,721	7,958	177,200	53	4.00
5.00	41.00 SUBPROVIDER - IRF	27,852	27,852	0	0	0	5.00
6.00	53.00 ANESTHESIOLOGY	2,106,710	2,106,710	0	0	0	6.00
7.00	76.02 PSYCH SERVICES	239,706	239,706	0	0	0	7.00
8.00	91.00 EMERGENCY	551,649	551,649	0	0	0	8.00
9.00	0.00	0	0	0	0	0	9.00
10.00	0.00	0	0	0	0	0	10.00
200.00		4,328,866	4,262,600	66,266		130	200.00

Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00 ADMINISTRATIVE & GENERAL	2,045	102	0	0	0	1.00
2.00	13.00 NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	30.00 ADULTS & PEDIATRICS	4,515	226	0	0	0	3.00
4.00	40.00 SUBPROVIDER - IPF	4,515	226	0	0	0	4.00
5.00	41.00 SUBPROVIDER - IRF	0	0	0	0	0	5.00
6.00	53.00 ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	76.02 PSYCH SERVICES	0	0	0	0	0	7.00
8.00	91.00 EMERGENCY	0	0	0	0	0	8.00
9.00	0.00	0	0	0	0	0	9.00
10.00	0.00	0	0	0	0	0	10.00
200.00		11,075	554	0	0	0	200.00

Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00 ADMINISTRATIVE & GENERAL	0	2,045	48,305	48,305	1.00
2.00	13.00 NURSING ADMINISTRATION	0	0	0	50	2.00
3.00	30.00 ADULTS & PEDIATRICS	0	4,515	3,443	1,157,355	3.00
4.00	40.00 SUBPROVIDER - IPF	0	4,515	3,443	186,164	4.00
5.00	41.00 SUBPROVIDER - IRF	0	0	0	27,852	5.00
6.00	53.00 ANESTHESIOLOGY	0	0	0	2,106,710	6.00
7.00	76.02 PSYCH SERVICES	0	0	0	239,706	7.00
8.00	91.00 EMERGENCY	0	0	0	551,649	8.00
9.00	0.00	0	0	0	0	9.00
10.00	0.00	0	0	0	0	10.00
200.00		0	11,075	55,191	4,317,791	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140125

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2013 4:00 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	4,499,476	4,499,476			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	4,345,113		4,345,113		2.00
4.00 00400	EMPLOYEE BENEFITS	5,014,210	19,055	18,401	5,051,666	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	10,405,200	564,362	545,000	683,712	5.00
7.00 00700	OPERATION OF PLANT	3,516,002	1,296,652	1,252,168	131,171	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	328,153	31,447	30,368	0	8.00
9.00 00900	HOUSEKEEPING	2,182,982	46,958	45,347	0	9.00
10.00 01000	DIETARY	1,627,024	69,715	67,324	0	10.00
11.00 01100	CAFETERIA	10,650	51,619	49,849	0	11.00
13.00 01300	NURSING ADMINISTRATION	2,075,903	1,893	1,828	268,716	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	512,688	57,190	55,228	43,803	14.00
15.00 01500	PHARMACY	1,619,869	40,779	39,380	234,705	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,103,882	162,989	157,397	111,294	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	9,352,896	593,457	573,098	1,145,308	30.00
31.00 03100	INTENSIVE CARE UNIT	1,284,844	180,301	174,116	154,618	31.00
40.00 04000	SUBPROVIDER - I/PF	1,101,573	93,766	90,549	135,341	40.00
41.00 04100	SUBPROVIDER - I/RF	628,968	58,666	56,653	79,179	41.00
43.00 04300	NURSERY	186,362	7,439	7,183	23,890	43.00
44.00 04400	SKILLED NURSING FACILITY	899,507	58,674	56,661	105,631	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	4,443,541	298,926	288,671	341,712	50.00
51.00 05100	RECOVERY ROOM	307,960	12,901	12,458	40,972	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	555,184	51,336	49,575	71,847	52.00
53.00 05300	ANESTHESIOLOGY	96,598	4,103	3,962	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,414,469	146,644	141,613	223,012	54.00
54.01 05401	ULTRA-SOUND	0	0	0	0	54.01
56.00 05600	RADIO SOTOP	0	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MRI	0	0	0	0	58.00
60.00 06000	LABORATORY	2,798,948	62,727	60,575	224,655	60.00
65.00 06500	RESPIRATORY THERAPY	971,962	59,533	57,491	118,519	65.00
66.00 06600	PHYSICAL THERAPY	1,281,091	140,448	135,630	181,492	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	1,674,059	41,045	39,637	172,446	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,244,227	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	1,489,968	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,750,177	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	206,478	0	0	0	74.00
76.00 03020	ACUPUNCTURE	0	0	0	0	76.00
76.01 03021	SLEEP LAB	238,668	55,989	54,068	30,960	76.01
76.02 03022	PSYCH SERVICES	133,515	28,937	27,944	19,576	76.02
76.03 03023	WOUND CARE	622,179	22,741	21,961	20,912	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00 09000	CLINIC	1,304,815	0	0	152,841	90.00
91.00 09100	EMERGENCY	2,857,566	84,034	81,151	302,062	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	75,086,707	4,344,326	4,195,286	5,018,374	74,748,438
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,704	5,508	0	11,212
192.00 19200	PHYSICIANS' PRIVATE OFFICES	264,888	133,835	129,244	0	527,967
193.00 19300	NONPAID WORKERS	0	0	0	0	0
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	15,611	15,075	0	30,686
194.01 07951	OTHER NONREIMB - MARKETING	519,706	0	0	14,006	533,712
194.02 07952	OTHER NONREIMB - SENIOR CIRCLE	174,196	0	0	19,286	193,482
194.03 07953	VNA	0	0	0	0	0
194.04 07954	OTHER NONREIMB. - MARKETING	0	0	0	0	0
194.05 07958	FREE STANDING HHA	158	0	0	0	158
194.06 07955	OTHER NONREIMB - TRI-LAB	0	0	0	0	0
194.07 07956	OTHER NONREIMB - CONVENT	0	0	0	0	0
194.08 07957	OTHER NONREIMB - UNOCCUPIED SPACE	0	0	0	0	0
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140125

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2013 4:00 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal			
		BLDG & FIXT	MVBLE EQUIP					
202.00	TOTAL (sum lines 118-201)	76,045,655	4,499,476	4,345,113	5,051,666	76,045,655	202.00	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATI ON 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	ADMI NI STRATI VE & GENERAL	12,198,274				5.00	
7.00	00700	OPERATI ON OF PLANT	1,183,769	7,379,762			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	74,505	88,597	553,070		8.00	
9.00	00900	HOUSEKEEPING	434,703	132,296	0	2,842,286	9.00	
10.00	01000	DIETARY	337,031	196,412	0	77,982	2,375,488	10.00
11.00	01100	CAFETERIA	21,421	145,430	0	57,740	0	11.00
13.00	01300	NURSI NG ADMI NI STRATI ON	448,660	5,333	0	2,117	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	127,798	161,124	2,345	63,971	0	14.00
15.00	01500	PHARMACY	369,638	114,887	0	45,614	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	293,375	459,196	0	182,314	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	2,228,576	1,671,965	294,037	663,822	1,741,487	30.00
31.00	03100	INTENSIVE CARE UNIT	342,728	507,970	29,793	201,679	56,831	31.00
40.00	04000	SUBPROVIDER - IPF	271,531	264,170	22,841	104,883	238,787	40.00
41.00	04100	SUBPROVIDER - IRF	157,326	165,282	0	65,622	74,189	41.00
43.00	04300	NURSERY	42,963	20,957	0	8,321	0	43.00
44.00	04400	SKILLED NURSING FACILITY	214,071	165,306	39,443	65,631	171,448	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,026,504	842,176	58,768	334,369	2,703	50.00
51.00	05100	RECOVERY ROOM	71,510	36,346	0	14,430	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	139,076	144,631	28,645	57,423	43,314	52.00
53.00	05300	ANESTHESIOLOGY	19,996	11,559	0	4,589	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	558,974	413,147	27,122	164,032	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	601,229	176,724	0	70,165	0	60.00
65.00	06500	RESPIRATORY THERAPY	230,699	167,726	0	66,592	0	65.00
66.00	06600	PHYSICAL THERAPY	332,178	395,691	2,137	157,101	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	368,197	115,639	3,937	45,912	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	237,715	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	284,664	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	334,378	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	39,448	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03021	SLEEP LAB	72,540	157,741	0	62,628	0	76.01
76.02	03022	PSYCH SERVICES	40,116	81,525	0	32,368	0	76.02
76.03	03023	WOUND CARE	131,406	64,069	0	25,437	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	278,491	0	253	0	0	90.00
91.00	09100	EMERGENCY	635,219	236,752	43,749	93,998	46,729	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,950,435	6,942,651	553,070	2,668,740	2,375,488	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,142	16,070	0	6,380	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	100,870	377,060	0	149,704	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	5,863	43,981	0	17,462	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	101,968	0	0	0	0	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	36,966	0	0	0	0	194.02
194.03	07953	VNA	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMB. - MARKETING	0	0	0	0	0	194.04
194.05	07958	FREE STANDING HHA	30	0	0	0	0	194.05
194.06	07955	OTHER NONREIMB - TRI-LAB	0	0	0	0	0	194.06

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140125

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2013 4:00 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
194.07	07956 OTHER NONREIMB - CONVENT	0	0	0	0	0	194.07
194.08	07957 OTHER NONREIMB - UNOCCUPIED SPACE	0	0	0	0	0	194.08
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	12,198,274	7,379,762	553,070	2,842,286	2,375,488	202.00
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<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
11.00	01100 CAFETERIA	336,709					11.00
13.00	01300 NURSING ADMINISTRATION	16,191	2,820,641				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	6,119	0	1,030,266			14.00
15.00	01500 PHARMACY	13,997	251,216	18,170	2,748,255		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	14,066	0	3,984	0	2,488,497	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	94,088	1,233,135	56,291	0	479,490	30.00
31.00	03100 INTENSIVE CARE UNIT	9,477	165,495	14,389	0	42,695	31.00
40.00	04000 SUBPROVIDER - IPF	10,453	144,862	2,363	0	57,479	40.00
41.00	04100 SUBPROVIDER - IRF	6,625	84,749	3,398	0	13,121	41.00
43.00	04300 NURSERY	1,474	32,839	4,486	0	4,436	43.00
44.00	04400 SKILLED NURSING FACILITY	9,366	113,062	9,453	0	22,982	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	23,723	365,751	225,702	0	267,935	50.00
51.00	05100 RECOVERY ROOM	2,748	43,855	3,255	0	36,960	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4,423	62,365	3,684	0	13,341	52.00
53.00	05300 ANESTHESIOLOGY	0	0	10,461	0	46,486	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	18,365	0	16,557	0	180,439	54.00
54.01	05401 ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
60.00	06000 LABORATORY	23,301	0	72,622	0	327,879	60.00
65.00	06500 RESPIRATORY THERAPY	12,031	0	20,447	0	89,382	65.00
66.00	06600 PHYSICAL THERAPY	13,803	0	2,491	0	73,981	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	11,976	0	75,684	0	219,051	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	185,064	0	32,770	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	232,400	0	55,434	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	2,748,255	129,927	73.00
74.00	07400 RENAL DIALYSIS	0	0	367	0	11,353	74.00
76.00	03020 ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03021 SLEEP LAB	2,700	0	1,498	0	5,319	76.01
76.02	03022 PSYCH SERVICES	1,945	0	68	0	15,438	76.02
76.03	03023 WOUND CARE	1,779	0	8,017	0	6,215	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000 CLINIC	12,315	0	13,570	0	7,292	90.00
91.00	09100 EMERGENCY	22,041	323,312	44,739	0	349,092	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	333,006	2,820,641	1,029,160	2,748,255	2,488,497	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	5	0	0	192.00
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951 OTHER NONREIMB - MARKETING	983	0	0	0	0	194.01
194.02	07952 OTHER NONREIMB - SENIOR CIRCLE	2,720	0	1,101	0	0	194.02
194.03	07953 VNA	0	0	0	0	0	194.03
194.04	07954 OTHER NONREIMB. - MARKETING	0	0	0	0	0	194.04
194.05	07958 FREE STANDING HHA	0	0	0	0	0	194.05
194.06	07955 OTHER NONREIMB - TRI-LAB	0	0	0	0	0	194.06

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140125

Period:  
From 01/01/2012  
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
194.07	07956	OTHER NONREIMB - CONVENT	0	0	0	0	0	194.07
194.08	07957	OTHER NONREIMB - UNOCCUPIED SPACE	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	336,709	2,820,641	1,030,266	2,748,255	2,488,497	202.00
Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total			
			24.00	25.00	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
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	20,127,650	0	20,127,650			30.00
31.00	03100	INTENSIVE CARE UNIT	3,164,936	0	3,164,936			31.00
40.00	04000	SUBPROVIDER - I/PF	2,538,598	0	2,538,598			40.00
41.00	04100	SUBPROVIDER - I/RF	1,393,778	0	1,393,778			41.00
43.00	04300	NURSERY	340,350	0	340,350			43.00
44.00	04400	SKILLED NURSING FACILITY	1,931,235	0	1,931,235			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	8,520,481	0	8,520,481			50.00
51.00	05100	RECOVERY ROOM	583,395	0	583,395			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,224,844	0	1,224,844			52.00
53.00	05300	ANESTHESIOLOGY	197,754	0	197,754			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,304,374	0	4,304,374			54.00
54.01	05401	ULTRA-SOUND	0	0	0			54.01
56.00	05600	RADIOISOTOPE	0	0	0			56.00
57.00	05700	CT SCAN	0	0	0			57.00
58.00	05800	MRI	0	0	0			58.00
60.00	06000	LABORATORY	4,418,825	0	4,418,825			60.00
65.00	06500	RESPIRATORY THERAPY	1,794,382	0	1,794,382			65.00
66.00	06600	PHYSICAL THERAPY	2,716,043	0	2,716,043			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0			68.00
69.00	06900	ELECTROCARDIOLOGY	2,767,583	0	2,767,583			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,699,776	0	1,699,776			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,062,466	0	2,062,466			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,962,737	0	4,962,737			73.00
74.00	07400	RENAL DIALYSIS	257,646	0	257,646			74.00
76.00	03020	ACUPUNCTURE	0	0	0			76.00
76.01	03021	SLEEP LAB	682,111	0	682,111			76.01
76.02	03022	PSYCH SERVICES	381,432	0	381,432			76.02
76.03	03023	WOUND CARE	924,716	0	924,716			76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
90.00	09000	CLINIC	1,769,577	0	1,769,577			90.00
91.00	09100	EMERGENCY	5,120,444	0	5,120,444			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0			96.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	73,885,133	0	73,885,133			118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	35,804	0	35,804			190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,155,606	0	1,155,606			192.00
193.00	19300	NONPAID WORKERS	0	0	0			193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	97,992	0	97,992			194.00
194.01	07951	OTHER NONREIMB - MARKETING	636,663	0	636,663			194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	234,269	0	234,269			194.02
194.03	07953	VNA	0	0	0			194.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140125

Period:  
From 01/01/2012  
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
194.04	07954 OTHER NONREIMB. - MARKETING	0	0	0	194.04
194.05	07958 FREE STANDING HHA	188	0	188	194.05
194.06	07955 OTHER NONREIMB - TRI-LAB	0	0	0	194.06
194.07	07956 OTHER NONREIMB - CONVENT	0	0	0	194.07
194.08	07957 OTHER NONREIMB - UNOCCUPIED SPACE	0	0	0	194.08
200.00	Cross Foot Adjustments	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	76,045,655	0	76,045,655	202.00

COST ALLOCATION STATISTICS

Provider CCN: 140125

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

Worksheet Non-CMS W  
Date/Time Prepared:  
5/30/2013 4:00 pm

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	3	POUNDS	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	4	MEALS SERVED	10.00
11.00	CAFETERIA	5	FTE'S	11.00
13.00	NURSING ADMINISTRATION	6	NURSING SALARIE	13.00
14.00	CENTRAL SERVICES & SUPPLY	7	COSTED REQS	14.00
15.00	PHARMACY	8	COSTED REQS	15.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS CHARGES	16.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140125

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/30/2013 4:00 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<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	19,055	18,401	37,456	37,456 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	564,362	545,000	1,109,362	5,068 5.00
7.00 00700	OPERATION OF PLANT	0	1,296,652	1,252,168	2,548,820	972 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	31,447	30,368	61,815	0 8.00
9.00 00900	HOUSEKEEPING	0	46,958	45,347	92,305	0 9.00
10.00 01000	DIETARY	0	69,715	67,324	137,039	0 10.00
11.00 01100	CAFETERIA	0	51,619	49,849	101,468	0 11.00
13.00 01300	NURSING ADMINISTRATION	0	1,893	1,828	3,721	1,992 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	57,190	55,228	112,418	325 14.00
15.00 01500	PHARMACY	0	40,779	39,380	80,159	1,740 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	162,989	157,397	320,386	825 16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	593,457	573,098	1,166,555	8,500 30.00
31.00 03100	INTENSIVE CARE UNIT	0	180,301	174,116	354,417	1,146 31.00
40.00 04000	SUBPROVIDER - I/P	0	93,766	90,549	184,315	1,003 40.00
41.00 04100	SUBPROVIDER - I/R	0	58,666	56,653	115,319	587 41.00
43.00 04300	NURSERY	0	7,439	7,183	14,622	177 43.00
44.00 04400	SKILLED NURSING FACILITY	0	58,674	56,661	115,335	783 44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	298,926	288,671	587,597	2,533 50.00
51.00 05100	RECOVERY ROOM	0	12,901	12,458	25,359	304 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	51,336	49,575	100,911	533 52.00
53.00 05300	ANESTHESIOLOGY	0	4,103	3,962	8,065	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	146,644	141,613	288,257	1,653 54.00
54.01 05401	ULTRA-SOUND	0	0	0	0	0 54.01
56.00 05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MRI	0	0	0	0	0 58.00
60.00 06000	LABORATORY	0	62,727	60,575	123,302	1,665 60.00
65.00 06500	RESPIRATORY THERAPY	0	59,533	57,491	117,024	879 65.00
66.00 06600	PHYSICAL THERAPY	0	140,448	135,630	276,078	1,345 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	41,045	39,637	80,682	1,278 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0 74.00
76.00 03020	ACUPUNCTURE	0	0	0	0	0 76.00
76.01 03021	SLEEP LAB	0	55,989	54,068	110,057	229 76.01
76.02 03022	PSYCH SERVICES	0	28,937	27,944	56,881	145 76.02
76.03 03023	WOUND CARE	0	22,741	21,961	44,702	155 76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
90.00 09000	CLINIC	0	0	0	0	1,133 90.00
91.00 09100	EMERGENCY	0	84,034	81,151	165,185	2,239 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0 96.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	4,344,326	4,195,286	8,539,612	37,209 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,704	5,508	11,212	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	133,835	129,244	263,079	0 192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	15,611	15,075	30,686	0 194.00
194.01 07951	OTHER NONREIMB - MARKETING	0	0	0	0	104 194.01
194.02 07952	OTHER NONREIMB - SENIOR CIRCLE	0	0	0	0	143 194.02
194.03 07953	VNA	0	0	0	0	0 194.03
194.04 07954	OTHER NONREIMB. - MARKETING	0	0	0	0	0 194.04
194.05 07958	FREE STANDING HHA	0	0	0	0	0 194.05
194.06 07955	OTHER NONREIMB - TRI-LAB	0	0	0	0	0 194.06
194.07 07956	OTHER NONREIMB - CONVENT	0	0	0	0	0 194.07
194.08 07957	OTHER NONREIMB - UNOCCUPIED SPACE	0	0	0	0	0 194.08
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	4,499,476	4,345,113	8,844,589	37,456 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140125

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	1,114,430				5.00	
7.00	00700	OPERATION OF PLANT	108,151	2,657,943			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	6,807	31,910	100,532		8.00	
9.00	00900	HOUSEKEEPING	39,715	47,649	0	179,669	9.00	
10.00	01000	DIETARY	30,792	70,741	0	4,929	10.00	
11.00	01100	CAFETERIA	1,957	52,379	0	3,650	11.00	
13.00	01300	NURSING ADMINISTRATION	40,990	1,921	0	134	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	11,676	58,031	426	4,044	14.00	
15.00	01500	PHARMACY	33,771	41,378	0	2,883	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	26,803	165,387	0	11,525	16.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	203,583	602,188	53,447	41,963	178,513	30.00
31.00	03100	INTENSIVE CARE UNIT	31,312	182,954	5,416	12,749	5,825	31.00
40.00	04000	SUBPROVIDER - I PF	24,808	95,145	4,152	6,630	24,477	40.00
41.00	04100	SUBPROVIDER - I RF	14,374	59,529	0	4,148	7,605	41.00
43.00	04300	NURSERY	3,925	7,548	0	526	0	43.00
44.00	04400	SKILLED NURSING FACILITY	19,558	59,538	7,170	4,149	17,574	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	93,783	303,323	10,682	21,136	277	50.00
51.00	05100	RECOVERY ROOM	6,533	13,090	0	912	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,706	52,091	5,207	3,630	4,440	52.00
53.00	05300	ANESTHESIOLOGY	1,827	4,163	0	290	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	51,069	148,802	4,930	10,369	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	54,929	63,650	0	4,435	0	60.00
65.00	06500	RESPIRATORY THERAPY	21,077	60,409	0	4,209	0	65.00
66.00	06600	PHYSICAL THERAPY	30,348	142,514	388	9,931	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	33,639	41,649	716	2,902	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,718	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26,007	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,549	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	3,604	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03021	SLEEP LAB	6,627	56,813	0	3,959	0	76.01
76.02	03022	PSYCH SERVICES	3,665	29,363	0	2,046	0	76.02
76.03	03023	WOUND CARE	12,005	23,075	0	1,608	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	25,443	0	46	0	0	90.00
91.00	09100	EMERGENCY	58,035	85,270	7,952	5,942	4,790	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,091,786	2,500,510	100,532	168,699	243,501	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	196	5,788	0	403	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,216	135,804	0	9,463	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	536	15,841	0	1,104	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	9,316	0	0	0	0	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	3,377	0	0	0	0	194.02
194.03	07953	VNA	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMB. - MARKETING	0	0	0	0	0	194.04
194.05	07958	FREE STANDING HHA	3	0	0	0	0	194.05
194.06	07955	OTHER NONREIMB - TRI-LAB	0	0	0	0	0	194.06
194.07	07956	OTHER NONREIMB - CONVENT	0	0	0	0	0	194.07
194.08	07957	OTHER NONREIMB - UNOCCUPIED SPACE	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,114,430	2,657,943	100,532	179,669	243,501	202.00



ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet B Part II Date/Time Prepared: 5/30/2013 4:00 pm
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	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
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	2,436,784	0	2,436,784	30.00
31.00	03100	INTENSIVE CARE UNIT	613,405	0	613,405	31.00
40.00	04000	SUBPROVIDER - IPF	361,112	0	361,112	40.00
41.00	04100	SUBPROVIDER - IRF	209,828	0	209,828	41.00
43.00	04300	NURSERY	29,929	0	29,929	43.00
44.00	04400	SKILLED NURSING FACILITY	237,464	0	237,464	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	1,136,798	0	1,136,798	50.00
51.00	05100	RECOVERY ROOM	56,885	0	56,885	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	186,395	0	186,395	52.00
53.00	05300	ANESTHESIOLOGY	26,219	0	26,219	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	555,437	0	555,437	54.00
54.01	05401	ULTRA-SOUND	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
60.00	06000	LABORATORY	342,554	0	342,554	60.00
65.00	06500	RESPIRATORY THERAPY	232,188	0	232,188	65.00
66.00	06600	PHYSICAL THERAPY	483,430	0	483,430	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	227,354	0	227,354	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	62,826	0	62,826	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	80,686	0	80,686	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	233,283	0	233,283	73.00
74.00	07400	RENAL DIALYSIS	6,101	0	6,101	74.00
76.00	03020	ACUPUNCTURE	0	0	0	76.00
76.01	03021	SLEEP LAB	180,377	0	180,377	76.01
76.02	03022	PSYCH SERVICES	96,337	0	96,337	76.02
76.03	03023	WOUND CARE	85,194	0	85,194	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
90.00	09000	CLINIC	36,514	0	36,514	90.00
91.00	09100	EMERGENCY	429,260	0	429,260	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,346,360	0	8,346,360	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,599	0	17,599	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	417,563	0	417,563	192.00
193.00	19300	NONPAID WORKERS	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	48,167	0	48,167	194.00
194.01	07951	OTHER NONREIMB - MARKETING	9,886	0	9,886	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	5,011	0	5,011	194.02
194.03	07953	VNA	0	0	0	194.03
194.04	07954	OTHER NONREIMB. - MARKETING	0	0	0	194.04
194.05	07958	FREE STANDING HHA	3	0	3	194.05
194.06	07955	OTHER NONREIMB - TRI-LAB	0	0	0	194.06
194.07	07956	OTHER NONREIMB - CONVENT	0	0	0	194.07
194.08	07957	OTHER NONREIMB - UNOCCUPIED SPACE	0	0	0	194.08
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	8,844,589	0	8,844,589	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140125

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

Worksheet B-1  
Date/Time Prepared:  
5/30/2013 4:00 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	539,559				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		539,559			2.00
4.00 00400	EMPLOYEE BENEFITS	2,285	2,285	31,625,846		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	67,676	67,676	4,280,370	-12,198,274	5.00
7.00 00700	OPERATION OF PLANT	155,489	155,489	821,192	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	3,771	3,771	0	0	8.00
9.00 00900	HOUSEKEEPING	5,631	5,631	0	0	9.00
10.00 01000	DIETARY	8,360	8,360	0	0	10.00
11.00 01100	CAFETERIA	6,190	6,190	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	227	227	1,682,294	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	6,858	6,858	274,226	0	14.00
15.00 01500	PHARMACY	4,890	4,890	1,469,368	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	19,545	19,545	696,756	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	71,165	71,165	7,170,152	0	30.00
31.00 03100	INTENSIVE CARE UNIT	21,621	21,621	967,985	0	31.00
40.00 04000	SUBPROVIDER - I/PF	11,244	11,244	847,298	0	40.00
41.00 04100	SUBPROVIDER - I/RF	7,035	7,035	495,699	0	41.00
43.00 04300	NURSERY	892	892	149,562	0	43.00
44.00 04400	SKILLED NURSING FACILITY	7,036	7,036	661,299	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	35,846	35,846	2,139,282	0	50.00
51.00 05100	RECOVERY ROOM	1,547	1,547	256,506	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	6,156	6,156	449,796	0	52.00
53.00 05300	ANESTHESIOLOGY	492	492	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	17,585	17,585	1,396,162	0	54.00
54.01 05401	ULTRA-SOUND	0	0	0	0	54.01
56.00 05600	RADIOISOTOPE	0	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MRI	0	0	0	0	58.00
60.00 06000	LABORATORY	7,522	7,522	1,406,451	0	60.00
65.00 06500	RESPIRATORY THERAPY	7,139	7,139	741,988	0	65.00
66.00 06600	PHYSICAL THERAPY	16,842	16,842	1,136,226	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	4,922	4,922	1,079,597	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00 03020	ACUPUNCTURE	0	0	0	0	76.00
76.01 03021	SLEEP LAB	6,714	6,714	193,824	0	76.01
76.02 03022	PSYCH SERVICES	3,470	3,470	122,555	0	76.02
76.03 03023	WOUND CARE	2,727	2,727	130,921	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00 09000	CLINIC	0	0	956,859	0	90.00
91.00 09100	EMERGENCY	10,077	10,077	1,891,056	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	520,954	520,954	31,417,424	-12,198,274	62,550,164
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	684	684	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	16,049	16,049	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	1,872	1,872	0	0	194.00
194.01 07951	OTHER NONREIMB - MARKETING	0	0	87,683	0	194.01
194.02 07952	OTHER NONREIMB - SENIOR CIRCLE	0	0	120,739	0	194.02
194.03 07953	VNA	0	0	0	0	194.03
194.04 07954	OTHER NONREIMB. - MARKETING	0	0	0	0	194.04
194.05 07958	FREE STANDING HHA	0	0	0	0	194.05
194.06 07955	OTHER NONREIMB - TRI-LAB	0	0	0	0	194.06
194.07 07956	OTHER NONREIMB - CONVENT	0	0	0	0	194.07
194.08 07957	OTHER NONREIMB - UNOCCUPIED SPACE	0	0	0	0	194.08
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140125

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

Worksheet B-1

Date/Time Prepared:  
5/30/2013 4:00 pm

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
		1.00	2.00	4.00				
202.00	Cost to be allocated (per Wkst. B, Part I)	4,499,476	4,345,113	5,051,666	5A	12,198,274	202.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	8.339173	8.053082	0.159732		0.191054	203.00	
204.00	Cost to be allocated (per Wkst. B, Part II)			37,456		1,114,430	204.00	
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001184		0.017455	205.00	



COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140125

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

Worksheet B-1

Date/Time Prepared:  
5/30/2013 4:00 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	2,657,943	100,532	179,669	243,501	159,454	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	8.461849	0.270480	0.589645	2.083502	3.278181	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140125

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

Worksheet B-1

Date/Time Prepared:  
5/30/2013 4:00 pm

Cost Center Description		NURSING ADMINISTRATION  (NURSING SALARY)	CENTRAL SERVICES & SUPPLY (COSTED REQS)	PHARMACY (COSTED REQS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		13.00	14.00	15.00	16.00	
<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
11.00	01100					11.00
13.00	01300	16,498,003				13.00
14.00	01400	0	6,605,317			14.00
15.00	01500	1,469,368	116,491	1,750,177		15.00
16.00	01600	0	25,544	0	666,472,762	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	7,212,664	360,898	0	128,441,948	30.00
31.00	03100	967,985	92,255	0	11,434,238	31.00
40.00	04000	847,298	15,152	0	15,393,388	40.00
41.00	04100	495,699	21,786	0	3,513,861	41.00
43.00	04300	192,074	28,761	0	1,188,002	43.00
44.00	04400	661,299	60,604	0	6,154,857	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	2,139,282	1,447,042	0	71,755,605	50.00
51.00	05100	256,506	20,869	0	9,898,242	51.00
52.00	05200	364,772	23,619	0	3,572,835	52.00
53.00	05300	0	67,071	0	12,449,415	53.00
54.00	05400	0	106,149	0	48,323,231	54.00
54.01	05401	0	0	0	0	54.01
56.00	05600	0	0	0	0	56.00
57.00	05700	0	0	0	0	57.00
58.00	05800	0	0	0	0	58.00
60.00	06000	0	465,600	0	87,809,018	60.00
65.00	06500	0	131,090	0	23,937,246	65.00
66.00	06600	0	15,969	0	19,812,696	66.00
67.00	06700	0	0	0	0	67.00
68.00	06800	0	0	0	0	68.00
69.00	06900	0	485,229	0	58,663,961	69.00
71.00	07100	0	1,186,498	0	8,776,160	71.00
72.00	07200	0	1,489,968	0	14,845,634	72.00
73.00	07300	0	0	1,750,177	34,795,642	73.00
74.00	07400	0	2,354	0	3,040,466	74.00
76.00	03020	0	0	0	0	76.00
76.01	03021	0	9,603	0	1,424,500	76.01
76.02	03022	0	436	0	4,134,475	76.02
76.03	03023	0	51,400	0	1,664,360	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	0	0	0	0	88.00
90.00	09000	0	87,000	0	1,952,832	90.00
91.00	09100	1,891,056	286,834	0	93,490,150	91.00
92.00	09200					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00	09600	0	0	0	0	96.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		16,498,003	6,598,222	1,750,177	666,472,762	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	0	0	0	0	190.00
192.00	19200	0	35	0	0	192.00
193.00	19300	0	0	0	0	193.00
194.00	07950	0	0	0	0	194.00
194.01	07951	0	0	0	0	194.01
194.02	07952	0	7,060	0	0	194.02
194.03	07953	0	0	0	0	194.03
194.04	07954	0	0	0	0	194.04
194.05	07958	0	0	0	0	194.05
194.06	07955	0	0	0	0	194.06
194.07	07956	0	0	0	0	194.07
194.08	07957	0	0	0	0	194.08
200.00						200.00
201.00						201.00
202.00		2,820,641	1,030,266	2,748,255	2,488,497	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140125

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

Worksheet B-1

Date/Time Prepared:  
5/30/2013 4:00 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY (COSTED REQS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
		(NURSING SALARIES)	(COSTED REQS)				
		13.00	14.00	15.00	16.00		
203.00	Unit cost multiplier (Wkst. B, Part I)	0.170969	0.155975	1.570273	0.003734		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	56,426	189,818	174,932	532,321		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.003420	0.028737	0.099951	0.000799		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140125

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/30/2013 4:00 pm

			Title XVIII		Hospital		PPS		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			
			Total Costs	RCE Diallowance	Total Costs	Inpatient			
			1.00	2.00	3.00	4.00	5.00	6.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00	03000	ADULTS & PEDIATRICS	20,127,650		20,127,650	3,443	20,131,093	126,190,259	30.00
31.00	03100	INTENSIVE CARE UNIT	3,164,936		3,164,936	0	3,164,936	11,434,238	31.00
40.00	04000	SUBPROVIDER - I/PF	2,538,598		2,538,598	3,443	2,542,041	15,393,388	40.00
41.00	04100	SUBPROVIDER - I/RF	1,393,778		1,393,778	0	1,393,778	3,513,861	41.00
43.00	04300	NURSERY	340,350		340,350	0	340,350	1,188,002	43.00
44.00	04400	SKILLED NURSING FACILITY	1,931,235		1,931,235	0	1,931,235	6,154,857	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	8,520,481		8,520,481	0	8,520,481	27,519,010	50.00
51.00	05100	RECOVERY ROOM	583,395		583,395	0	583,395	3,823,261	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,224,844		1,224,844	0	1,224,844	3,316,022	52.00
53.00	05300	ANESTHESIOLOGY	197,754		197,754	0	197,754	6,053,777	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,304,374		4,304,374	0	4,304,374	12,624,353	54.00
54.01	05401	ULTRA-SOUND	0		0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	0	57.00
58.00	05800	MRI	0		0	0	0	0	58.00
60.00	06000	LABORATORY	4,418,825		4,418,825	0	4,418,825	49,801,681	60.00
65.00	06500	RESPIRATORY THERAPY	1,794,382	0	1,794,382	0	1,794,382	21,415,348	65.00
66.00	06600	PHYSICAL THERAPY	2,716,043	0	2,716,043	0	2,716,043	10,500,976	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,767,583		2,767,583	0	2,767,583	31,963,620	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,699,776		1,699,776	0	1,699,776	8,671,435	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,062,466		2,062,466	0	2,062,466	9,990,566	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,962,737		4,962,737	0	4,962,737	27,494,472	73.00
74.00	07400	RENAL DIALYSIS	257,646		257,646	0	257,646	3,021,508	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	0	76.00
76.01	03021	SLEEP LAB	682,111		682,111	0	682,111	0	76.01
76.02	03022	PSYCH SERVICES	381,432		381,432	0	381,432	1,459,066	76.02
76.03	03023	WOUND CARE	924,716		924,716	0	924,716	68,833	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>									
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	0	88.00
90.00	09000	CLINIC	1,769,577		1,769,577	0	1,769,577	0	90.00
91.00	09100	EMERGENCY	5,120,444		5,120,444	0	5,120,444	27,865,110	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	496,886		496,886		496,886	318,353	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	0	96.00
200.00		Subtotal (see instructions)	74,382,019	0	74,382,019	6,886	74,388,905	409,781,996	200.00
201.00		Less Observation Beds	496,886		496,886		496,886		201.00
202.00		Total (see instructions)	73,885,133	0	73,885,133	6,886	73,892,019	409,781,996	202.00
			Charges						
Cost Center Description			Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
			7.00	8.00	9.00	10.00	11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00	03000	ADULTS & PEDIATRICS		126,190,259					30.00
31.00	03100	INTENSIVE CARE UNIT		11,434,238					31.00
40.00	04000	SUBPROVIDER - I/PF		15,393,388					40.00
41.00	04100	SUBPROVIDER - I/RF		3,513,861					41.00
43.00	04300	NURSERY		1,188,002					43.00
44.00	04400	SKILLED NURSING FACILITY		6,154,857					44.00
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	44,236,595	71,755,605	0.118743	0.000000	0.118743		50.00
51.00	05100	RECOVERY ROOM	6,074,981	9,898,242	0.058939	0.000000	0.058939		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	256,813	3,572,835	0.342821	0.000000	0.342821		52.00
53.00	05300	ANESTHESIOLOGY	6,395,638	12,449,415	0.015885	0.000000	0.015885		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,698,878	48,323,231	0.089075	0.000000	0.089075		54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0.000000	0.000000		54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0.000000		56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0.000000		57.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140125

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/30/2013 4:00 pm

Cost Center Description			Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
			Outpatient	Total (col. 6 + col. 7)					
			7.00	8.00					
58.00	05800	MRI	0	0	0.000000	0.000000	0.000000		58.00
60.00	06000	LABORATORY	38,007,337	87,809,018	0.050323	0.000000	0.050323		60.00
65.00	06500	RESPIRATORY THERAPY	2,521,898	23,937,246	0.074962	0.000000	0.074962		65.00
66.00	06600	PHYSICAL THERAPY	9,311,720	19,812,696	0.137086	0.000000	0.137086		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	26,700,341	58,663,961	0.047177	0.000000	0.047177		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	104,725	8,776,160	0.193681	0.000000	0.193681		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,855,068	14,845,634	0.138927	0.000000	0.138927		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,301,170	34,795,642	0.142625	0.000000	0.142625		73.00
74.00	07400	RENAL DIALYSIS	18,958	3,040,466	0.084739	0.000000	0.084739		74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0.000000		76.00
76.01	03021	SLEEP LAB	1,424,500	1,424,500	0.478842	0.000000	0.478842		76.01
76.02	03022	PSYCH SERVICES	2,675,409	4,134,475	0.092256	0.000000	0.092256		76.02
76.03	03023	WOUND CARE	1,595,527	1,664,360	0.555599	0.000000	0.555599		76.03
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0					88.00
90.00	09000	CLINIC	1,952,832	1,952,832	0.906159	0.000000	0.906159		90.00
91.00	09100	EMERGENCY	65,625,040	93,490,150	0.054770	0.000000	0.054770		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,933,336	2,251,689	0.220673	0.000000	0.220673		92.00
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0.000000		96.00
200.00		Subtotal (see instructions)	256,690,766	666,472,762					200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	256,690,766	666,472,762					202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140125

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/30/2013 4:00 pm

			Title XIX		Hospital		PPS		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			
			Total Costs	RCE Diallowance	Total Costs	Inpatient			
			1.00	2.00	3.00	4.00	5.00	6.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00	03000	ADULTS & PEDIATRICS	20,127,650		20,127,650	3,443	20,131,093	126,190,259	30.00
31.00	03100	INTENSIVE CARE UNIT	3,164,936		3,164,936	0	3,164,936	11,434,238	31.00
40.00	04000	SUBPROVIDER - I/PF	2,538,598		2,538,598	3,443	2,542,041	15,393,388	40.00
41.00	04100	SUBPROVIDER - I/RF	1,393,778		1,393,778	0	1,393,778	3,513,861	41.00
43.00	04300	NURSERY	340,350		340,350	0	340,350	1,188,002	43.00
44.00	04400	SKILLED NURSING FACILITY	1,931,235		1,931,235	0	1,931,235	6,154,857	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	8,520,481		8,520,481	0	8,520,481	27,519,010	50.00
51.00	05100	RECOVERY ROOM	583,395		583,395	0	583,395	3,823,261	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,224,844		1,224,844	0	1,224,844	3,316,022	52.00
53.00	05300	ANESTHESIOLOGY	197,754		197,754	0	197,754	6,053,777	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,304,374		4,304,374	0	4,304,374	12,624,353	54.00
54.01	05401	ULTRA-SOUND	0		0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	0	57.00
58.00	05800	MRI	0		0	0	0	0	58.00
60.00	06000	LABORATORY	4,418,825		4,418,825	0	4,418,825	49,801,681	60.00
65.00	06500	RESPIRATORY THERAPY	1,794,382	0	1,794,382	0	1,794,382	21,415,348	65.00
66.00	06600	PHYSICAL THERAPY	2,716,043	0	2,716,043	0	2,716,043	10,500,976	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,767,583		2,767,583	0	2,767,583	31,963,620	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,699,776		1,699,776	0	1,699,776	8,671,435	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,062,466		2,062,466	0	2,062,466	9,990,566	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,962,737		4,962,737	0	4,962,737	27,494,472	73.00
74.00	07400	RENAL DIALYSIS	257,646		257,646	0	257,646	3,021,508	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	0	76.00
76.01	03021	SLEEP LAB	682,111		682,111	0	682,111	0	76.01
76.02	03022	PSYCH SERVICES	381,432		381,432	0	381,432	1,459,066	76.02
76.03	03023	WOUND CARE	924,716		924,716	0	924,716	68,833	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>									
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	0	88.00
90.00	09000	CLINIC	1,769,577		1,769,577	0	1,769,577	0	90.00
91.00	09100	EMERGENCY	5,120,444		5,120,444	0	5,120,444	27,865,110	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	496,886		496,886		496,886	318,353	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	0	96.00
200.00		Subtotal (see instructions)	74,382,019	0	74,382,019	6,886	74,388,905	409,781,996	200.00
201.00		Less Observation Beds	496,886		496,886		496,886		201.00
202.00		Total (see instructions)	73,885,133	0	73,885,133	6,886	73,892,019	409,781,996	202.00
			Charges						
Cost Center Description			Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
			7.00	8.00	9.00	10.00	11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00	03000	ADULTS & PEDIATRICS		126,190,259					30.00
31.00	03100	INTENSIVE CARE UNIT		11,434,238					31.00
40.00	04000	SUBPROVIDER - I/PF		15,393,388					40.00
41.00	04100	SUBPROVIDER - I/RF		3,513,861					41.00
43.00	04300	NURSERY		1,188,002					43.00
44.00	04400	SKILLED NURSING FACILITY		6,154,857					44.00
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	44,236,595	71,755,605	0.118743	0.000000	0.118743		50.00
51.00	05100	RECOVERY ROOM	6,074,981	9,898,242	0.058939	0.000000	0.058939		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	256,813	3,572,835	0.342821	0.000000	0.342821		52.00
53.00	05300	ANESTHESIOLOGY	6,395,638	12,449,415	0.015885	0.000000	0.015885		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,698,878	48,323,231	0.089075	0.000000	0.089075		54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0.000000	0.000000		54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0.000000		56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0.000000		57.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140125

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/30/2013 4:00 pm

Cost Center Description			Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
			Outpatient	Total (col. 6 + col. 7)					
			7.00	8.00					
58.00	05800	MRI	0	0	0.000000	0.000000	0.000000		58.00
60.00	06000	LABORATORY	38,007,337	87,809,018	0.050323	0.000000	0.050323		60.00
65.00	06500	RESPIRATORY THERAPY	2,521,898	23,937,246	0.074962	0.000000	0.074962		65.00
66.00	06600	PHYSICAL THERAPY	9,311,720	19,812,696	0.137086	0.000000	0.137086		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	26,700,341	58,663,961	0.047177	0.000000	0.047177		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	104,725	8,776,160	0.193681	0.000000	0.193681		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,855,068	14,845,634	0.138927	0.000000	0.138927		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,301,170	34,795,642	0.142625	0.000000	0.142625		73.00
74.00	07400	RENAL DIALYSIS	18,958	3,040,466	0.084739	0.000000	0.084739		74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0.000000		76.00
76.01	03021	SLEEP LAB	1,424,500	1,424,500	0.478842	0.000000	0.478842		76.01
76.02	03022	PSYCH SERVICES	2,675,409	4,134,475	0.092256	0.000000	0.092256		76.02
76.03	03023	WOUND CARE	1,595,527	1,664,360	0.555599	0.000000	0.555599		76.03
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0.000000		88.00
90.00	09000	CLINIC	1,952,832	1,952,832	0.906159	0.000000	0.906159		90.00
91.00	09100	EMERGENCY	65,625,040	93,490,150	0.054770	0.000000	0.054770		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,933,336	2,251,689	0.220673	0.000000	0.220673		92.00
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0.000000		96.00
200.00		Subtotal (see instructions)	256,690,766	666,472,762					200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	256,690,766	666,472,762					202.00

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

Provider CCN: 140125

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

Worksheet C Part II Date/Time Prepared: 5/30/2013 4:00 pm

Cost Center Description		Title XIX			Hospital	PPS		
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	8,520,481	1,136,798	7,383,683	0	0	50.00
51.00	05100	RECOVERY ROOM	583,395	56,885	526,510	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,224,844	186,395	1,038,449	0	0	52.00
53.00	05300	ANESTHESIOLOGY	197,754	26,219	171,535	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,304,374	555,437	3,748,937	0	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	4,418,825	342,554	4,076,271	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,794,382	232,188	1,562,194	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,716,043	483,430	2,232,613	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,767,583	227,354	2,540,229	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,699,776	62,826	1,636,950	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,062,466	80,686	1,981,780	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,962,737	233,283	4,729,454	0	0	73.00
74.00	07400	RENAL DIALYSIS	257,646	6,101	251,545	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03021	SLEEP LAB	682,111	180,377	501,734	0	0	76.01
76.02	03022	PSYCH SERVICES	381,432	96,337	285,095	0	0	76.02
76.03	03023	WOUND CARE	924,716	85,194	839,522	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	1,769,577	36,514	1,733,063	0	0	90.00
91.00	09100	EMERGENCY	5,120,444	429,260	4,691,184	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	496,886	60,146	436,740	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Subtotal (sum of lines 50 thru 199)	44,885,472	4,517,984	40,367,488	0	0	200.00
201.00		Less Observation Beds	496,886	60,146	436,740	0	0	201.00
202.00		Total (line 200 minus line 201)	44,388,586	4,457,838	39,930,748	0	0	202.00

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

Provider CCN: 140125

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

Worksheet C Part II Date/Time Prepared: 5/30/2013 4:00 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	8,520,481	71,755,605	0.118743		50.00
51.00	05100 RECOVERY ROOM	583,395	9,898,242	0.058939		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,224,844	3,572,835	0.342821		52.00
53.00	05300 ANESTHESIOLOGY	197,754	12,449,415	0.015885		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,304,374	48,323,231	0.089075		54.00
54.01	05401 ULTRA-SOUND	0	0	0.000000		54.01
56.00	05600 RADIOISOTOPE	0	0	0.000000		56.00
57.00	05700 CT SCAN	0	0	0.000000		57.00
58.00	05800 MRI	0	0	0.000000		58.00
60.00	06000 LABORATORY	4,418,825	87,809,018	0.050323		60.00
65.00	06500 RESPIRATORY THERAPY	1,794,382	23,937,246	0.074962		65.00
66.00	06600 PHYSICAL THERAPY	2,716,043	19,812,696	0.137086		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	2,767,583	58,663,961	0.047177		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,699,776	8,776,160	0.193681		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2,062,466	14,845,634	0.138927		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,962,737	34,795,642	0.142625		73.00
74.00	07400 RENAL DIALYSIS	257,646	3,040,466	0.084739		74.00
76.00	03020 ACUPUNCTURE	0	0	0.000000		76.00
76.01	03021 SLEEP LAB	682,111	1,424,500	0.478842		76.01
76.02	03022 PSYCH SERVICES	381,432	4,134,475	0.092256		76.02
76.03	03023 WOUND CARE	924,716	1,664,360	0.555599		76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000		88.00
90.00	09000 CLINIC	1,769,577	1,952,832	0.906159		90.00
91.00	09100 EMERGENCY	5,120,444	93,490,150	0.054770		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	496,886	2,251,689	0.220673		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000		96.00
200.00	Subtotal (sum of lines 50 thru 199)	44,885,472	502,598,157			200.00
201.00	Less Observation Beds	496,886	0			201.00
202.00	Total (line 200 minus line 201)	44,388,586	502,598,157			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part I Date/Time Prepared: 5/30/2013 4:00 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,436,784	0	2,436,784	30,548	79.77	30.00
31.00	INTENSIVE CARE UNIT	613,405	0	613,405	1,677	365.78	31.00
40.00	SUBPROVIDER - IPF	361,112	0	361,112	3,943	91.58	40.00
41.00	SUBPROVIDER - IRF	209,828	0	209,828	1,274	164.70	41.00
43.00	NURSERY	29,929		29,929	624	47.96	43.00
44.00	SKILLED NURSING FACILITY	237,464		237,464	2,913	81.52	44.00
200.00	Total (lines 30-199)	3,888,522		3,888,522	40,979		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	9,141	729,178				
31.00	INTENSIVE CARE UNIT	815	298,111				
40.00	SUBPROVIDER - IPF	2,639	241,680				
41.00	SUBPROVIDER - IRF	832	137,030				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	1,899	154,806				
200.00	Total (lines 30-199)	15,326	1,560,805				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part II Date/Time Prepared: 5/30/2013 4:00 pm
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Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,136,798	71,755,605	0.015843	10,817,553	171,382	50.00
51.00	05100	RECOVERY ROOM	56,885	9,898,242	0.005747	1,301,537	7,480	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	186,395	3,572,835	0.052170	35,664	1,861	52.00
53.00	05300	ANESTHESIOLOGY	26,219	12,449,415	0.002106	2,232,869	4,702	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	555,437	48,323,231	0.011494	5,985,498	68,797	54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	342,554	87,809,018	0.003901	19,811,033	77,283	60.00
65.00	06500	RESPIRATORY THERAPY	232,188	23,937,246	0.009700	9,935,928	96,379	65.00
66.00	06600	PHYSICAL THERAPY	483,430	19,812,696	0.024400	2,310,778	56,383	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	227,354	58,663,961	0.003876	14,625,787	56,690	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	62,826	8,776,160	0.007159	4,089,566	29,277	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	80,686	14,845,634	0.005435	5,389,705	29,293	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	233,283	34,795,642	0.006704	9,843,155	65,989	73.00
74.00	07400	RENAL DIALYSIS	6,101	3,040,466	0.002007	1,399,844	2,809	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03021	SLEEP LAB	180,377	1,424,500	0.126625	0	0	76.01
76.02	03022	PSYCH SERVICES	96,337	4,134,475	0.023301	152,715	3,558	76.02
76.03	03023	WOUND CARE	85,194	1,664,360	0.051187	63,001	3,225	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
90.00	09000	CLINIC	36,514	1,952,832	0.018698	0	0	90.00
91.00	09100	EMERGENCY	429,260	93,490,150	0.004591	10,977,869	50,399	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	60,146	2,251,689	0.026712	187,818	5,017	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (Lines 50-199)	4,517,984	502,598,157		99,160,320	730,524	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part III Date/Time Prepared: 5/30/2013 4:00 pm
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Cost Center Description		Title XVIII				Hospital		PPS
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School		
		6.00	7.00	8.00	9.00	11.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	30,548	0.00	9,141	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,677	0.00	815	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	3,943	0.00	2,639	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	1,274	0.00	832	0	0	41.00
43.00	04300	NURSERY	624	0.00	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,913	0.00	1,899	0	0	44.00
200.00		Total (lines 30-199)	40,979		15,326	0	0	200.00
Cost Center Description		PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost					
		12.00	13.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0	0				31.00
40.00	04000	SUBPROVIDER - IPF	0	0				40.00
41.00	04100	SUBPROVIDER - IRF	0	0				41.00
43.00	04300	NURSERY	0	0				43.00
44.00	04400	SKILLED NURSING FACILITY	0	0				44.00
200.00		Total (lines 30-199)	0	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140125

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/30/2013 4:00 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>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03021	SLEEP LAB	0	0	0	0	76.01
76.02	03022	PSYCH SERVICES	0	0	0	0	76.02
76.03	03023	WOUND CARE	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 4:00 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	71,755,605	0.000000	0.000000	10,817,553	50.00
51.00	05100	RECOVERY ROOM	0	9,898,242	0.000000	0.000000	1,301,537	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,572,835	0.000000	0.000000	35,664	52.00
53.00	05300	ANESTHESIOLOGY	0	12,449,415	0.000000	0.000000	2,232,869	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	48,323,231	0.000000	0.000000	5,985,498	54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	87,809,018	0.000000	0.000000	19,811,033	60.00
65.00	06500	RESPIRATORY THERAPY	0	23,937,246	0.000000	0.000000	9,935,928	65.00
66.00	06600	PHYSICAL THERAPY	0	19,812,696	0.000000	0.000000	2,310,778	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	58,663,961	0.000000	0.000000	14,625,787	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,776,160	0.000000	0.000000	4,089,566	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,845,634	0.000000	0.000000	5,389,705	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	34,795,642	0.000000	0.000000	9,843,155	73.00
74.00	07400	RENAL DIALYSIS	0	3,040,466	0.000000	0.000000	1,399,844	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03021	SLEEP LAB	0	1,424,500	0.000000	0.000000	0	76.01
76.02	03022	PSYCH SERVICES	0	4,134,475	0.000000	0.000000	152,715	76.02
76.03	03023	WOUND CARE	0	1,664,360	0.000000	0.000000	63,001	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	1,952,832	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	93,490,150	0.000000	0.000000	10,977,869	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,251,689	0.000000	0.000000	187,818	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	0	502,598,157			99,160,320	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 4:00 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	PPS
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	9,926,914	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	997,366	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	5,221	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	1,155,541	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	8,096,594	0	0	0	54.00
54.01	05401 ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
60.00	06000 LABORATORY	0	253,361	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	997,135	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	2,662	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	10,155,642	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	100,201	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	2,544,887	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,804,031	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	6,319	0	0	0	74.00
76.00	03020 ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03021 SLEEP LAB	0	411,500	0	0	0	76.01
76.02	03022 PSYCH SERVICES	0	174,942	0	0	0	76.02
76.03	03023 WOUND CARE	0	965,577	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	11,221,806	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	273,953	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00	Total (Lines 50-199)	0	49,093,652	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 4:00 pm
	Title XVIII	Hospital	PPS

Cost Center Description	PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost		
	23.00	24.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 05401 ULTRA-SOUND	0	0		54.01
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
60.00 06000 LABORATORY	0	0		60.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03020 ACUPUNCTURE	0	0		76.00
76.01 03021 SLEEP LAB	0	0		76.01
76.02 03022 PSYCH SERVICES	0	0		76.02
76.03 03023 WOUND CARE	0	0		76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00 Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/30/2013 4:00 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.118743	9,926,914	0	0	1,178,752	50.00
51.00	05100 RECOVERY ROOM	0.058939	997,366	0	0	58,784	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.342821	5,221	0	0	1,790	52.00
53.00	05300 ANESTHESIOLOGY	0.015885	1,155,541	0	0	18,356	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.089075	8,096,594	0	0	721,204	54.00
54.01	05401 ULTRA-SOUND	0.000000	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MRI	0.000000	0	0	0	0	58.00
60.00	06000 LABORATORY	0.050323	253,361	0	0	12,750	60.00
65.00	06500 RESPIRATORY THERAPY	0.074962	997,135	0	0	74,747	65.00
66.00	06600 PHYSICAL THERAPY	0.137086	2,662	0	0	365	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.047177	10,155,642	0	0	479,113	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.193681	100,201	0	0	19,407	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.138927	2,544,887	0	0	353,554	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.142625	1,804,031	0	0	257,300	73.00
74.00	07400 RENAL DIALYSIS	0.084739	6,319	0	0	535	74.00
76.00	03020 ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03021 SLEEP LAB	0.478842	411,500	0	0	197,043	76.01
76.02	03022 PSYCH SERVICES	0.092256	174,942	0	0	16,139	76.02
76.03	03023 WOUND CARE	0.555599	965,577	0	0	536,474	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000 CLINIC	0.906159	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.054770	11,221,806	0	0	614,618	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.220673	273,953	0	0	60,454	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00	Subtotal (see instructions)		49,093,652	0	0	4,601,385	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		49,093,652	0	0	4,601,385	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/30/2013 4:00 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	ULTRA-SOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	76.00
76.01	03021	SLEEP LAB	0	0	76.01
76.02	03022	PSYCH SERVICES	0	0	76.02
76.03	03023	WOUND CARE	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	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	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140125 Component CCN: 14S125		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part II Date/Time Prepared: 5/30/2013 4:00 pm		
		Title XVIII		Subprovider - IPF		PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,136,798	71,755,605	0.015843	0	0	50.00
51.00	05100	RECOVERY ROOM	56,885	9,898,242	0.005747	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	186,395	3,572,835	0.052170	0	0	52.00
53.00	05300	ANESTHESIOLOGY	26,219	12,449,415	0.002106	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	555,437	48,323,231	0.011494	104,383	1,200	54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOLOGY-SOFT	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	342,554	87,809,018	0.003901	1,119,054	4,365	60.00
65.00	06500	RESPIRATORY THERAPY	232,188	23,937,246	0.009700	170,969	1,658	65.00
66.00	06600	PHYSICAL THERAPY	483,430	19,812,696	0.024400	89,853	2,192	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	227,354	58,663,961	0.003876	67,000	260	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	62,826	8,776,160	0.007159	62,351	446	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	80,686	14,845,634	0.005435	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	233,283	34,795,642	0.006704	1,115,255	7,477	73.00
74.00	07400	RENAL DIALYSIS	6,101	3,040,466	0.002007	120,066	241	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03021	SLEEP LAB	180,377	1,424,500	0.126625	0	0	76.01
76.02	03022	PSYCH SERVICES	96,337	4,134,475	0.023301	144,996	3,379	76.02
76.03	03023	WOUND CARE	85,194	1,664,360	0.051187	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
90.00	09000	CLINIC	36,514	1,952,832	0.018698	0	0	90.00
91.00	09100	EMERGENCY	429,260	93,490,150	0.004591	827,517	3,799	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,251,689	0.000000	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50-199)	4,457,838	502,598,157		3,821,444	25,017	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140125 Component CCN: 14S125	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 4:00 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020 ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03021 SLEEP LAB	0	0	0	0	0	76.01
76.02	03022 PSYCH SERVICES	0	0	0	0	0	76.02
76.03	03023 WOUND CARE	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 140125 Component CCN: 14S125	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 4:00 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	71,755,605	0.000000	0.000000	0	50.00
51.00	05100 RECOVERY ROOM	0	9,898,242	0.000000	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	3,572,835	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	12,449,415	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	48,323,231	0.000000	0.000000	104,383	54.00
54.01	05401 ULTRA-SOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000 LABORATORY	0	87,809,018	0.000000	0.000000	1,119,054	60.00
65.00	06500 RESPIRATORY THERAPY	0	23,937,246	0.000000	0.000000	170,969	65.00
66.00	06600 PHYSICAL THERAPY	0	19,812,696	0.000000	0.000000	89,853	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	58,663,961	0.000000	0.000000	67,000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,776,160	0.000000	0.000000	62,351	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	14,845,634	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	34,795,642	0.000000	0.000000	1,115,255	73.00
74.00	07400 RENAL DIALYSIS	0	3,040,466	0.000000	0.000000	120,066	74.00
76.00	03020 ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03021 SLEEP LAB	0	1,424,500	0.000000	0.000000	0	76.01
76.02	03022 PSYCH SERVICES	0	4,134,475	0.000000	0.000000	144,996	76.02
76.03	03023 WOUND CARE	0	1,664,360	0.000000	0.000000	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000 CLINIC	0	1,952,832	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	93,490,150	0.000000	0.000000	827,517	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2,251,689	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00	Total (lines 50-199)	0	502,598,157			3,821,444	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140125 Component CCN: 14S125	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 4:00 pm
Title XVIII		Subprovider - IPF	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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020 ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03021 SLEEP LAB	0	0	0	0	0	76.01
76.02	03022 PSYCH SERVICES	0	0	0	0	0	76.02
76.03	03023 WOUND CARE	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 140125 Component CCN: 14S125	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 4:00 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401 ULTRA-SOUND	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03020 ACUPUNCTURE	0	0	76.00
76.01	03021 SLEEP LAB	0	0	76.01
76.02	03022 PSYCH SERVICES	0	0	76.02
76.03	03023 WOUND CARE	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140125 Component CCN: 14T125		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part II Date/Time Prepared: 5/30/2013 4:00 pm		
		Title XVIII		Subprovider - IRF		PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,136,798	71,755,605	0.015843	23,241	368	50.00
51.00	05100	RECOVERY ROOM	56,885	9,898,242	0.005747	2,193	13	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	186,395	3,572,835	0.052170	0	0	52.00
53.00	05300	ANESTHESIOLOGY	26,219	12,449,415	0.002106	1,514	3	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	555,437	48,323,231	0.011494	71,460	821	54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOLOGY-SOFT	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	342,554	87,809,018	0.003901	537,161	2,095	60.00
65.00	06500	RESPIRATORY THERAPY	232,188	23,937,246	0.009700	350,265	3,398	65.00
66.00	06600	PHYSICAL THERAPY	483,430	19,812,696	0.024400	2,116,063	51,632	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	227,354	58,663,961	0.003876	40,538	157	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	62,826	8,776,160	0.007159	141,755	1,015	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	80,686	14,845,634	0.005435	2,731	15	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	233,283	34,795,642	0.006704	498,141	3,340	73.00
74.00	07400	RENAL DIALYSIS	6,101	3,040,466	0.002007	242,257	486	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03021	SLEEP LAB	180,377	1,424,500	0.126625	0	0	76.01
76.02	03022	PSYCH SERVICES	96,337	4,134,475	0.023301	0	0	76.02
76.03	03023	WOUND CARE	85,194	1,664,360	0.051187	3,546	182	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
90.00	09000	CLINIC	36,514	1,952,832	0.018698	0	0	90.00
91.00	09100	EMERGENCY	429,260	93,490,150	0.004591	3,680	17	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,251,689	0.000000	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50-199)	4,457,838	502,598,157		4,034,545	63,542	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140125 Component CCN: 14T125	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 4:00 pm
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020 ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03021 SLEEP LAB	0	0	0	0	0	76.01
76.02	03022 PSYCH SERVICES	0	0	0	0	0	76.02
76.03	03023 WOUND CARE	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 140125 Component CCN: 14T125	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 4:00 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	71,755,605	0.000000	0.000000	23,241	50.00
51.00	05100 RECOVERY ROOM	0	9,898,242	0.000000	0.000000	2,193	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	3,572,835	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	12,449,415	0.000000	0.000000	1,514	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	48,323,231	0.000000	0.000000	71,460	54.00
54.01	05401 ULTRA-SOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000 LABORATORY	0	87,809,018	0.000000	0.000000	537,161	60.00
65.00	06500 RESPIRATORY THERAPY	0	23,937,246	0.000000	0.000000	350,265	65.00
66.00	06600 PHYSICAL THERAPY	0	19,812,696	0.000000	0.000000	2,116,063	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	58,663,961	0.000000	0.000000	40,538	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,776,160	0.000000	0.000000	141,755	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	14,845,634	0.000000	0.000000	2,731	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	34,795,642	0.000000	0.000000	498,141	73.00
74.00	07400 RENAL DIALYSIS	0	3,040,466	0.000000	0.000000	242,257	74.00
76.00	03020 ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03021 SLEEP LAB	0	1,424,500	0.000000	0.000000	0	76.01
76.02	03022 PSYCH SERVICES	0	4,134,475	0.000000	0.000000	0	76.02
76.03	03023 WOUND CARE	0	1,664,360	0.000000	0.000000	3,546	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000 CLINIC	0	1,952,832	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	93,490,150	0.000000	0.000000	3,680	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2,251,689	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00	Total (lines 50-199)	0	502,598,157			4,034,545	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140125 Component CCN: 14T125	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 4:00 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01 05401 ULTRA-SOUND	0	0	0	0	0	54.01
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MRI	0	0	0	0	0	58.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00 03020 ACUPUNCTURE	0	0	0	0	0	76.00
76.01 03021 SLEEP LAB	0	0	0	0	0	76.01
76.02 03022 PSYCH SERVICES	0	0	0	0	0	76.02
76.03 03023 WOUND CARE	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 140125 Component CCN: 14T125	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 4:00 pm
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401 ULTRA-SOUND	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03020 ACUPUNCTURE	0	0	76.00
76.01	03021 SLEEP LAB	0	0	76.01
76.02	03022 PSYCH SERVICES	0	0	76.02
76.03	03023 WOUND CARE	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140125 Component CCN: 145562	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 4:00 pm
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020 ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03021 SLEEP LAB	0	0	0	0	0	76.01
76.02	03022 PSYCH SERVICES	0	0	0	0	0	76.02
76.03	03023 WOUND CARE	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 140125 Component CCN: 145562	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 4:00 pm
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	71,755,605	0.000000	0.000000	0	50.00
51.00	05100 RECOVERY ROOM	0	9,898,242	0.000000	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	3,572,835	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	12,449,415	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	48,323,231	0.000000	0.000000	55,532	54.00
54.01	05401 ULTRA-SOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000 LABORATORY	0	87,809,018	0.000000	0.000000	962,542	60.00
65.00	06500 RESPIRATORY THERAPY	0	23,937,246	0.000000	0.000000	1,217,764	65.00
66.00	06600 PHYSICAL THERAPY	0	19,812,696	0.000000	0.000000	1,944,253	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	58,663,961	0.000000	0.000000	100,501	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,776,160	0.000000	0.000000	730,068	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	14,845,634	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	34,795,642	0.000000	0.000000	1,235,360	73.00
74.00	07400 RENAL DIALYSIS	0	3,040,466	0.000000	0.000000	0	74.00
76.00	03020 ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03021 SLEEP LAB	0	1,424,500	0.000000	0.000000	0	76.01
76.02	03022 PSYCH SERVICES	0	4,134,475	0.000000	0.000000	0	76.02
76.03	03023 WOUND CARE	0	1,664,360	0.000000	0.000000	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000 CLINIC	0	1,952,832	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	93,490,150	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2,251,689	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00	Total (lines 50-199)	0	502,598,157			6,246,020	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140125 Component CCN: 145562	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 4:00 pm
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020 ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03021 SLEEP LAB	0	0	0	0	0	76.01
76.02	03022 PSYCH SERVICES	0	0	0	0	0	76.02
76.03	03023 WOUND CARE	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 140125 Component CCN: 145562	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 4:00 pm
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401 ULTRA-SOUND	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03020 ACUPUNCTURE	0	0	76.00
76.01	03021 SLEEP LAB	0	0	76.01
76.02	03022 PSYCH SERVICES	0	0	76.02
76.03	03023 WOUND CARE	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part I Date/Time Prepared: 5/30/2013 4:00 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,436,784	0	2,436,784	30,548	79.77	30.00
31.00	INTENSIVE CARE UNIT	613,405	0	613,405	1,677	365.78	31.00
40.00	SUBPROVIDER - IPF	361,112	0	361,112	3,943	91.58	40.00
41.00	SUBPROVIDER - IRF	209,828	0	209,828	1,274	164.70	41.00
43.00	NURSERY	29,929		29,929	624	47.96	43.00
44.00	SKILLED NURSING FACILITY	237,464		237,464	2,913	81.52	44.00
200.00	Total (lines 30-199)	3,888,522		3,888,522	40,979		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	10,295	821,232				
31.00	INTENSIVE CARE UNIT	260	95,103				
40.00	SUBPROVIDER - IPF	529	48,446				
41.00	SUBPROVIDER - IRF	177	29,152				
43.00	NURSERY	531	25,467				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (lines 30-199)	11,792	1,019,400				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part II Date/Time Prepared: 5/30/2013 4:00 pm
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Cost Center Description		Title XIX			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,136,798	71,755,605	0.015843	0	0	50.00
51.00	05100	RECOVERY ROOM	56,885	9,898,242	0.005747	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	186,395	3,572,835	0.052170	0	0	52.00
53.00	05300	ANESTHESIOLOGY	26,219	12,449,415	0.002106	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	555,437	48,323,231	0.011494	0	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	342,554	87,809,018	0.003901	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	232,188	23,937,246	0.009700	0	0	65.00
66.00	06600	PHYSICAL THERAPY	483,430	19,812,696	0.024400	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	227,354	58,663,961	0.003876	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	62,826	8,776,160	0.007159	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	80,686	14,845,634	0.005435	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	233,283	34,795,642	0.006704	0	0	73.00
74.00	07400	RENAL DIALYSIS	6,101	3,040,466	0.002007	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03021	SLEEP LAB	180,377	1,424,500	0.126625	0	0	76.01
76.02	03022	PSYCH SERVICES	96,337	4,134,475	0.023301	0	0	76.02
76.03	03023	WOUND CARE	85,194	1,664,360	0.051187	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
90.00	09000	CLINIC	36,514	1,952,832	0.018698	0	0	90.00
91.00	09100	EMERGENCY	429,260	93,490,150	0.004591	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	60,146	2,251,689	0.026712	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50-199)	4,517,984	502,598,157		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part III Date/Time Prepared: 5/30/2013 4:00 pm
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Cost Center Description		Title XIX			Hospital	PPS	
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
200.00		Total (lines 30-199)	0	0	0	0	200.00
Cost Center Description		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
		6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	30,548	0.00	10,295	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,677	0.00	260	0	31.00
40.00	04000	SUBPROVIDER - IPF	3,943	0.00	529	0	40.00
41.00	04100	SUBPROVIDER - IRF	1,274	0.00	177	0	41.00
43.00	04300	NURSERY	624	0.00	531	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,913	0.00	0	0	44.00
200.00		Total (lines 30-199)	40,979		11,792	0	200.00
Cost Center Description		PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost				
		12.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0			30.00
31.00	03100	INTENSIVE CARE UNIT	0	0			31.00
40.00	04000	SUBPROVIDER - IPF	0	0			40.00
41.00	04100	SUBPROVIDER - IRF	0	0			41.00
43.00	04300	NURSERY	0	0			43.00
44.00	04400	SKILLED NURSING FACILITY	0	0			44.00
200.00		Total (lines 30-199)	0	0			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140125

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/30/2013 4:00 pm

Cost Center Description		Title XIX				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00		5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	0	76.00
76.01	03021	SLEEP LAB	0	0	0	0	0	0	76.01
76.02	03022	PSYCH SERVICES	0	0	0	0	0	0	76.02
76.03	03023	WOUND CARE	0	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 4:00 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges		
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS			
		6.00	7.00	8.00	9.00	10.00			
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	0	71,755,605	0.000000	0.000000		0	50.00
51.00	05100	RECOVERY ROOM	0	9,898,242	0.000000	0.000000		0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,572,835	0.000000	0.000000		0	52.00
53.00	05300	ANESTHESIOLOGY	0	12,449,415	0.000000	0.000000		0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	48,323,231	0.000000	0.000000		0	54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0.000000		0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000		0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000		0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000		0	58.00
60.00	06000	LABORATORY	0	87,809,018	0.000000	0.000000		0	60.00
65.00	06500	RESPIRATORY THERAPY	0	23,937,246	0.000000	0.000000		0	65.00
66.00	06600	PHYSICAL THERAPY	0	19,812,696	0.000000	0.000000		0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000		0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000		0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	58,663,961	0.000000	0.000000		0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,776,160	0.000000	0.000000		0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,845,634	0.000000	0.000000		0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	34,795,642	0.000000	0.000000		0	73.00
74.00	07400	RENAL DIALYSIS	0	3,040,466	0.000000	0.000000		0	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000		0	76.00
76.01	03021	SLEEP LAB	0	1,424,500	0.000000	0.000000		0	76.01
76.02	03022	PSYCH SERVICES	0	4,134,475	0.000000	0.000000		0	76.02
76.03	03023	WOUND CARE	0	1,664,360	0.000000	0.000000		0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>									
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000		0	88.00
90.00	09000	CLINIC	0	1,952,832	0.000000	0.000000		0	90.00
91.00	09100	EMERGENCY	0	93,490,150	0.000000	0.000000		0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,251,689	0.000000	0.000000		0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000		0	96.00
200.00		Total (lines 50-199)	0	502,598,157				0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140125

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/30/2013 4:00 pm

Cost Center Description		Title XIX			Hospital	PPS	
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	76.00
76.01	03021	SLEEP LAB	0	0	0	0	76.01
76.02	03022	PSYCH SERVICES	0	0	0	0	76.02
76.03	03023	WOUND CARE	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 4:00 pm
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Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XIX	Hospital	PPS
		23.00	24.00			
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0			50.00
51.00	05100 RECOVERY ROOM	0	0			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			52.00
53.00	05300 ANESTHESIOLOGY	0	0			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0			54.00
54.01	05401 ULTRA-SOUND	0	0			54.01
56.00	05600 RADIOISOTOPE	0	0			56.00
57.00	05700 CT SCAN	0	0			57.00
58.00	05800 MRI	0	0			58.00
60.00	06000 LABORATORY	0	0			60.00
65.00	06500 RESPIRATORY THERAPY	0	0			65.00
66.00	06600 PHYSICAL THERAPY	0	0			66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0			67.00
68.00	06800 SPEECH PATHOLOGY	0	0			68.00
69.00	06900 ELECTROCARDIOLOGY	0	0			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			73.00
74.00	07400 RENAL DIALYSIS	0	0			74.00
76.00	03020 ACUPUNCTURE	0	0			76.00
76.01	03021 SLEEP LAB	0	0			76.01
76.02	03022 PSYCH SERVICES	0	0			76.02
76.03	03023 WOUND CARE	0	0			76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0	0			88.00
90.00	09000 CLINIC	0	0			90.00
91.00	09100 EMERGENCY	0	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0			96.00
200.00	Total (lines 50-199)	0	0			200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140125 Component CCN: 14S125		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part II Date/Time Prepared: 5/30/2013 4:00 pm	
		Title XIX		Subprovider - IPF		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	1,136,798	71,755,605	0.015843	0	0 50.00
51.00	05100	RECOVERY ROOM	56,885	9,898,242	0.005747	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	186,395	3,572,835	0.052170	0	0 52.00
53.00	05300	ANESTHESIOLOGY	26,219	12,449,415	0.002106	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	555,437	48,323,231	0.011494	0	0 54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0	0 54.01
56.00	05600	RADIOLOGY-SOFT	0	0	0.000000	0	0 56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0 57.00
58.00	05800	MRI	0	0	0.000000	0	0 58.00
60.00	06000	LABORATORY	342,554	87,809,018	0.003901	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	232,188	23,937,246	0.009700	0	0 65.00
66.00	06600	PHYSICAL THERAPY	483,430	19,812,696	0.024400	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	227,354	58,663,961	0.003876	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	62,826	8,776,160	0.007159	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	80,686	14,845,634	0.005435	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	233,283	34,795,642	0.006704	0	0 73.00
74.00	07400	RENAL DIALYSIS	6,101	3,040,466	0.002007	0	0 74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0 76.00
76.01	03021	SLEEP LAB	180,377	1,424,500	0.126625	0	0 76.01
76.02	03022	PSYCH SERVICES	96,337	4,134,475	0.023301	0	0 76.02
76.03	03023	WOUND CARE	85,194	1,664,360	0.051187	0	0 76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0 88.00
90.00	09000	CLINIC	36,514	1,952,832	0.018698	0	0 90.00
91.00	09100	EMERGENCY	429,260	93,490,150	0.004591	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,251,689	0.000000	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0 96.00
200.00		Total (lines 50-199)	4,457,838	502,598,157		0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140125 Component CCN: 14S125	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 4:00 pm
Title XIX		Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020 ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03021 SLEEP LAB	0	0	0	0	0	76.01
76.02	03022 PSYCH SERVICES	0	0	0	0	0	76.02
76.03	03023 WOUND CARE	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 140125 Component CCN: 14S125	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 4:00 pm
	Title XIX	Subprovider - IPF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	71,755,605	0.000000	0.000000	0	50.00
51.00	05100 RECOVERY ROOM	0	9,898,242	0.000000	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	3,572,835	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	12,449,415	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	48,323,231	0.000000	0.000000	0	54.00
54.01	05401 ULTRA-SOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000 LABORATORY	0	87,809,018	0.000000	0.000000	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	23,937,246	0.000000	0.000000	0	65.00
66.00	06600 PHYSICAL THERAPY	0	19,812,696	0.000000	0.000000	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	58,663,961	0.000000	0.000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,776,160	0.000000	0.000000	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	14,845,634	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	34,795,642	0.000000	0.000000	0	73.00
74.00	07400 RENAL DIALYSIS	0	3,040,466	0.000000	0.000000	0	74.00
76.00	03020 ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03021 SLEEP LAB	0	1,424,500	0.000000	0.000000	0	76.01
76.02	03022 PSYCH SERVICES	0	4,134,475	0.000000	0.000000	0	76.02
76.03	03023 WOUND CARE	0	1,664,360	0.000000	0.000000	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000 CLINIC	0	1,952,832	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	93,490,150	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2,251,689	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00	Total (lines 50-199)	0	502,598,157			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140125 Component CCN: 14S125	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 4:00 pm
Title XIX		Subprovider - IPF	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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03021	SLEEP LAB	0	0	0	0	0	76.01
76.02	03022	PSYCH SERVICES	0	0	0	0	0	76.02
76.03	03023	WOUND CARE	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 140125 Component CCN: 14S125	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 4:00 pm
	Title XIX	Subprovider - IPF	PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401 ULTRA-SOUND	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03020 ACUPUNCTURE	0	0	76.00
76.01	03021 SLEEP LAB	0	0	76.01
76.02	03022 PSYCH SERVICES	0	0	76.02
76.03	03023 WOUND CARE	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140125 Component CCN: 14T125		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part II Date/Time Prepared: 5/30/2013 4:00 pm	
		Title XIX		Subprovider - IRF		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	1,136,798	71,755,605	0.015843	0	0 50.00
51.00	05100	RECOVERY ROOM	56,885	9,898,242	0.005747	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	186,395	3,572,835	0.052170	0	0 52.00
53.00	05300	ANESTHESIOLOGY	26,219	12,449,415	0.002106	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	555,437	48,323,231	0.011494	0	0 54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0	0 54.01
56.00	05600	RADIOLOGY-SOFT	0	0	0.000000	0	0 56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0 57.00
58.00	05800	MRI	0	0	0.000000	0	0 58.00
60.00	06000	LABORATORY	342,554	87,809,018	0.003901	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	232,188	23,937,246	0.009700	0	0 65.00
66.00	06600	PHYSICAL THERAPY	483,430	19,812,696	0.024400	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	227,354	58,663,961	0.003876	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	62,826	8,776,160	0.007159	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	80,686	14,845,634	0.005435	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	233,283	34,795,642	0.006704	0	0 73.00
74.00	07400	RENAL DIALYSIS	6,101	3,040,466	0.002007	0	0 74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0 76.00
76.01	03021	SLEEP LAB	180,377	1,424,500	0.126625	0	0 76.01
76.02	03022	PSYCH SERVICES	96,337	4,134,475	0.023301	0	0 76.02
76.03	03023	WOUND CARE	85,194	1,664,360	0.051187	0	0 76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0 88.00
90.00	09000	CLINIC	36,514	1,952,832	0.018698	0	0 90.00
91.00	09100	EMERGENCY	429,260	93,490,150	0.004591	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,251,689	0.000000	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0 96.00
200.00		Total (lines 50-199)	4,457,838	502,598,157		0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140125 Component CCN: 14T125	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 4:00 pm
	Title XIX	Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020 ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03021 SLEEP LAB	0	0	0	0	0	76.01
76.02	03022 PSYCH SERVICES	0	0	0	0	0	76.02
76.03	03023 WOUND CARE	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 140125 Component CCN: 14T125	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 4:00 pm
	Title XIX	Subprovider - IRF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	71,755,605	0.000000	0.000000	0	50.00
51.00	05100 RECOVERY ROOM	0	9,898,242	0.000000	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	3,572,835	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	12,449,415	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	48,323,231	0.000000	0.000000	0	54.00
54.01	05401 ULTRA-SOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000 LABORATORY	0	87,809,018	0.000000	0.000000	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	23,937,246	0.000000	0.000000	0	65.00
66.00	06600 PHYSICAL THERAPY	0	19,812,696	0.000000	0.000000	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	58,663,961	0.000000	0.000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,776,160	0.000000	0.000000	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	14,845,634	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	34,795,642	0.000000	0.000000	0	73.00
74.00	07400 RENAL DIALYSIS	0	3,040,466	0.000000	0.000000	0	74.00
76.00	03020 ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03021 SLEEP LAB	0	1,424,500	0.000000	0.000000	0	76.01
76.02	03022 PSYCH SERVICES	0	4,134,475	0.000000	0.000000	0	76.02
76.03	03023 WOUND CARE	0	1,664,360	0.000000	0.000000	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000 CLINIC	0	1,952,832	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	93,490,150	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2,251,689	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00	Total (lines 50-199)	0	502,598,157			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140125 Component CCN: 14T125	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 4:00 pm
Title XIX		Subprovider - IRF	PPS

Cost Center Description			Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03021	SLEEP LAB	0	0	0	0	0	76.01
76.02	03022	PSYCH SERVICES	0	0	0	0	0	76.02
76.03	03023	WOUND CARE	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 140125 Component CCN: 14T125	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 4:00 pm
	Title XIX	Subprovider - IRF	PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401 ULTRA-SOUND	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03020 ACUPUNCTURE	0	0	76.00
76.01	03021 SLEEP LAB	0	0	76.01
76.02	03022 PSYCH SERVICES	0	0	76.02
76.03	03023 WOUND CARE	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140125 Component CCN: 145562	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 4:00 pm
Title XIX		Skilled Nursing Facility	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020 ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03021 SLEEP LAB	0	0	0	0	0	76.01
76.02	03022 PSYCH SERVICES	0	0	0	0	0	76.02
76.03	03023 WOUND CARE	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 140125 Component CCN: 145562		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part IV Date/Time Prepared: 5/30/2013 4:00 pm	
				Title XIX		Skilled Nursing Facility	PPS
Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	71,755,605	0.000000	0.000000	0 50.00
51.00	05100	RECOVERY ROOM	0	9,898,242	0.000000	0.000000	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,572,835	0.000000	0.000000	0 52.00
53.00	05300	ANESTHESIOLOGY	0	12,449,415	0.000000	0.000000	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	48,323,231	0.000000	0.000000	0 54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0.000000	0 54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0 56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0 57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0 58.00
60.00	06000	LABORATORY	0	87,809,018	0.000000	0.000000	0 60.00
65.00	06500	RESPIRATORY THERAPY	0	23,937,246	0.000000	0.000000	0 65.00
66.00	06600	PHYSICAL THERAPY	0	19,812,696	0.000000	0.000000	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	58,663,961	0.000000	0.000000	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,776,160	0.000000	0.000000	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,845,634	0.000000	0.000000	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	34,795,642	0.000000	0.000000	0 73.00
74.00	07400	RENAL DIALYSIS	0	3,040,466	0.000000	0.000000	0 74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0 76.00
76.01	03021	SLEEP LAB	0	1,424,500	0.000000	0.000000	0 76.01
76.02	03022	PSYCH SERVICES	0	4,134,475	0.000000	0.000000	0 76.02
76.03	03023	WOUND CARE	0	1,664,360	0.000000	0.000000	0 76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0 88.00
90.00	09000	CLINIC	0	1,952,832	0.000000	0.000000	0 90.00
91.00	09100	EMERGENCY	0	93,490,150	0.000000	0.000000	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,251,689	0.000000	0.000000	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0 96.00
200.00		Total (lines 50-199)	0	502,598,157			0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140125 Component CCN: 145562	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 4:00 pm
Title XIX		Skilled Nursing Facility	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020 ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03021 SLEEP LAB	0	0	0	0	0	76.01
76.02	03022 PSYCH SERVICES	0	0	0	0	0	76.02
76.03	03023 WOUND CARE	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 140125 Component CCN: 145562	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/30/2013 4:00 pm
Title XIX		Skilled Nursing Facility	PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401 ULTRA-SOUND	0	0	54.01
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03020 ACUPUNCTURE	0	0	76.00
76.01	03021 SLEEP LAB	0	0	76.01
76.02	03022 PSYCH SERVICES	0	0	76.02
76.03	03023 WOUND CARE	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00	Total (lines 50-199)	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/30/2013 4:00 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)		30,548	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		30,548	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.		4,150	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		25,644	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		9,141	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)		20,131,093	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)		20,131,093	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		126,190,259	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		126,190,259	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.159530	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)		4,920.85	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)		20,131,093	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)		659.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,023,919	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)		6,023,919	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140125		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 5/30/2013 4:00 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)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	3,164,936	1,677	1,887.26	815	1,538,117		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)					8,445,761		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					16,007,797		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,027,289		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					730,524		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,757,813		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					14,249,984		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)					754		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					659.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					496,886		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140125		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/30/2013 4:00 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	2,436,784	20,131,093	0.121046	496,886	60,146	90.00
91.00	Nursing School cost	0	20,131,093	0.000000	496,886	0	91.00
92.00	Allied health cost	0	20,131,093	0.000000	496,886	0	92.00
93.00	All other Medical Education	0	20,131,093	0.000000	496,886	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Component CCN: 14S125		Date/Time Prepared: 5/30/2013 4:00 pm
		Title XVIII	Subprovider - IPF	PPS
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)		3,943	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,943	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)		3,943	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,639	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)		2,542,041	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)		2,542,041	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		15,393,388	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		15,393,388	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.165138	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		3,903.98	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)		2,542,041	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)		644.70	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,701,363	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,701,363	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140125		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1	
		Component CCN: 14S125				Date/Time Prepared: 5/30/2013 4:00 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					333,920		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,035,283		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)					241,680		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					25,017		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					266,697		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,768,586		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: 140125 Component CCN: 14S125		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/30/2013 4:00 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	361,112	2,542,041	0.142056	0	0	90.00
91.00	Nursing School cost	0	2,542,041	0.000000	0	0	91.00
92.00	Allied health cost	0	2,542,041	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,542,041	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140125 Component CCN: 14T125	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/30/2013 4:00 pm
		Title XVIII	Subprovider - IRF	PPS
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)			1,274 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,274 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,274 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)			832 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)			1,393,778 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,393,778 27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)			3,513,861 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			3,513,861 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.396651 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)			2,758.13 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			1,393,778 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)			1,094.02 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			910,225 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)			910,225 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140125		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1	
		Component CCN: 14T125		Date/Time Prepared: 5/30/2013 4:00 pm			
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					476,144	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,386,369	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)					137,030	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					63,542	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					200,572	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,185,797	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: 140125 Component CCN: 14T125		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/30/2013 4:00 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	209,828	1,393,778	0.150546	0	0	90.00
91.00	Nursing School cost	0	1,393,778	0.000000	0	0	91.00
92.00	Allied health cost	0	1,393,778	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,393,778	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Component CCN: 145562		Date/Time Prepared: 5/30/2013 4:00 pm
		Title XVIII	Skilled Nursing Facility	PPS
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)		2,913	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,913	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.		868	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,045	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,899	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)		1,931,235	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,931,235	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		6,154,857	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		6,154,857	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.313774	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		3,009.71	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,931,235	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)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1	
		Component CCN: 145562		Date/Time Prepared: 5/30/2013 4:00 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				49.00
PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				54.00
55.00	Target amount per discharge				55.00
56.00	Target amount (line 54 x line 55)				56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				57.00
58.00	Bonus payment (see instructions)				58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				61.00
62.00	Relief payment (see instructions)				62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)				1,931,235 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				662.97 71.00
72.00	Program routine service cost (line 9 x line 71)				1,258,980 72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				0 73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				1,258,980 74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				0 75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				0.00 76.00
77.00	Program capital-related costs (line 9 x line 76)				0 77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				0 78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				0 79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				0 80.00
81.00	Inpatient routine service cost per diem limitation				0.00 81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				0 82.00
83.00	Reasonable inpatient routine service costs (see instructions)				1,258,980 83.00
84.00	Program inpatient ancillary services (see instructions)				733,535 84.00
85.00	Utilization review - physician compensation (see instructions)				0 85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				1,992,515 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: 140125 Component CCN: 145562		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/30/2013 4:00 pm	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital -related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/30/2013 4:00 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)		30,548	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		30,548	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)		29,794	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)		10,295	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)		624	15.00
16.00	Nursery days (title V or XIX only)		531	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)		20,131,093	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)		20,131,093	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		126,190,259	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		126,190,259	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.159530	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)		4,235.43	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)		20,131,093	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)		659.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,784,405	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)		6,784,405	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140125		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1	
Title XIX		Hospital		PPS		Date/Time Prepared: 5/30/2013 4:00 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)		
42.00 NURSERY (title V & XIX only)	340,350	624	545.43	531	289,623		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	3,164,936	1,677	1,887.26	260	490,688		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)						0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						7,564,716	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)						941,802	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)						941,802	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						6,622,914	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)						754	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						659.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						496,886	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140125		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/30/2013 4:00 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	2,436,784	20,131,093	0.121046	496,886	60,146	90.00
91.00	Nursing School cost	0	20,131,093	0.000000	496,886	0	91.00
92.00	Allied health cost	0	20,131,093	0.000000	496,886	0	92.00
93.00	All other Medical Education	0	20,131,093	0.000000	496,886	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Component CCN: 14S125		Date/Time Prepared: 5/30/2013 4:00 pm
		Title XIX	Subprovider - IPF	PPS
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)		3,943	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,943	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)		3,943	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)		529	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)		624	15.00
16.00	Nursery days (title V or XIX only)		531	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)		2,542,041	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)		2,542,041	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		15,393,388	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		15,393,388	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.165138	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		3,903.98	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)		2,542,041	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)		644.70	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		341,046	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)		341,046	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140125		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1	
		Component CCN: 14S125				Date/Time Prepared: 5/30/2013 4:00 pm	
		Title XIX		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					341,046		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)					48,446		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)					48,446		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					292,600		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: 140125 Component CCN: 14S125		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/30/2013 4:00 pm	
		Title XIX		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	361,112	2,542,041	0.142056	0	0	90.00
91.00	Nursing School cost	0	2,542,041	0.000000	0	0	91.00
92.00	Allied health cost	0	2,542,041	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,542,041	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Component CCN: 14T125		Date/Time Prepared: 5/30/2013 4:00 pm
		Title XIX	Subprovider - IRF	PPS
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)		1,274	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,274	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,274	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)		177	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)		624	15.00
16.00	Nursery days (title V or XIX only)		531	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)		1,393,778	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,393,778	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		3,513,861	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		3,513,861	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.396651	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)		2,758.13	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,393,778	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)		1,094.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		193,642	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)		193,642	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140125		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1	
		Component CCN: 14T125				Date/Time Prepared: 5/30/2013 4:00 pm	
		Title XIX		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					193,642		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)					29,152		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)					29,152		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					164,490		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: 140125 Component CCN: 14T125		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/30/2013 4:00 pm	
		Title XIX		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	209,828	1,393,778	0.150546	0	0	90.00
91.00	Nursing School cost	0	1,393,778	0.000000	0	0	91.00
92.00	Allied health cost	0	1,393,778	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,393,778	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Component CCN: 145562		Date/Time Prepared: 5/30/2013 4:00 pm
		Title XIX	Skilled Nursing Facility	PPS
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)		2,913	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,913	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,913	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)		0	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)		624	15.00
16.00	Nursery days (title V or XIX only)		531	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)		1,931,235	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,931,235	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		6,154,857	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		6,154,857	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.313774	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)		2,112.89	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,931,235	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)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1	
		Component CCN: 145562		Date/Time Prepared: 5/30/2013 4:00 pm	
		Title XIX	Skilled Nursing Facility	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
	Intensive Care Type Inpatient Hospital Units				
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
	Cost Center Description				
					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				49.00
	PASS THROUGH COST ADJUSTMENTS				
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				53.00
	TARGET AMOUNT AND LIMIT COMPUTATION				
54.00	Program discharges				54.00
55.00	Target amount per discharge				55.00
56.00	Target amount (line 54 x line 55)				56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				57.00
58.00	Bonus payment (see instructions)				58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				61.00
62.00	Relief payment (see instructions)				62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST				
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY				
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)				1,931,235 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				662.97 71.00
72.00	Program routine service cost (line 9 x line 71)				0 72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				0 73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				0 74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				237,464 75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				81.52 76.00
77.00	Program capital-related costs (line 9 x line 76)				0 77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				0 78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				0 79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				0 80.00
81.00	Inpatient routine service cost per diem limitation				0.00 81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				0 82.00
83.00	Reasonable inpatient routine service costs (see instructions)				0 83.00
84.00	Program inpatient ancillary services (see instructions)				0 84.00
85.00	Utilization review - physician compensation (see instructions)				0 85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				0 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: 140125 Component CCN: 145562		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/30/2013 4:00 pm	
		Title XIX		Skilled Nursing Facility		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital -related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/30/2013 4:00 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		38,855,428	30.00
31.00	03100	INTENSIVE CARE UNIT		5,545,023	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.118743	10,817,553	50.00
51.00	05100	RECOVERY ROOM	0.058939	1,301,537	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.342821	35,664	52.00
53.00	05300	ANESTHESIOLOGY	0.015885	2,232,869	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.089075	5,985,498	54.00
54.01	05401	ULTRA-SOUND	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MRI	0.000000	0	58.00
60.00	06000	LABORATORY	0.050323	19,811,033	60.00
65.00	06500	RESPIRATORY THERAPY	0.074962	9,935,928	65.00
66.00	06600	PHYSICAL THERAPY	0.137086	2,310,778	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047177	14,625,787	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.193681	4,089,566	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.138927	5,389,705	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.142625	9,843,155	73.00
74.00	07400	RENAL DIALYSIS	0.084739	1,399,844	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	76.00
76.01	03021	SLEEP LAB	0.478842	0	76.01
76.02	03022	PSYCH SERVICES	0.092256	152,715	76.02
76.03	03023	WOUND CARE	0.555599	63,001	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
90.00	09000	CLINIC	0.906159	0	90.00
91.00	09100	EMERGENCY	0.054770	10,977,869	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.220673	187,818	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		99,160,320	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)		99,160,320	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3	
		Component CCN: 14S125		Date/Time Prepared: 5/30/2013 4:00 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		10,296,592	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.118743	0	50.00
51.00	05100	RECOVERY ROOM	0.058939	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.342821	0	52.00
53.00	05300	ANESTHESIOLOGY	0.015885	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.089075	104,383	54.00
54.01	05401	ULTRA-SOUND	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MRI	0.000000	0	58.00
60.00	06000	LABORATORY	0.050323	1,119,054	60.00
65.00	06500	RESPIRATORY THERAPY	0.074962	170,969	65.00
66.00	06600	PHYSICAL THERAPY	0.137086	89,853	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047177	67,000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.193681	62,351	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.138927	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.142625	1,115,255	73.00
74.00	07400	RENAL DIALYSIS	0.084739	120,066	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	76.00
76.01	03021	SLEEP LAB	0.478842	0	76.01
76.02	03022	PSYCH SERVICES	0.092256	144,996	76.02
76.03	03023	WOUND CARE	0.555599	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
90.00	09000	CLINIC	0.906159	0	90.00
91.00	09100	EMERGENCY	0.054770	827,517	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.220673	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		3,821,444	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)		3,821,444	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3	
		Component CCN: 14T125		Date/Time Prepared: 5/30/2013 4:00 pm	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		2,304,851	41.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.118743	23,241	50.00
51.00	05100	RECOVERY ROOM	0.058939	2,193	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.342821	0	52.00
53.00	05300	ANESTHESIOLOGY	0.015885	1,514	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.089075	71,460	54.00
54.01	05401	ULTRA-SOUND	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MRI	0.000000	0	58.00
60.00	06000	LABORATORY	0.050323	537,161	60.00
65.00	06500	RESPIRATORY THERAPY	0.074962	350,265	65.00
66.00	06600	PHYSICAL THERAPY	0.137086	2,116,063	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047177	40,538	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.193681	141,755	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.138927	2,731	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.142625	498,141	73.00
74.00	07400	RENAL DIALYSIS	0.084739	242,257	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	76.00
76.01	03021	SLEEP LAB	0.478842	0	76.01
76.02	03022	PSYCH SERVICES	0.092256	0	76.02
76.03	03023	WOUND CARE	0.555599	3,546	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.906159	0	90.00
91.00	09100	EMERGENCY	0.054770	3,680	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.220673	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		4,034,545	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)		4,034,545	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3	
		Component CCN: 145562		Date/Time Prepared: 5/30/2013 4:00 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.118743	0	50.00
51.00	05100	RECOVERY ROOM	0.058939	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.342821	0	52.00
53.00	05300	ANESTHESIOLOGY	0.015885	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.089075	55,532	54.00
54.01	05401	ULTRA-SOUND	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MRI	0.000000	0	58.00
60.00	06000	LABORATORY	0.050323	962,542	60.00
65.00	06500	RESPIRATORY THERAPY	0.074962	1,217,764	65.00
66.00	06600	PHYSICAL THERAPY	0.137086	1,944,253	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047177	100,501	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.193681	730,068	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.138927	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.142625	1,235,360	73.00
74.00	07400	RENAL DIALYSIS	0.084739	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	76.00
76.01	03021	SLEEP LAB	0.478842	0	76.01
76.02	03022	PSYCH SERVICES	0.092256	0	76.02
76.03	03023	WOUND CARE	0.555599	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
90.00	09000	CLINIC	0.906159	0	90.00
91.00	09100	EMERGENCY	0.054770	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.220673	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		6,246,020	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)		6,246,020	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/30/2013 4:00 pm
		Title VIII	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER PPS</b>				
1.00	DRG Amounts Other than Outlier Payments		12,161,302	1.00
2.00	Outlier payments for discharges. (see instructions)		156,320	2.00
2.01	Outlier reconciliation amount		0	2.01
3.00	Managed Care Simulated Payments		2,665,740	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		306.94	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		11.35	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		38.52	31.00
32.00	Sum of lines 30 and 31		49.87	32.00
33.00	Allowable disproportionate share percentage (see instructions)		30.36	33.00
34.00	Disproportionate share adjustment (see instructions)		3,692,171	34.00
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0	46.00
47.00	Subtotal (see instructions)		16,009,793	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		16,009,793	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		1,101,292	50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0	56.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/30/2013 4:00 pm
		Title XVIII	Hospital	PPS
		1.00		
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).			0 57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)			0 58.00
59.00	Total (sum of amounts on lines 49 through 58)			17,111,085 59.00
60.00	Primary payer payments			7,327 60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			17,103,758 61.00
62.00	Deductibles billed to program beneficiaries			1,606,192 62.00
63.00	Coinurance billed to program beneficiaries			120,513 63.00
64.00	Allowable bad debts (see instructions)			1,531,275 64.00
65.00	Adjusted reimbursable bad debts (see instructions)			1,071,893 65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,406,300 66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			16,448,946 67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)			0 68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)			0 69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 70.00
70.93	HVBP incentive payment (see instructions)			-474 70.93
70.94	Hospital readmissions reduction adjustment (see instructions)			-4,164 70.94
70.95	Recovery of Accelerated Depreciation			0 70.95
70.96	Low Volume Payment-1			0 70.96
70.97	Low Volume Payment-2			0 70.97
70.98	Low Volume Payment-3			0 70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			16,444,308 71.00
72.00	Interim payments			15,925,394 72.00
73.00	Tentative settlement (for contractor use only)			0 73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)			518,914 74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			1,387,698 75.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)			0 90.00
91.00	Capital outlier from Worksheet L, Part I, line 2			0 91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0 92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0 93.00
94.00	The rate used to calculate the Time Value of Money			0.00 94.00
95.00	Time Value of Money for operating expenses(see instructions)			0 95.00
96.00	Time Value of Money for capital related expenses (see instructions)			0 96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/30/2013 4:00 pm
		Title XVII	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)			4,601,385 2.00
3.00	PPS payments			4,340,526 3.00
4.00	Outlier payment (see instructions)			27,896 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)			4,368,422 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)			1,017,675 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			3,350,747 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)			3,350,747 30.00
31.00	Primary payer payments			1,350 31.00
32.00	Subtotal (line 30 minus line 31)			3,349,397 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)			362,130 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			253,491 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			322,109 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			3,602,888 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)			3,602,888 40.00
41.00	Interim payments			3,563,697 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)			39,191 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
				Overrides
				1.00
<b>WORKSHEET OVERRIDE VALUES</b>				
112.00	Override of Ancillary service charges (line 12)			0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140125

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/30/2013 4:00 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		15,925,394		3,563,697	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		15,925,394		3,563,697	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		518,914		39,191	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		16,444,308		3,602,888	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140125  
Component CCN: 14S125

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/30/2013 4:00 pm  
PPS

Title XVIII

Subprovider -  
IPF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,907,645		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,907,645		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		1,956		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,909,601		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140125  
Component CCN: 14T125

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/30/2013 4:00 pm  
PPS

Title XVIII

Subprovider -  
IRF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider				0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,243,094		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,243,094		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		29,784		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,272,878		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140125  
Component CCN: 145562

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/30/2013 4:00 pm  
PPS

Title XVIII

Skilled Nursing  
Facility

		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		650,635		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		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		650,635		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		727		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		651,362		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 140125

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

Worksheet E-1  
Part II  
Date/Time Prepared:  
5/30/2013 4:00 pm

		Title XVIII	Hospital	PPS		
					1.00	
<b>TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS</b>						
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>						
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			6,922	1.00	
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			9,956	2.00	
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			2,110	3.00	
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			31,471	4.00	
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			666,472,762	5.00	
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			29,937,345	6.00	
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0	7.00	
8.00	Calculation of the HIT incentive payment (see instructions)			1,266,373	8.00	
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>						
30.00	Initial/interim HIT payment adjustment (see instructions)			1,428,953	30.00	
31.00	Other Adjustment (specify)			0	31.00	
32.00	Balance due provider (line 8 minus line 30 and line 31)			-162,580	32.00	
		<b>Overrides</b>				
					1.00	
<b>CONTRACTOR OVERRIDES</b>						
108.00	Override of HIT payment				0	
					108.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140125 Component CCN: 14S125	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part II Date/Time Prepared: 5/30/2013 4:00 pm
		Title XVIIII	Subprovider - IPF	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)			2,059,975 1.00
2.00	Net IPF PPS Outlier Payments			5,094 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)			10.773224 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)			2,065,069 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)			2,065,069 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			2,065,069 18.00
19.00	Deductibles			186,068 19.00
20.00	Subtotal (line 18 minus line 19)			1,879,001 20.00
21.00	Coinsurance			58,956 21.00
22.00	Subtotal (line 20 minus line 21)			1,820,045 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			127,937 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			89,556 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			116,765 25.00
26.00	Subtotal (sum of lines 22 and 24)			1,909,601 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)			1,909,601 31.00
32.00	Interim payments			1,907,645 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)			1,956 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 35.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			5,094 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: 140125 Component CCN: 14T125	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part III Date/Time Prepared: 5/30/2013 4:00 pm
		Title XVIIII	Subprovider - IRF	PPS
				1.00
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)			1,072,755 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0950 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			125,406 3.00
4.00	Outlier Payments			85,270 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			3.480874 10.00
11.00	Medical Education Adjustment Factor $\{((1 + (\text{line } 9/\text{line } 10)) \text{ raised to the power of } .6876 - 1)\}$ .			0.000000 11.00
12.00	Medical Education Adjustment (line 1 multiplied by line 11).			0 12.00
13.00	Total PPS Payment (sum of lines 1, 3, 4 and 12)			1,283,431 13.00
14.00	Nursing and Allied Health Managed Care payment (see instruction)			0 14.00
15.00	Organ acquisition			0 15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 16.00
17.00	Subtotal (see instructions)			1,283,431 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			1,283,431 19.00
20.00	Deductibles			4,624 20.00
21.00	Subtotal (line 19 minus line 20)			1,278,807 21.00
22.00	Coinsurance			7,514 22.00
23.00	Subtotal (line 21 minus line 22)			1,271,293 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			2,264 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			1,585 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			2,264 26.00
27.00	Subtotal (sum of lines 23 and 25)			1,272,878 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			1,272,878 32.00
33.00	Interim payments			1,243,094 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus the sum lines 33 and 34)			29,784 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			12,980 36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4			85,270 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: 140125 Component CCN: 145562	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part VI Date/Time Prepared: 5/30/2013 4:00 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		674,044	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		674,044	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		23,409	7.00
8.00	Allowable bad debts (see instructions)		917	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		283	9.00
10.00	Allowable reimbursable bad debts (see instructions)		727	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)		651,362	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14)		651,362	15.00
16.00	Interim payments		650,635	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus the sum of lines 16 and 17)		727	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2		0	19.00

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

Provider CCN: 140125

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

Worksheet G

Date/Time Prepared:  
5/30/2013 4:00 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	-1,567,111	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	18,095,566	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,562,736	0	0	0	6.00
7.00	Inventory	2,075,995	0	0	0	7.00
8.00	Prepaid expenses	595,257	0	0	0	8.00
9.00	Other current assets	139,226	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)	14,776,197	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	2,904,596	0	0	0	12.00
13.00	Land improvements	3,192,458	0	0	0	13.00
14.00	Accumulated depreciation	-1,168,368	0	0	0	14.00
15.00	Buildings	20,647,133	0	0	0	15.00
16.00	Accumulated depreciation	-6,745,778	0	0	0	16.00
17.00	Leasehold improvements	28,963,370	0	0	0	17.00
18.00	Accumulated depreciation	-7,359,839	0	0	0	18.00
19.00	Fixed equipment	5,301,683	0	0	0	19.00
20.00	Accumulated depreciation	-1,835,050	0	0	0	20.00
21.00	Automobiles and trucks	58,595	0	0	0	21.00
22.00	Accumulated depreciation	-52,083	0	0	0	22.00
23.00	Major movable equipment	16,641,824	0	0	0	23.00
24.00	Accumulated depreciation	-8,885,007	0	0	0	24.00
25.00	Minor equipment depreciable	5,159,041	0	0	0	25.00
26.00	Accumulated depreciation	-2,016,502	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)	54,806,073	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	2,160,974	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,160,974	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	71,743,244	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	8,949,400	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,017,163	0	0	0	38.00
39.00	Payroll taxes payable	383,579	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	-3,143,997	0	0	0	43.00
44.00	Other current liabilities	1,056,815	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,262,960	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)	10,262,960	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	61,480,284				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)	61,480,284	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	71,743,244	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140125

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

Worksheet G-1

Date/Time Prepared:  
5/30/2013 4:00 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		70,002,006			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-8,521,722				2.00
3.00	Total (sum of line 1 and line 2)		61,480,284			0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0			0	10.00
11.00	Subtotal (line 3 plus line 10)		61,480,284			0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		61,480,284			0	19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140125

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/30/2013 4:00 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	127,378,261		127,378,261	1.00
2.00	SUBPROVIDER - IPF	15,393,388		15,393,388	2.00
3.00	SUBPROVIDER - IRF	3,513,861		3,513,861	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	6,154,857		6,154,857	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)	152,440,367		152,440,367	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	11,434,238		11,434,238	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)	11,434,238		11,434,238	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	163,874,605		163,874,605	17.00
18.00	Ancillary services	217,723,928	187,179,558	404,903,486	18.00
19.00	Outpatient services	28,183,463	69,511,713	97,695,176	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)	409,781,996	256,691,271	666,473,267	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		119,308,426		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		119,308,426		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140125

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

Worksheet G-3

Date/Time Prepared:  
5/30/2013 4:00 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	666,473,267	1.00
2.00	Less contractual allowances and discounts on patients' accounts	560,065,767	2.00
3.00	Net patient revenues (line 1 minus line 2)	106,407,500	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	119,308,426	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-12,900,926	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 (SPECIFY)	4,379,204	24.00
25.00	Total other income (sum of lines 6-24)	4,379,204	25.00
26.00	Total (line 5 plus line 25)	-8,521,722	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)	-8,521,722	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140125	Period: From 01/01/2012 To 12/31/2012	Worksheet L Parts I-III Date/Time Prepared: 5/30/2013 4:00 pm
		Title XVII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		972,341	1.00
2.00	Capital DRG outlier payments		25,591	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		85.99	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		11.35	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		38.52	8.00
9.00	Sum of lines 7 and 8		49.87	9.00
10.00	Allowable disproportionate share percentage (see instructions)		10.63	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		103,360	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		1,101,292	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00