

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: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet S Parts I-III Date/Time Prepared: 1/31/2013 2:42 pm
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<b>PART I - COST REPORT STATUS</b>			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 1/31/2013 Time: 2:42 pm	
	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.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WESTVIEW HOSPITAL ( 150129 ) for the cost reporting period beginning 09/01/2011 and ending 08/31/2012 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	76,981	-8,860	0	-82,609	1.00
2.00 Subprovider - IPF	0	328	0		0	2.00
3.00 Subprovider - IRF	0	-14,174	0		22,431	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0	0	0		0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0		0	11.00
12.00 CMHC I	0	0	0		0	12.00
200.00 Total	0	63,135	-8,860	0	-60,178	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: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet S-2 Part I Date/Time Prepared: 1/31/2013 2:24 pm
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1.00 Hospital and Hospital Health Care Complex Address:	2.00 Street: 3630 GUION ROAD	PO Box:	3.00 State: IN	4.00 Zip Code: 46222-	County: MARION	1.00	2.00
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Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
					V	XVIII	XIX		
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital -Based Component Identification:									
3.00 Hospital	WESTVIEW HOSPITAL	150129	26900	1	01/01/1975	N	P	O	3.00
4.00 Subprovider - IPF	GERI PSYCH	15S129	26900	4	09/01/1996	N	P	N	4.00
5.00 Subprovider - IRF	REHAB	15T129	26900	5	09/01/2004	N	P	O	5.00
6.00 Subprovider - (Other)									6.00
7.00 Swing Beds - SNF									7.00
8.00 Swing Beds - NF									8.00
9.00 Hospital -Based SNF									9.00
10.00 Hospital -Based NF									10.00
11.00 Hospital -Based OLTC									11.00
12.00 Hospital -Based HHA									12.00
13.00 Separately Certified ASC									13.00
14.00 Hospital -Based Hospice									14.00
15.00 Hospital -Based Health Clinic - RHC									15.00
16.00 Hospital -Based Health Clinic - FQHC									16.00
17.00 Hospital -Based (CMHC) I									17.00
17.10 Hospital -Based (CORF) I									17.10
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)					09/01/2011	08/31/2012	20.00	
21.00 Type of Control (see instructions)					2		21.00	

Inpatient PPS Information								
22.00 Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N	22.00	
23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					0		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	
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.	254	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	134	177	0	0	30	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: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet S-2 Part I Date/Time Prepared: 1/31/2013 2:24 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				
39.00	Does this facility qualify for the Inpatient Hospital Payment Adjustment for Low Volume Hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no.					39.00
		V	XVIII	XIX		
		1.00	2.00	3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	Y	Y			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	IME Average	Direct GME Average		
		1.00	2.00	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)	Y	4.21	4.75		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)	Y				63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
		1.00	2.00	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)	0.17	3.25	0.049708		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet S-2  
Part I  
Date/Time Prepared:  
1/31/2013 2:24 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)			1.08	3.16	0.254717	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)			0.29	5.39	0.051056	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.			2.05	3.78	0.351630	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 reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N		0		71.00
<b>Inpatient Rehabilitation Facility PPS</b>						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y				75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N		0		76.00
				1.00		
<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	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00
				1.00	2.00	3.00
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00

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

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							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.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet S-2 Part II Date/Time Prepared: 1/31/2013 2:24 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	Y			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	Y			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A			
		Description	Y/N	Date	
		0	1.00	2.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	12/12/2012		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N			20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet S-2 Part II Date/Time Prepared: 1/31/2013 2:24 pm
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		Part A		
		Description	Y/N	Date
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	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		Y	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?		N	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.		N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	40.00
				1.00
				2.00
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE	SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO. LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957	KCSMITH@BLUEANDCO.COM	43.00

		Part B		
		Y/N	Date	
		3.00	4.00	
<b>PS&amp;R Data</b>				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	12/12/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
		3.00		
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet S-3  
Part I  
Date/Time Prepared:  
1/31/2013 2:24 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours		
	Line Number					
	1.00	2.00	3.00	4.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	37	13,542	0.00		1.00
2.00 HMO						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		37	13,542	0.00		7.00
8.00 INTENSIVE CARE UNIT	31.00	5	1,830	0.00		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)		42	15,372	0.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	40.00	12	4,392			16.00
17.00 SUBPROVIDER - IRF	41.00	12	4,392			17.00
18.00 SUBPROVIDER	42.00	0	0			18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10					25.10
26.00 RURAL HEALTH CLINIC	88.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00					26.25
27.00 Total (sum of lines 14-26)		66				27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet S-3  
Part I  
Date/Time Prepared:  
1/31/2013 2:24 pm

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	2,794	221	5,223		1.00
2.00 HMO		852	28			2.00
3.00 HMO IPF Subprovider		146	0			3.00
4.00 HMO IRF Subprovider		17	207			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,794	221	5,223		7.00
8.00 INTENSIVE CARE UNIT	0	374	33	658		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	3,168	254	5,881		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF	0	2,692	0	3,067		16.00
17.00 SUBPROVIDER - IRF	0	1,554	134	2,705		17.00
18.00 SUBPROVIDER	0	0	0	0		18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0		25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0		26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	487		28.00
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				0		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			0	0		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet S-3  
Part I  
Date/Time Prepared:  
1/31/2013 2:24 pm

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	562	1.00
2.00 HMO					0	2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	11.51	432.98	0.00	0	562	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	21.56	0.00	0	230	16.00
17.00 SUBPROVIDER - IRF	0.00	23.30	0.00	0	135	17.00
18.00 SUBPROVIDER	0.00	0.00	0.00	0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00	0.00	0.00			25.10
26.00 RURAL HEALTH CLINIC	0.00	0.00	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00 Total (sum of lines 14-26)	11.51	477.84	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet S-3  
Part I  
Date/Time Prepared:  
1/31/2013 2:24 pm

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	50	1,188		1.00
2.00 HMO				2.00
3.00 HMO IPF Subprovider				3.00
4.00 HMO IRF Subprovider				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF				5.00
6.00 Hospital Adults & Peds. Swing Bed NF				6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)				7.00
8.00 INTENSIVE CARE UNIT				8.00
9.00 CORONARY CARE UNIT				9.00
10.00 BURN INTENSIVE CARE UNIT				10.00
11.00 SURGICAL INTENSIVE CARE UNIT				11.00
12.00 OTHER SPECIAL CARE (SPECIFY)				12.00
13.00 NURSERY				13.00
14.00 Total (see instructions)	50	1,188		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF	0	267		16.00
17.00 SUBPROVIDER - IRF	9	219		17.00
18.00 SUBPROVIDER	0	0		18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
25.10 CMHC - CORF				25.10
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet S-3 Part II Date/Time Prepared: 1/31/2013 2:24 pm			
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
<b>PART II - WAGE DATA</b>								
<b>SALARIES</b>								
1.00	Total salaries (see instructions)	200.00	29,427,627	600,016	30,027,643	993,915.00	30.21	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		943,400	0	943,400	9,777.00	96.49	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	4,639	600,016	604,655	25,360.00	23.84	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		13,044,658	0	13,044,658	373,077.00	34.97	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11.00	Contract labor (see instructions)		570,064	0	570,064	9,590.00	59.44	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		123,250	0	123,250	1,291.00	95.47	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Administrative		0	0	0	0.00	0.00	16.00
<b>WAGE-RELATED COSTS</b>								
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		3,989,014	0	3,989,014			17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV line 25		0	0	0			18.00
19.00	Excluded areas		2,592,051	0	2,592,051			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		89,676	0	89,676			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26.00	Employee Benefits	4.00	33,090	0	33,090	1,324.00	24.99	26.00
27.00	Administrative & General	5.00	3,134,607	0	3,134,607	115,942.00	27.04	27.00
28.00	Administrative & General under contract (see inst.)		910,358	0	910,358	12,103.00	75.22	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	496,351	0	496,351	8,634.00	57.49	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	245,703	0	245,703	21,951.00	11.19	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	506,814	-349,115	157,699	9,468.00	16.66	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	349,115	349,115	20,959.00	16.66	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	575,115	0	575,115	15,617.00	36.83	38.00
39.00	Central Services and Supply	14.00	41,223	0	41,223	2,606.00	15.82	39.00
40.00	Pharmacy	15.00	99,236	0	99,236	6,777.00	14.64	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet S-3  
Part II  
Date/Time Prepared:  
1/31/2013 2:24 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjus ted 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	
41.00	Medical Records & Medical Records Library	16.00 715,537	0	715,537	38,477.00	18.60	41.00
42.00	Social Service	17.00 0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet S-3  
Part III  
Date/Time Prepared:  
1/31/2013 2:24 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adj uste d Sal ari es (col . 2 ± col . 3)	Pai d Hours Rel ated 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	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	29,389,946	0	29,389,946	970,881.00	30.27	1.00
2.00	Excluded area salaries (see instructions)	13,044,658	0	13,044,658	373,077.00	34.97	2.00
3.00	Subtotal salaries (line 1 minus line 2)	16,345,288	0	16,345,288	597,804.00	27.34	3.00
4.00	Subtotal other wages & related costs (see inst.)	693,314	0	693,314	10,881.00	63.72	4.00
5.00	Subtotal wage-related costs (see inst.)	3,989,014	0	3,989,014	0.00	24.40	5.00
6.00	Total (sum of lines 3 thru 5)	21,027,616	0	21,027,616	608,685.00	34.55	6.00
7.00	Total overhead cost (see instructions)	6,758,034	0	6,758,034	253,858.00	26.62	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet S-3 Part IV Date/Time Prepared: 1/31/2013 2:24 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			0 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		982,467	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)		3,410,907	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		95	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		122,275	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		21,066	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		2,022,675	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		70,325	19.00
20.00	State or Federal Unemployment Taxes		0	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		40,929	23.00
24.00	<b>Total Wage Related cost (Sum of lines 1 -23)</b>		<b>6,670,739</b>	<b>24.00</b>
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet S-3  
Part V  
Date/Time Prepared:  
1/31/2013 2:24 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	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			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	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet S-10 Date/Time Prepared: 1/31/2013 2:24 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)		0.247563	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		2,671,288	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		9,481,379	6.00	
7.00	Medicaid cost (line 1 times line 6)		2,347,239	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	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00	
			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	2,147,112	0	2,147,112	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	531,545	0	531,545	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	531,545	0	531,545	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)		7,067,323	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		63,077	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		7,004,246	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		1,733,992	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		2,265,537	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,265,537	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 150129		Period: From 09/01/2011 To 08/31/2012		Worksheet A	
Date/Time Prepared: 1/31/2013 2:24 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 NEW CAP REL COSTS-BLDG & FIXT		2,239,053	2,239,053	132,705	2,371,758	1.00	
4.00 00400 EMPLOYEE BENEFITS	33,090	6,718,917	6,752,007	113,755	6,865,762	4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	3,134,607	7,409,840	10,544,447	-182,210	10,362,237	5.00	
7.00 00700 OPERATION OF PLANT	496,351	1,202,465	1,698,816	50,771	1,749,587	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	0	155,783	155,783	0	155,783	8.00	
9.00 00900 HOUSEKEEPING	245,703	128,071	373,774	0	373,774	9.00	
10.00 01000 DIETARY	506,814	430,168	936,982	-645,432	291,550	10.00	
11.00 01100 CAFETERIA	0	0	0	645,432	645,432	11.00	
13.00 01300 NURSING ADMINISTRATION	575,115	15,204	590,319	0	590,319	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	41,223	18,883	60,106	0	60,106	14.00	
15.00 01500 PHARMACY	99,236	2,654,869	2,754,105	0	2,754,105	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	715,537	102,698	818,235	0	818,235	16.00	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	4,639	702,482	707,121	-204,630	502,491	21.00	
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	204,630	204,630	22.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	2,331,476	479,857	2,811,333	0	2,811,333	30.00	
31.00 03100 INTENSIVE CARE UNIT	752,878	312,546	1,065,424	0	1,065,424	31.00	
40.00 04000 SUBPROVIDER - IPF	1,079,292	94,566	1,173,858	0	1,173,858	40.00	
41.00 04100 SUBPROVIDER - IRF	1,094,194	384,124	1,478,318	0	1,478,318	41.00	
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	1,586,874	879,025	2,465,899	0	2,465,899	50.00	
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	667,716	107,672	775,388	0	775,388	54.00	
57.00 05700 CT SCAN	62,228	195,439	257,667	0	257,667	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	76,969	135,164	212,133	0	212,133	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00 06000 LABORATORY	836,475	1,736,347	2,572,822	0	2,572,822	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01	
65.00 06500 RESPIRATORY THERAPY	465,668	51,076	516,744	0	516,744	65.00	
66.00 06600 PHYSICAL THERAPY	1,006,202	170,304	1,176,506	-293,860	882,646	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	229,391	229,391	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0	0	64,469	64,469	68.00	
69.00 06900 ELECTROCARDIOLOGY	441,196	43,095	484,291	0	484,291	69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,937,694	2,937,694	-1,486,679	1,451,015	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,486,679	1,486,679	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	84,980	84,980	0	84,980	73.00	
76.00 03020 ONCOLOGY	143,568	6,761	150,329	0	150,329	76.00	
76.01 03021 WOUND CARE CENTER	268,850	25,432	294,282	0	294,282	76.01	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00	
90.00 09000 CLINIC	0	0	0	0	0	90.00	
91.00 09100 EMERGENCY	1,890,554	71,622	1,962,176	0	1,962,176	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10 09910 CORF	0	0	0	0	0	99.10	
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00	
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00	
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	18,556,455	29,494,137	48,050,592	115,021	48,165,613	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00 19200 PHYSICIANS' PRIVATE OFFICES	10,871,172	4,858,465	15,729,637	-115,021	15,614,616	192.00	
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	50,637	50,637	0	50,637	194.00	
200.00	TOTAL (SUM OF LINES 118-199)	29,427,627	34,403,239	63,830,866	0	63,830,866	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet A  
Date/Time Prepared:  
1/31/2013 2:24 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 NEW CAP REL COSTS-BLDG & FIXT	-253,954	2,117,804	1.00
4.00	00400 EMPLOYEE BENEFITS	0	6,865,762	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-4,458,528	5,903,709	5.00
7.00	00700 OPERATION OF PLANT	-124,465	1,625,122	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	155,783	8.00
9.00	00900 HOUSEKEEPING	0	373,774	9.00
10.00	01000 DIETARY	0	291,550	10.00
11.00	01100 CAFETERIA	-214,120	431,312	11.00
13.00	01300 NURSING ADMINISTRATION	0	590,319	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	60,106	14.00
15.00	01500 PHARMACY	-843	2,753,262	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-20,656	797,579	16.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	502,491	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	204,630	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS	0	2,811,333	30.00
31.00	03100 INTENSIVE CARE UNIT	-6,515	1,058,909	31.00
40.00	04000 SUBPROVIDER - I/PF	-11,362	1,162,496	40.00
41.00	04100 SUBPROVIDER - I/RF	0	1,478,318	41.00
42.00	04200 SUBPROVIDER	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	-582,232	1,883,667	50.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,789	781,177	54.00
57.00	05700 CT SCAN	0	257,667	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	212,133	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	-37,912	2,534,910	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	516,744	65.00
66.00	06600 PHYSICAL THERAPY	-44,018	838,628	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	229,391	67.00
68.00	06800 SPEECH PATHOLOGY	0	64,469	68.00
69.00	06900 ELECTROCARDIOLOGY	0	484,291	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,451,015	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1,486,679	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	84,980	73.00
76.00	03020 ONCOLOGY	-3,447	146,882	76.00
76.01	03021 WOUND CARE CENTER	-305	293,977	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	-943,400	1,018,776	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	09910 CORF	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
109.00	10900 PANCREAS ACQUISITION	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-6,695,968	41,469,645	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
192.00	19200 PHYSICIANS' PRIVATE OFFICES	-71,443	15,543,173	192.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	50,637	194.00
200.00	TOTAL (SUM OF LINES 118-199)	-6,767,411	57,063,455	200.00

RECLASSIFICATIONS

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet A-6

Date/Time Prepared:  
1/31/2013 2:24 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
<b>A - CAFETERIA</b>						
1.00	CAFETERIA	11.00	349,115	296,317		1.00
	TOTALS		349,115	296,317		
<b>B - INSURANCE</b>						
1.00	EMPLOYEE BENEFITS	4.00	0	113,755		1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	68,455		2.00
	TOTALS		0	182,210		
<b>C - THERAPY</b>						
1.00	OCCUPATIONAL THERAPY	67.00	200,031	29,360		1.00
2.00	SPEECH PATHOLOGY	68.00	50,122	14,347		2.00
	TOTALS		250,153	43,707		
<b>D - POB</b>						
1.00	OPERATION OF PLANT	7.00	0	50,771		1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	64,250		2.00
	TOTALS		0	115,021		
<b>E - TEACHING</b>						
1.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	204,630		1.00
	TOTALS		0	204,630		
<b>F - IMPLANTABLE DEVICES</b>						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,486,679		1.00
	TOTALS		0	1,486,679		
<b>G - INTERNS AND RESIDENCE</b>						
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	600,016	0		1.00
	TOTALS		600,016	0		
500.00	Grand Total: Increases		1,199,284	2,328,564		500.00

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - CAFETERIA</b>							
1.00	DIETARY	10.00	349,115	296,317	0		1.00
	TOTALS		349,115	296,317			
<b>B - INSURANCE</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	182,210	0		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	182,210			
<b>C - THERAPY</b>							
1.00	PHYSICAL THERAPY	66.00	250,153	43,707	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		250,153	43,707			
<b>D - POB</b>							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	115,021	0		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	115,021			
<b>E - TEACHING</b>							
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	0	204,630	0		1.00
	TOTALS		0	204,630			
<b>F - IMPLANTABLE DEVICES</b>							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,486,679	0		1.00
	TOTALS		0	1,486,679			
<b>G - INTERNS AND RESIDENCE</b>							
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	0	600,016	0		1.00
	TOTALS		0	600,016			
500.00	Grand Total: Decreases		599,268	2,928,580			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
1/31/2013 2:24 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	2,926,819	6,200	0	6,200	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	27,370,105	1,982,623	0	1,982,623	713,735	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	19,192,400	1,762,349	0	1,762,349	523,438	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	49,489,324	3,751,172	0	3,751,172	1,237,173	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	49,489,324	3,751,172	0	3,751,172	1,237,173	10.00
<b>SUMMARY OF CAPITAL</b>							
Cost Center Description		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,658,364	0	304,864	0	0	1.00
3.00	Total (sum of lines 1-2)	1,658,364	0	304,864	0	0	3.00
<b>COMPUTATION OF RATIOS</b>							
Cost Center Description		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	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	52,003,322	0	52,003,322	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	52,003,322	0	52,003,322	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet A-7  
Parts I-III  
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		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	2,933,019	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	28,638,993	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	20,431,311	0			5.00
6.00	Movable Equipment	0	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	52,003,323	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	52,003,323	0			10.00
<b>SUMMARY OF CAPITAL</b>						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	275,825	2,239,053			1.00
3.00	Total (sum of lines 1-2)	275,825	2,239,053			3.00
<b>ALLOCATION OF OTHER CAPITAL</b>						
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,658,446	0 1.00
3.00	Total (sum of lines 1-2)	0	0	0	1,658,446	0 3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
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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	NEW CAP REL COSTS-BLDG & FIXT	115,078	68,455	0	275,825	2,117,804	1.00
3.00	Total (sum of lines 1-2)	115,078	68,455	0	275,825	2,117,804	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet A-8

Date/Time Prepared:  
1/31/2013 2:24 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	
			Cost Center	Line #
			1.00	2.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-5,583	NEW CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00 2.00
3.00 Investment income - other (chapter 2)		0		0.00 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00 7.00
8.00 Television and radio service (chapter 21)		0		0.00 8.00
9.00 Parking lot (chapter 21)		0		0.00 9.00
10.00 Provider-based physician adjustment	A-8-2	-1,067,866		10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-106,466		12.00
13.00 Laundry and linen service		0		0.00 13.00
14.00 Cafeteria-employees and guests		0		0.00 14.00
15.00 Rental of quarters to employee and others		0		0.00 15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00 16.00
17.00 Sale of drugs to other than patients		0		0.00 17.00
18.00 Sale of medical records and abstracts	B	-20,656	MEDICAL RECORDS & LIBRARY	16.00 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00 19.00
20.00 Vending machines		0		0.00 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		ORESPIRATORY THERAPY	65.00 23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY	66.00 24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00 25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00 27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00 28.00
29.00 Physicians' assistant		0		0.00 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00 30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY	68.00 31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00 32.00
33.00 DONATED ASSETS	A	-548,035	ADMINISTRATIVE & GENERAL	5.00 33.00
34.00 HAF PROGRAM	A	-3,106,623	ADMINISTRATIVE & GENERAL	5.00 34.00
35.00 INTEREST INCOME ON LOAN TO HII	B	-214,953	NEW CAP REL COSTS-BLDG & FIXT	1.00 35.00
36.00 MISCELLANEOUS INCOME - A&G	B	-126,244	ADMINISTRATIVE & GENERAL	5.00 36.00
37.00 MISC REVENUE	B	-49,514	ADMINISTRATIVE & GENERAL	5.00 37.00
38.00 MISCELLANEOUS INCOME - PLANT	B	-124,465	OPERATION OF PLANT	7.00 38.00
39.00 MISCELLANEOUS INCOME MISC	B	-2,481	CAFETERIA	11.00 39.00
40.00 CAFETERIA REVENUE	B	-181,195	CAFETERIA	11.00 40.00
41.00 MEALS ON WHEELS	B	-30,444	CAFETERIA	11.00 41.00
42.00 MISCELLANEOUS INCOME - PHARMACY	B	-843	PHARMACY	15.00 42.00
43.00 MISCELLANEOUS INCOME - RADIOLOGY	B	-1,110	RADIOLOGY-DIAGNOSTIC	54.00 43.00
44.00 MISCELLANEOUS INCOME - LAB	B	-22,312	LABORATORY	60.00 44.00
45.00 HEALTHPLEX SUBSIDY	A	-1,070	ADMINISTRATIVE & GENERAL	5.00 45.00
45.01 ADVERTISING	A	-537,303	ADMINISTRATIVE & GENERAL	5.00 45.01
45.02 ADVERTISING	A	-1,151	PHYSICAL THERAPY	66.00 45.02
45.03 ADVERTISING	A	-3,447	ONCOLOGY	76.00 45.03
45.04 PHYSICIAN COVERAGE ADJ	A	-33,500	NEW CAP REL COSTS-BLDG & FIXT	1.00 45.04
45.05 ANESTHESIA COVERAGE	A	-582,232	OPERATING ROOM	50.00 45.05

Provider CCN: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet A-8 Date/Time Prepared: 1/31/2013 2:24 pm
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #
			Cost Center	Line #	
	1.00	2.00	3.00	4.00	
45.06 1992 AHA LIVES	A	82	NEW CAP REL COSTS-BLDG & FIXT	1.00	45.06
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,767,411			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet A-8

Date/Time Prepared:  
1/31/2013 2:24 pm

Cost Center Description	Wkst. A-7 Ref.	
	5.00	
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	11	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00 Investment income - other (chapter 2)	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00 Television and radio service (chapter 21)	0	8.00
9.00 Parking lot (chapter 21)	0	9.00
10.00 Provider-based physician adjustment	0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00 Related organization transactions (chapter 10)	0	12.00
13.00 Laundry and linen service	0	13.00
14.00 Cafeteria-employees and guests	0	14.00
15.00 Rental of quarters to employee and others	0	15.00
16.00 Sale of medical and surgical supplies to other than patients	0	16.00
17.00 Sale of drugs to other than patients	0	17.00
18.00 Sale of medical records and abstracts	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)	0	19.00
20.00 Vending machines	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00 Non-physician Anesthetist		28.00
29.00 Physicians' assistant	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00 DONATED ASSETS	0	33.00
34.00 HAF PROGRAM	0	34.00
35.00 INTEREST INCOME ON LOAN TO HII	11	35.00
36.00 MISCELLANEOUS INCOME - A&G	0	36.00
37.00 MISC REVENUE	0	37.00
38.00 MISCELLANEOUS INCOME - PLANT	0	38.00
39.00 MISCELLANEOUS INCOME MISC	0	39.00
40.00 CAFETERIA REVENUE	0	40.00
41.00 MEALS ON WHEELS	0	41.00
42.00 MISCELLANEOUS INCOME - PHARMACY	0	42.00
43.00 MISCELLANEOUS INCOME - RADIOLOGY	0	43.00
44.00 MISCELLANEOUS INCOME - LAB	0	44.00
45.00 HEALTHPLEX SUBSIDY	0	45.00
45.01 ADVERTISING	0	45.01
45.02 ADVERTISING	0	45.02
45.03 ADVERTISING	0	45.03
45.04 PHYSICIAN COVERAGE ADJ	11	45.04
45.05 ANESTHESIA COVERAGE	0	45.05
45.06 1992 AHA LIVES	9	45.06
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

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

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet A-8-1

Date/Time Prepared:  
1/31/2013 2:24 pm

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	54.00	RADIOLOGY-DIAGNOSTIC	RADIOLOGY	1.00
2.00	66.00	PHYSICAL THERAPY	PT	2.00
3.00	192.00	PHYSICIANS' PRIVATE OFFICES	INTEGRATED MEDICINE	3.00
4.00	0.00			4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5.00

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

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

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

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

6.00	B		70.00	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:			100.00

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

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

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

Provider CCN: 150129

Period: From 09/01/2011 To 08/31/2012

Worksheet A-8-1

Date/Time Prepared: 1/31/2013 2:24 pm

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	39,988	33,089	6,899	0	1.00
2.00	76,543	118,465	-41,922	0	2.00
3.00	145,208	216,651	-71,443	0	3.00
4.00	0	0	0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				5.00
	261,739	368,205	-106,466		

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

Related Organization(s) and/or Home Office			
Name	Percentage of Ownership	Type of Business	
	5.00	6.00	
<b>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>			

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet A-8-2

Date/Time Prepared:  
1/31/2013 2:24 pm

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		5.00	ADMINISTRATIVE & GENERAL	94,254	87,854	1.00
2.00		31.00	INTENSIVE CARE UNIT	44,000	0	2.00
3.00		40.00	SUBPROVIDER - IPF	61,000	0	3.00
4.00		60.00	LABORATORY	15,600	15,600	4.00
5.00		66.00	PHYSICAL THERAPY	11,850	0	5.00
6.00		76.01	WOUND CARE CENTER	305	305	6.00
7.00		91.00	EMERGENCY	943,400	943,400	7.00
8.00		0.00		0	0	8.00
9.00		0.00		0	0	9.00
10.00		0.00		0	0	10.00
200.00				1,170,409	1,047,159	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet A-8-2

Date/Time Prepared:  
1/31/2013 2:24 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	6,400	177,200	53	4,515	226	1.00
2.00	44,000	177,200	440	37,485	1,874	2.00
3.00	61,000	154,100	670	49,638	2,482	3.00
4.00	0	215,700	0	0	0	4.00
5.00	11,850	177,200	128	10,905	545	5.00
6.00	0	177,200	0	0	0	6.00
7.00	0	177,200	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	123,250		1,291	102,543	5,127	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet A-8-2

Date/Time Prepared:  
1/31/2013 2:24 pm

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 16.00	
1.00	0	0	0	0	4,515	1.00
2.00	0	0	0	0	37,485	2.00
3.00	0	0	0	0	49,638	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	10,905	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	0	0	0	0	102,543	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet A-8-2

Date/Time Prepared:  
1/31/2013 2:24 pm

	RCE	Adjustment	
	Disallowance	18.00	
1.00	1,885	89,739	1.00
2.00	6,515	6,515	2.00
3.00	11,362	11,362	3.00
4.00	0	15,600	4.00
5.00	945	945	5.00
6.00	0	305	6.00
7.00	0	943,400	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	20,707	1,067,866	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet B  
Part I  
Date/Time Prepared:  
1/31/2013 2:24 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	2,117,804	2,117,804				1.00
4.00 00400	EMPLOYEE BENEFITS	6,865,762	0	6,865,762			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	5,903,709	560,030	717,512	7,181,251	7,181,251	5.00
7.00 00700	OPERATION OF PLANT	1,625,122	159,934	113,615	1,898,671	273,340	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	155,783	2,251	0	158,034	22,751	8.00
9.00 00900	HOUSEKEEPING	373,774	19,350	56,241	449,365	64,692	9.00
10.00 01000	DIETARY	291,550	38,821	36,097	366,468	52,758	10.00
11.00 01100	CAFETERIA	431,312	13,400	79,912	524,624	75,527	11.00
13.00 01300	NURSING ADMINISTRATION	590,319	13,735	131,644	735,698	105,914	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	60,106	27,859	9,436	97,401	14,022	14.00
15.00 01500	PHARMACY	2,753,262	15,183	22,715	2,791,160	401,827	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	797,579	32,965	163,786	994,330	143,148	16.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	502,491	4,771	138,406	645,668	92,953	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	204,630	0	0	204,630	29,459	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	2,811,333	259,727	533,675	3,604,735	518,952	30.00
31.00 03100	INTENSIVE CARE UNIT	1,058,909	38,339	172,334	1,269,582	182,774	31.00
40.00 04000	SUBPROVIDER - I PF	1,162,496	91,217	247,050	1,500,763	216,056	40.00
41.00 04100	SUBPROVIDER - I RF	1,478,318	96,765	250,461	1,825,544	262,813	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	1,883,667	222,675	363,235	2,469,577	355,530	50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	781,177	199,720	152,840	1,133,737	163,217	54.00
57.00 05700	CT SCAN	257,667	0	14,244	271,911	39,145	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	212,133	0	17,618	229,751	33,076	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	2,534,910	48,778	191,469	2,775,157	399,523	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	516,744	11,900	106,591	635,235	91,451	65.00
66.00 06600	PHYSICAL THERAPY	838,628	112,068	173,060	1,123,756	161,780	66.00
67.00 06700	OCCUPATIONAL THERAPY	229,391	0	45,787	275,178	39,616	67.00
68.00 06800	SPEECH PATHOLOGY	64,469	0	11,473	75,942	10,933	68.00
69.00 06900	ELECTROCARDIOLOGY	484,291	15,102	100,990	600,383	86,434	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,451,015	0	0	1,451,015	208,894	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	1,486,679	0	0	1,486,679	214,028	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	84,980	0	0	84,980	12,234	73.00
76.00 03020	ONCOLOGY	146,882	16,885	32,863	196,630	28,308	76.00
76.01 03021	WOUND CARE CENTER	293,977	68,342	61,540	423,859	61,020	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	0	0	0	0	0	90.00
91.00 09100	EMERGENCY	1,018,776	47,987	432,748	1,499,511	215,876	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10 09910	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	41,469,645	2,117,804	4,377,342	38,981,225	4,578,051	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00 19200	PHYSICIANS' PRIVATE OFFICES	15,543,173	0	2,488,420	18,031,593	2,595,910	192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	50,637	0	0	50,637	7,290	194.00
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	57,063,455	2,117,804	6,865,762	57,063,455	7,181,251	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150129

Period: From 09/01/2011 To 08/31/2012

Worksheet B Part I Date/Time Prepared: 1/31/2013 2:24 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	2,172,011				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,498	184,283			8.00
9.00	00900	HOUSEKEEPING	30,067	0	544,124		9.00
10.00	01000	DIETARY	60,321	0	15,349	494,896	10.00
11.00	01100	CAFETERIA	20,822	0	5,298	0	626,271
13.00	01300	NURSING ADMINISTRATION	21,343	0	5,431	0	18,207
14.00	01400	CENTRAL SERVICES & SUPPLY	43,289	4,008	11,015	0	3,038
15.00	01500	PHARMACY	23,591	0	6,003	0	7,901
16.00	01600	MEDICAL RECORDS & LIBRARY	51,222	0	13,033	0	44,857
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	7,413	0	1,886	0	29,565
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	403,574	51,651	102,689	221,824	111,791
31.00	03100	INTENSIVE CARE UNIT	59,572	9,395	15,158	27,944	24,326
40.00	04000	SUBPROVIDER - I/PF	141,736	23,389	36,064	130,254	52,291
41.00	04100	SUBPROVIDER - I/RF	150,356	19,329	38,258	114,874	56,490
42.00	04200	SUBPROVIDER	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	346,000	35,096	88,039	0	66,154
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	310,332	10,226	78,963	0	30,711
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	75,792	0	19,285	0	41,116
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	18,490	0	4,705	0	19,861
66.00	06600	PHYSICAL THERAPY	174,135	0	44,308	0	29,537
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	7,479
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1,873
69.00	06900	ELECTROCARDIOLOGY	23,466	4,254	5,971	0	18,090
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	ONCOLOGY	26,236	3,489	6,676	0	4,586
76.01	03021	WOUND CARE CENTER	106,192	569	27,020	0	11,109
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	74,564	22,877	18,973	0	47,289
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,172,011	184,283	544,124	494,896	626,271
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	2,172,011	184,283	544,124	494,896	626,271

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet B  
Part I  
Date/Time Prepared:  
1/31/2013 2:24 pm

Cost Center Description		NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
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	886,593				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	172,773			14.00
15.00	01500 PHARMACY	0	0	3,230,482		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	1,246,590	16.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS	276,590	368	0	207,189	30.00
31.00	03100 INTENSIVE CARE UNIT	60,186	66	0	82,151	31.00
40.00	04000 SUBPROVIDER - I/PF	129,377	2	0	233,874	40.00
41.00	04100 SUBPROVIDER - I/RF	139,764	27	0	111,322	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	163,676	365	0	348,277	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	45	0	0	54.00
57.00	05700 CT SCAN	0	34	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	60.01
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 PATIENTS	0	171,368	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	3,230,482	0	73.00
76.00	03020 ONCOLOGY	0	90	0	0	76.00
76.01	03021 WOUND CARE CENTER	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	90.00
91.00	09100 EMERGENCY	117,000	408	0	263,777	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	09910 CORF	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	886,593	172,773	3,230,482	1,246,590	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	886,593	172,773	3,230,482	1,246,590	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet B  
Part I  
Date/Time Prepared:  
1/31/2013 2:24 pm

Cost Center Description	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS					
	21.00	22.00					24.00
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00	
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	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	777,485					21.00	
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	234,089				22.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	359,807	108,330	5,967,500	-468,137	5,499,363	30.00	
31.00 03100 INTENSIVE CARE UNIT	20,129	6,061	1,757,344	-26,190	1,731,154	31.00	
40.00 04000 SUBPROVIDER - IPF	10,065	3,030	2,476,901	-13,095	2,463,806	40.00	
41.00 04100 SUBPROVIDER - IRF	0	0	2,718,777	0	2,718,777	41.00	
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	95,613	28,788	3,997,115	-124,401	3,872,714	50.00	
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	1,727,231	0	1,727,231	54.00	
57.00 05700 CT SCAN	2,516	758	314,364	-3,274	311,090	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	262,827	0	262,827	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00 06000 LABORATORY	2,516	758	3,314,147	-3,274	3,310,873	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01	
65.00 06500 RESPIRATORY THERAPY	0	0	769,742	0	769,742	65.00	
66.00 06600 PHYSICAL THERAPY	20,129	6,061	1,559,706	-26,190	1,533,516	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0	0	322,273	0	322,273	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0	88,748	0	88,748	68.00	
69.00 06900 ELECTROCARDIOLOGY	0	0	738,598	0	738,598	69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,831,277	0	1,831,277	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1,700,707	0	1,700,707	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	3,327,696	0	3,327,696	73.00	
76.00 03020 ONCOLOGY	0	0	266,015	0	266,015	76.00	
76.01 03021 WOUND CARE CENTER	7,548	2,273	639,590	-9,821	629,769	76.01	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00	
90.00 09000 CLINIC	0	0	0	0	0	90.00	
91.00 09100 EMERGENCY	105,678	31,818	2,397,771	-137,496	2,260,275	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10 09910 CORF	0	0	0	0	0	99.10	
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00	
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00	
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	624,001	187,877	36,178,329	-811,878	35,366,451	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00 19200 PHYSICIANS' PRIVATE OFFICES	153,484	46,212	20,827,199	-199,696	20,627,503	192.00	
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	57,927	0	57,927	194.00	
200.00	Cross Foot Adjustments	0	0	0	0	200.00	
201.00	Negative Cost Centers	0	0	0	0	201.00	
202.00	TOTAL (sum lines 118-201)	777,485	234,089	57,063,455	-1,011,574	56,051,881	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet B  
Part II  
Date/Time Prepared:  
1/31/2013 2:24 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS	0	0	0	0		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	560,030	560,030	0	560,030	5.00
7.00 00700	OPERATION OF PLANT	0	159,934	159,934	0	21,316	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	2,251	2,251	0	1,774	8.00
9.00 00900	HOUSEKEEPING	0	19,350	19,350	0	5,045	9.00
10.00 01000	DIETARY	0	38,821	38,821	0	4,114	10.00
11.00 01100	CAFETERIA	0	13,400	13,400	0	5,890	11.00
13.00 01300	NURSING ADMINISTRATION	0	13,735	13,735	0	8,260	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	27,859	27,859	0	1,094	14.00
15.00 01500	PHARMACY	0	15,183	15,183	0	31,336	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	32,965	32,965	0	11,163	16.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	4,771	4,771	0	7,249	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	2,297	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	0	259,727	259,727	0	40,470	30.00
31.00 03100	INTENSIVE CARE UNIT	0	38,339	38,339	0	14,254	31.00
40.00 04000	SUBPROVIDER - I PF	0	91,217	91,217	0	16,849	40.00
41.00 04100	SUBPROVIDER - I RF	0	96,765	96,765	0	20,495	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	0	222,675	222,675	0	27,726	50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	199,720	199,720	0	12,728	54.00
57.00 05700	CT SCAN	0	0	0	0	3,053	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	2,579	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	0	48,778	48,778	0	31,157	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0	11,900	11,900	0	7,132	65.00
66.00 06600	PHYSICAL THERAPY	0	112,068	112,068	0	12,616	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	3,089	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	853	68.00
69.00 06900	ELECTROCARDIOLOGY	0	15,102	15,102	0	6,740	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	16,291	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	16,691	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	954	73.00
76.00 03020	ONCOLOGY	0	16,885	16,885	0	2,208	76.00
76.01 03021	WOUND CARE CENTER	0	68,342	68,342	0	4,759	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	0	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	47,987	47,987	0	16,835	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10 09910	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,117,804	2,117,804	0	357,017	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	202,444	192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	569	194.00
200.00	Cross Foot Adjustments			0			200.00
201.00	Negative Cost Centers			0			201.00
202.00	TOTAL (sum lines 118-201)	0	2,117,804	2,117,804	0	560,030	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet B  
Part II  
Date/Time Prepared:  
1/31/2013 2:24 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	181,250				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	292	4,317			8.00
9.00	00900	HOUSEKEEPING	2,509	0	26,904		9.00
10.00	01000	DIETARY	5,034	0	759	48,728	10.00
11.00	01100	CAFETERIA	1,738	0	262	0	21,290
13.00	01300	NURSING ADMINISTRATION	1,781	0	269	0	619
14.00	01400	CENTRAL SERVICES & SUPPLY	3,612	94	545	0	103
15.00	01500	PHARMACY	1,969	0	297	0	269
16.00	01600	MEDICAL RECORDS & LIBRARY	4,274	0	644	0	1,525
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	619	0	93	0	1,005
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	33,676	1,209	5,077	21,841	3,799
31.00	03100	INTENSIVE CARE UNIT	4,971	220	749	2,751	827
40.00	04000	SUBPROVIDER - IPF	11,828	548	1,783	12,825	1,778
41.00	04100	SUBPROVIDER - IRF	12,547	453	1,892	11,311	1,920
42.00	04200	SUBPROVIDER	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	28,873	822	4,353	0	2,249
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,897	240	3,904	0	1,044
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	6,325	0	954	0	1,398
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,543	0	233	0	675
66.00	06600	PHYSICAL THERAPY	14,531	0	2,191	0	1,004
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	254
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	64
69.00	06900	ELECTROCARDIOLOGY	1,958	100	295	0	615
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	ONCOLOGY	2,189	82	330	0	156
76.01	03021	WOUND CARE CENTER	8,862	13	1,336	0	378
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	6,222	536	938	0	1,608
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	181,250	4,317	26,904	48,728	21,290
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	181,250	4,317	26,904	48,728	21,290

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet B  
Part II  
Date/Time Prepared:  
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Cost Center Description		NURSING	CENTRAL	PHARMACY	MEDICAL		
		ADMINISTRATIVE	SERVICES & SUPPLY		RECORDS & LIBRARY		
		13.00	14.00	15.00	16.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
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	24,664					13.00
14.00	01400	0	33,307				14.00
15.00	01500	0	0	49,054			15.00
16.00	01600	0	0	0	50,571		16.00
21.00	02100	0	0	0	0		21.00
22.00	02200	0	0	0	0		22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	7,695	71	0	8,406		30.00
31.00	03100	1,674	13	0	3,333		31.00
40.00	04000	3,599	0	0	9,489		40.00
41.00	04100	3,888	5	0	4,517		41.00
42.00	04200	0	0	0	0		42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	4,553	70	0	14,124		50.00
53.00	05300	0	0	0	0		53.00
54.00	05400	0	9	0	0		54.00
57.00	05700	0	7	0	0		57.00
58.00	05800	0	0	0	0		58.00
59.00	05900	0	0	0	0		59.00
60.00	06000	0	0	0	0		60.00
60.01	06001	0	0	0	0		60.01
65.00	06500	0	0	0	0		65.00
66.00	06600	0	0	0	0		66.00
67.00	06700	0	0	0	0		67.00
68.00	06800	0	0	0	0		68.00
69.00	06900	0	0	0	0		69.00
71.00	07100	0	33,036	0	0		71.00
72.00	07200	0	0	0	0		72.00
73.00	07300	0	0	49,054	0		73.00
76.00	03020	0	17	0	0		76.00
76.01	03021	0	0	0	0		76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0		88.00
89.00	08900	0	0	0	0		89.00
90.00	09000	0	0	0	0		90.00
91.00	09100	3,255	79	0	10,702		91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0		99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0		109.00
110.00	11000	0	0	0	0		110.00
111.00	11100	0	0	0	0		111.00
118.00		24,664	33,307	49,054	50,571		118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	0	0	0	0		192.00
194.00	07950	0	0	0	0		194.00
200.00							200.00
201.00		0	0	0	0		201.00
202.00		24,664	33,307	49,054	50,571		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet B  
Part II  
Date/Time Prepared:  
1/31/2013 2:24 pm

Cost Center Description		INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
		SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS			
		21.00	22.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
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
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	13,737			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		2,297		22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS		381,971	0	381,971 30.00
31.00	03100	INTENSIVE CARE UNIT		67,131	0	67,131 31.00
40.00	04000	SUBPROVIDER - IPF		149,916	0	149,916 40.00
41.00	04100	SUBPROVIDER - IRF		153,793	0	153,793 41.00
42.00	04200	SUBPROVIDER		0	0	0 42.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM		305,445	0	305,445 50.00
53.00	05300	ANESTHESIOLOGY		0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		243,542	0	243,542 54.00
57.00	05700	CT SCAN		3,060	0	3,060 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		2,579	0	2,579 58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0 59.00
60.00	06000	LABORATORY		88,612	0	88,612 60.00
60.01	06001	BLOOD LABORATORY		0	0	0 60.01
65.00	06500	RESPIRATORY THERAPY		21,483	0	21,483 65.00
66.00	06600	PHYSICAL THERAPY		142,410	0	142,410 66.00
67.00	06700	OCCUPATIONAL THERAPY		3,343	0	3,343 67.00
68.00	06800	SPEECH PATHOLOGY		917	0	917 68.00
69.00	06900	ELECTROCARDIOLOGY		24,810	0	24,810 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		49,327	0	49,327 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		16,691	0	16,691 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		50,008	0	50,008 73.00
76.00	03020	ONCOLOGY		21,867	0	21,867 76.00
76.01	03021	WOUND CARE CENTER		83,690	0	83,690 76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC		0	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0 89.00
90.00	09000	CLINIC		0	0	0 90.00
91.00	09100	EMERGENCY		88,162	0	88,162 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	09910	CORF		0	0	0 99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00	10900	PANCREAS ACQUISITION		0	0	0 109.00
110.00	11000	INTESTINAL ACQUISITION		0	0	0 110.00
111.00	11100	ISLET ACQUISITION		0	0	0 111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	1,898,757	1,898,757 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00	19200	PHYSICIANS' PRIVATE OFFICES		202,444	0	202,444 192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS		569	0	569 194.00
200.00		Cross Foot Adjustments	13,737	2,297	16,034	16,034 200.00
201.00		Negative Cost Centers	0	0	0	0 201.00
202.00		TOTAL (sum lines 118-201)	13,737	2,297	2,117,804	2,117,804 202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet B-1

Date/Time Prepared:  
1/31/2013 2:24 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)						
	1.00	4.00					
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	158,040					1.00
4.00 00400	EMPLOYEE BENEFITS	0	29,994,553				4.00
5.00 00500	ADMINISTRATIVE & GENERAL	41,792	3,134,607	-7,181,251	49,882,204		5.00
7.00 00700	OPERATION OF PLANT	11,935	496,351	0	1,898,671	104,313	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	168	0	0	158,034	168	8.00
9.00 00900	HOUSEKEEPING	1,444	245,703	0	449,365	1,444	9.00
10.00 01000	DIETARY	2,897	157,699	0	366,468	2,897	10.00
11.00 01100	CAFETERIA	1,000	349,115	0	524,624	1,000	11.00
13.00 01300	NURSING ADMINISTRATION	1,025	575,115	0	735,698	1,025	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	2,079	41,223	0	97,401	2,079	14.00
15.00 01500	PHARMACY	1,133	99,236	0	2,791,160	1,133	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,460	715,537	0	994,330	2,460	16.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	356	604,655	0	645,668	356	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	204,630	0	22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	19,382	2,331,476	0	3,604,735	19,382	30.00
31.00 03100	INTENSIVE CARE UNIT	2,861	752,878	0	1,269,582	2,861	31.00
40.00 04000	SUBPROVIDER - I PF	6,807	1,079,292	0	1,500,763	6,807	40.00
41.00 04100	SUBPROVIDER - I RF	7,221	1,094,194	0	1,825,544	7,221	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	16,617	1,586,874	0	2,469,577	16,617	50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	14,904	667,716	0	1,133,737	14,904	54.00
57.00 05700	CT SCAN	0	62,228	0	271,911	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	76,969	0	229,751	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	3,640	836,475	0	2,775,157	3,640	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	888	465,668	0	635,235	888	65.00
66.00 06600	PHYSICAL THERAPY	8,363	756,049	0	1,123,756	8,363	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	200,031	0	275,178	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	50,122	0	75,942	0	68.00
69.00 06900	ELECTROCARDIOLOGY	1,127	441,196	0	600,383	1,127	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,451,015	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,486,679	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	84,980	0	73.00
76.00 03020	ONCOLOGY	1,260	143,568	0	196,630	1,260	76.00
76.01 03021	WOUND CARE CENTER	5,100	268,850	0	423,859	5,100	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	0	0	0	0	0	90.00
91.00 09100	EMERGENCY	3,581	1,890,554	0	1,499,511	3,581	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10 09910	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	158,040	19,123,381	-7,181,251	31,799,974	104,313	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	10,871,172	0	18,031,593	0	192.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	50,637	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,117,804	6,865,762		7,181,251	2,172,011	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	13.400430	0.228900		0.143964	20.822055	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		0		560,030	181,250	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.000000		0.011227	1.737559	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

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Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
		8.00	9.00	10.00	11.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
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	224,718				8.00
9.00	00900	HOUSEKEEPING	0	102,701			9.00
10.00	01000	DIETARY	0	2,897	34,978		10.00
11.00	01100	CAFETERIA	0	1,000	0	537,196	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,025	0	15,617	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,888	2,079	0	2,606	0 14.00
15.00	01500	PHARMACY	0	1,133	0	6,777	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,460	0	38,477	0 16.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	356	0	25,360	0 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0 22.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	62,984	19,382	15,678	95,891	95,891 30.00
31.00	03100	INTENSIVE CARE UNIT	11,456	2,861	1,975	20,866	20,866 31.00
40.00	04000	SUBPROVIDER - I PF	28,521	6,807	9,206	44,854	44,854 40.00
41.00	04100	SUBPROVIDER - I RF	23,570	7,221	8,119	48,455	48,455 41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0 42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	42,797	16,617	0	56,745	56,745 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,470	14,904	0	26,343	0 54.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00	06000	LABORATORY	0	3,640	0	35,268	0 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	0	888	0	17,036	0 65.00
66.00	06600	PHYSICAL THERAPY	0	8,363	0	25,336	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	6,415	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,607	0 68.00
69.00	06900	ELECTROCARDIOLOGY	5,187	1,127	0	15,517	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
76.00	03020	ONCOLOGY	4,254	1,260	0	3,934	0 76.00
76.01	03021	WOUND CARE CENTER	694	5,100	0	9,529	0 76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	27,897	3,581	0	40,563	40,563 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0	0	0 99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0 109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0 111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	224,718	102,701	34,978	537,196	307,374 118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	184,283	544,124	494,896	626,271	886,593 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.820063	5.298137	14.148779	1.165815	2.884411 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,317	26,904	48,728	21,290	24,664 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.019211	0.261964	1.393104	0.039632	0.080241 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

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Cost Center Description	INTERNS & RESIDENTS						
	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)		
	14.00	15.00	16.00	21.00	22.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00	
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	2,961,804					14.00	
15.00 01500 PHARMACY	0	100				15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	26,989,452			16.00	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	1,545		21.00	
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0		1,545	22.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	6,314	0	4,485,776	715	715	30.00	
31.00 03100 INTENSIVE CARE UNIT	1,128	0	1,778,617	40	40	31.00	
40.00 04000 SUBPROVIDER - IPF	38	0	5,063,519	20	20	40.00	
41.00 04100 SUBPROVIDER - IRF	460	0	2,410,184	0	0	41.00	
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	6,262	0	7,540,409	190	190	50.00	
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	778	0	0	0	0	54.00	
57.00 05700 CT SCAN	586	0	0	5	5	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00 06000 LABORATORY	0	0	0	5	5	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01	
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	0	0	0	40	40	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 PATIENTS	2,937,694	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	100	0	0	0	73.00	
76.00 03020 ONCOLOGY	1,550	0	0	0	0	76.00	
76.01 03021 WOUND CARE CENTER	0	0	0	15	15	76.01	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00	
90.00 09000 CLINIC	0	0	0	0	0	90.00	
91.00 09100 EMERGENCY	6,994	0	5,710,947	210	210	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10 09910 CORF	0	0	0	0	0	99.10	
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00	
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00	
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,961,804	100	26,989,452	1,240	1,240	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	305	305	192.00	
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00	
200.00	Cross Foot Adjustments					200.00	
201.00	Negative Cost Centers					201.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	172,773	3,230,482	1,246,590	777,485	234,089	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.058334	32,304.820000	0.046188	503.226537	151.513916	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	33,307	49,054	50,571	13,737	2,297	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.011246	490.540000	0.001874	8.891262	1.486731	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet C  
Part I  
Date/Time Prepared:  
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		Title XVIII		Hospital		PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		5,499,363	0	5,499,363	30.00
31.00	03100 INTENSIVE CARE UNIT		1,731,154	6,515	1,737,669	31.00
40.00	04000 SUBPROVIDER - I/PF		2,463,806	11,362	2,475,168	40.00
41.00	04100 SUBPROVIDER - I/RF		2,718,777	0	2,718,777	41.00
42.00	04200 SUBPROVIDER		0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		3,872,714	0	3,872,714	50.00
53.00	05300 ANESTHESIOLOGY		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		1,727,231	0	1,727,231	54.00
57.00	05700 CT SCAN		311,090	0	311,090	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		262,827	0	262,827	58.00
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000 LABORATORY		3,310,873	0	3,310,873	60.00
60.01	06001 BLOOD LABORATORY		0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	769,742	0	769,742	65.00
66.00	06600 PHYSICAL THERAPY	0	1,533,516	945	1,534,461	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	322,273	0	322,273	67.00
68.00	06800 SPEECH PATHOLOGY	0	88,748	0	88,748	68.00
69.00	06900 ELECTROCARDIOLOGY		738,598	0	738,598	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1,831,277	0	1,831,277	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		1,700,707	0	1,700,707	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		3,327,696	0	3,327,696	73.00
76.00	03020 ONCOLOGY		266,015	0	266,015	76.00
76.01	03021 WOUND CARE CENTER		629,769	0	629,769	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
90.00	09000 CLINIC		0	0	0	90.00
91.00	09100 EMERGENCY		2,260,275	0	2,260,275	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		469,035	0	469,035	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	09910 CORF		0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00	10900 PANCREAS ACQUISITION		0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION		0	0	0	110.00
111.00	11100 ISLET ACQUISITION		0	0	0	111.00
200.00	Subtotal (see instructions)		35,835,486	18,822	35,854,308	200.00
201.00	Less Observation Beds		469,035		469,035	201.00
202.00	Total (see instructions)		35,366,451	18,822	35,385,273	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet C  
Part I  
Date/Time Prepared:  
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		Title XVIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	5,488,036		5,488,036		30.00
31.00	03100	INTENSIVE CARE UNIT	1,913,220		1,913,220		31.00
40.00	04000	SUBPROVIDER - IPF	4,396,836		4,396,836		40.00
41.00	04100	SUBPROVIDER - IRF	3,020,226		3,020,226		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	4,656,211	19,933,356	24,589,567	0.157494	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,866,733	9,178,507	11,045,240	0.156378	54.00
57.00	05700	CT SCAN	726,122	3,625,190	4,351,312	0.071493	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	300,986	2,426,015	2,727,001	0.096380	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	7,047,289	17,193,843	24,241,132	0.136581	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	2,338,721	812,854	3,151,575	0.244240	65.00
66.00	06600	PHYSICAL THERAPY	1,302,483	2,254,967	3,557,450	0.431072	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,269,366	60,379	1,329,745	0.242357	67.00
68.00	06800	SPEECH PATHOLOGY	424,383	30,229	454,612	0.195217	68.00
69.00	06900	ELECTROCARDIOLOGY	1,609,160	4,869,384	6,478,544	0.114007	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,791,629	6,021,068	9,812,697	0.186623	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,586,763	1,382,752	4,969,515	0.342228	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,840,861	6,351,959	14,192,820	0.234463	73.00
76.00	03020	ONCOLOGY	16,867	1,372,326	1,389,193	0.191489	76.00
76.01	03021	WOUND CARE CENTER	32,923	2,886,019	2,918,942	0.215752	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	2,538,506	9,638,827	12,177,333	0.185613	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	46,440	606,938	653,378	0.717862	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0		99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
200.00		Subtotal (see instructions)	54,213,761	88,644,613	142,858,374		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	54,213,761	88,644,613	142,858,374		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet C Part I Date/Time Prepared: 1/31/2013 2:24 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.157494		50.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.156378		54.00
57.00	05700 CT SCAN	0.071493		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.096380		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.136581		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.244240		65.00
66.00	06600 PHYSICAL THERAPY	0.431337		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.242357		67.00
68.00	06800 SPEECH PATHOLOGY	0.195217		68.00
69.00	06900 ELECTROCARDIOLOGY	0.114007		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.186623		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.342228		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.234463		73.00
76.00	03020 ONCOLOGY	0.191489		76.00
76.01	03021 WOUND CARE CENTER	0.215752		76.01
	OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.185613		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.717862		92.00
	OTHER REIMBURSABLE COST CENTERS			
99.10	09910 CORF			99.10
	SPECIAL PURPOSE COST CENTERS			
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet C  
Part I  
Date/Time Prepared:  
1/31/2013 2:24 pm

		Title XIX		Hospital		Cost		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs		
				Total Costs	RCE Disallowance			
		1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	5,499,363		5,499,363	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,731,154		1,731,154	0	0	31.00
40.00	04000	SUBPROVIDER - I/PF	2,463,806		2,463,806	0	0	40.00
41.00	04100	SUBPROVIDER - I/RF	2,718,777		2,718,777	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	3,872,714		3,872,714	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,727,231		1,727,231	0	0	54.00
57.00	05700	CT SCAN	311,090		311,090	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	262,827		262,827	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	3,310,873		3,310,873	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	769,742	0	769,742	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,533,516	0	1,533,516	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	322,273	0	322,273	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	88,748	0	88,748	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	738,598		738,598	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,831,277		1,831,277	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,700,707		1,700,707	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,327,696		3,327,696	0	0	73.00
76.00	03020	ONCOLOGY	266,015		266,015	0	0	76.00
76.01	03021	WOUND CARE CENTER	629,769		629,769	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	2,260,275		2,260,275	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	469,035		469,035	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0		0		0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	111.00
200.00		Subtotal (see instructions)	35,835,486	0	35,835,486	0	0	200.00
201.00		Less Observation Beds	469,035		469,035			201.00
202.00		Total (see instructions)	35,366,451	0	35,366,451	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet C  
Part I  
Date/Time Prepared:  
1/31/2013 2:24 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	5,488,036		5,488,036		30.00
31.00	03100	INTENSIVE CARE UNIT	1,913,220		1,913,220		31.00
40.00	04000	SUBPROVIDER - IPF	4,396,836		4,396,836		40.00
41.00	04100	SUBPROVIDER - IRF	3,020,226		3,020,226		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	4,656,211	19,933,356	24,589,567	0.157494	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,866,733	9,178,507	11,045,240	0.156378	54.00
57.00	05700	CT SCAN	726,122	3,625,190	4,351,312	0.071493	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	300,986	2,426,015	2,727,001	0.096380	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	7,047,289	17,193,843	24,241,132	0.136581	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	2,338,721	812,854	3,151,575	0.244240	65.00
66.00	06600	PHYSICAL THERAPY	1,302,483	2,254,967	3,557,450	0.431072	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,269,366	60,379	1,329,745	0.242357	67.00
68.00	06800	SPEECH PATHOLOGY	424,383	30,229	454,612	0.195217	68.00
69.00	06900	ELECTROCARDIOLOGY	1,609,160	4,869,384	6,478,544	0.114007	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,791,629	6,021,068	9,812,697	0.186623	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,586,763	1,382,752	4,969,515	0.342228	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,840,861	6,351,959	14,192,820	0.234463	73.00
76.00	03020	ONCOLOGY	16,867	1,372,326	1,389,193	0.191489	76.00
76.01	03021	WOUND CARE CENTER	32,923	2,886,019	2,918,942	0.215752	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	2,538,506	9,638,827	12,177,333	0.185613	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	46,440	606,938	653,378	0.717862	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0		99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
200.00		Subtotal (see instructions)	54,213,761	88,644,613	142,858,374		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	54,213,761	88,644,613	142,858,374		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet C  
Part I  
Date/Time Prepared:  
1/31/2013 2:24 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF				40.00
41.00	04100 SUBPROVIDER - IRF				41.00
42.00	04200 SUBPROVIDER				42.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000 LABORATORY	0.000000			60.00
60.01	06001 BLOOD LABORATORY	0.000000			60.01
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03020 ONCOLOGY	0.000000			76.00
76.01	03021 WOUND CARE CENTER	0.000000			76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.10	09910 CORF				99.10
<b>SPECIAL PURPOSE COST CENTERS</b>					
109.00	10900 PANCREAS ACQUISITION				109.00
110.00	11000 INTESTINAL ACQUISITION				110.00
111.00	11100 ISLET ACQUISITION				111.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part I Date/Time Prepared: 1/31/2013 2:24 pm
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Cost Center Description	Title XVIII			Hospital	PPS	
	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	381,971	0	381,971	5,710	66.90	30.00
31.00 03100 INTENSIVE CARE UNIT	67,131	0	67,131	658	102.02	31.00
40.00 04000 SUBPROVIDER - IPF	149,916	0	149,916	3,067	48.88	40.00
41.00 04100 SUBPROVIDER - IRF	153,793	0	153,793	2,705	56.86	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0.00	42.00
200.00 Total (lines 30-199)	752,811		752,811	12,140		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part I Date/Time Prepared: 1/31/2013 2:24 pm
		Title XVIII	Hospital	PPS

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	03000 ADULTS & PEDIATRICS	2,794	186,919	30.00
31.00	03100 INTENSIVE CARE UNIT	374	38,155	31.00
40.00	04000 SUBPROVIDER - IPF	2,692	131,585	40.00
41.00	04100 SUBPROVIDER - IRF	1,554	88,360	41.00
42.00	04200 SUBPROVIDER	0	0	42.00
200.00	Total (lines 30-199)	7,414	445,019	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part II Date/Time Prepared: 1/31/2013 2:24 pm
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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	305,445	24,589,567	0.012422	2,087,846	25,935	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	243,542	11,045,240	0.022049	1,447,059	31,906	54.00
57.00	05700 CT SCAN	3,060	4,351,312	0.000703	558,373	393	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2,579	2,727,001	0.000946	144,910	137	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	88,612	24,241,132	0.003655	3,485,905	12,741	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	21,483	3,151,575	0.006817	731,352	4,986	65.00
66.00	06600 PHYSICAL THERAPY	142,410	3,557,450	0.040031	172,271	6,896	66.00
67.00	06700 OCCUPATIONAL THERAPY	3,343	1,329,745	0.002514	107,865	271	67.00
68.00	06800 SPEECH PATHOLOGY	917	454,612	0.002017	30,862	62	68.00
69.00	06900 ELECTROCARDIOLOGY	24,810	6,478,544	0.003830	1,126,175	4,313	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	49,327	9,812,697	0.005027	1,753,433	8,815	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	16,691	4,969,515	0.003359	1,728,452	5,806	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	50,008	14,192,820	0.003523	3,244,927	11,432	73.00
76.00	03020 ONCOLOGY	21,867	1,389,193	0.015741	5,981	94	76.00
76.01	03021 WOUND CARE CENTER	83,690	2,918,942	0.028671	17,267	495	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	88,162	12,177,333	0.007240	920,429	6,664	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	32,578	653,378	0.049861	29,611	1,476	92.00
200.00	Total (lines 50-199)	1,178,524	128,040,056		17,592,718	122,422	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150129		Period: From 09/01/2011 To 08/31/2012		Worksheet D Part III Date/Time Prepared: 1/31/2013 2:24 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
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
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150129		Period: From 09/01/2011 To 08/31/2012		Worksheet D Part III Date/Time Prepared: 1/31/2013 2:24 pm	
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PPS	
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,710	0.00	2,794	0		30.00
31.00	03100	INTENSIVE CARE UNIT	658	0.00	374	0		31.00
40.00	04000	SUBPROVIDER - IPF	3,067	0.00	2,692	0		40.00
41.00	04100	SUBPROVIDER - IRF	2,705	0.00	1,554	0		41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0		42.00
200.00		Total (lines 30-199)	12,140		7,414	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part IV Date/Time Prepared: 1/31/2013 2:24 pm
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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	0	50.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
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 PATIENTS	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
76.00 03020 ONCOLOGY	0	0	0	0	0	76.00
76.01 03021 WOUND CARE CENTER	0	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
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
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: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part IV Date/Time Prepared: 1/31/2013 2:24 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	24,589,567	0.000000	0.000000	2,087,846	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,045,240	0.000000	0.000000	1,447,059	54.00
57.00	05700	CT SCAN	0	4,351,312	0.000000	0.000000	558,373	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,727,001	0.000000	0.000000	144,910	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	24,241,132	0.000000	0.000000	3,485,905	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	3,151,575	0.000000	0.000000	731,352	65.00
66.00	06600	PHYSICAL THERAPY	0	3,557,450	0.000000	0.000000	172,271	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,329,745	0.000000	0.000000	107,865	67.00
68.00	06800	SPEECH PATHOLOGY	0	454,612	0.000000	0.000000	30,862	68.00
69.00	06900	ELECTROCARDIOLOGY	0	6,478,544	0.000000	0.000000	1,126,175	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,812,697	0.000000	0.000000	1,753,433	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,969,515	0.000000	0.000000	1,728,452	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	14,192,820	0.000000	0.000000	3,244,927	73.00
76.00	03020	ONCOLOGY	0	1,389,193	0.000000	0.000000	5,981	76.00
76.01	03021	WOUND CARE CENTER	0	2,918,942	0.000000	0.000000	17,267	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	12,177,333	0.000000	0.000000	920,429	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	653,378	0.000000	0.000000	29,611	92.00
200.00		Total (lines 50-199)	0	128,040,056			17,592,718	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet D  
Part IV  
Date/Time Prepared:  
1/31/2013 2:24 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
Title XVIII Hospital PPS						
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,391,677	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,201,509	0	54.00
57.00	05700	CT SCAN	0	871,361	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	515,102	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	550,376	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	47,413	0	65.00
66.00	06600	PHYSICAL THERAPY	0	7,063	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	6,762	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,264,431	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,568,000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	534,504	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,734,641	0	73.00
76.00	03020	ONCOLOGY	0	635,792	0	76.00
76.01	03021	WOUND CARE CENTER	0	1,423,863	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	1,495,106	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	158,406	0	92.00
200.00		Total (lines 50-199)	0	20,406,006	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part V Date/Time Prepared: 1/31/2013 2:24 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges					
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	1.00	2.00	3.00	4.00			
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0.157494	5,391,677	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156378	2,201,509	0	0	54.00
57.00	05700	CT SCAN	0.071493	871,361	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.096380	515,102	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	06000	LABORATORY	0.136581	550,376	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.244240	47,413	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.431072	7,063	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.242357	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.195217	6,762	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.114007	1,264,431	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.186623	1,568,000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.342228	534,504	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.234463	3,734,641	0	864	73.00
76.00	03020	ONCOLOGY	0.191489	635,792	0	0	76.00
76.01	03021	WOUND CARE CENTER	0.215752	1,423,863	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0.000000				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00	09000	CLINIC	0.000000	0	0	0	90.00
91.00	09100	EMERGENCY	0.185613	1,495,106	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.717862	158,406	0	0	92.00
200.00		Subtotal (see instructions)		20,406,006	0	864	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		20,406,006	0	864	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part V Date/Time Prepared: 1/31/2013 2:24 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			Hospital	PPS	
	PPS Services (see inst.)	Cost	Cost			
		Reimbursed Services Subject To Ded. & Coins. (see inst.)	Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
5.00	6.00	7.00				
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	849,157	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	344,268	0	0	54.00
57.00	05700	CT SCAN	62,296	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	49,646	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	75,171	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	11,580	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,045	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,320	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	144,154	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	292,625	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	182,922	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	875,635	0	203	73.00
76.00	03020	ONCOLOGY	121,747	0	0	76.00
76.01	03021	WOUND CARE CENTER	307,201	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	277,511	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	113,714	0	0	92.00
200.00		Subtotal (see instructions)	3,711,992	0	203	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00		Net Charges (line 200 +/- line 201)	3,711,992	0	203	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150129 Component CCN: 15S129		Period: From 09/01/2011 To 08/31/2012		Worksheet D Part II Date/Time Prepared: 1/31/2013 2:24 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	305,445	24,589,567	0.012422	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	243,542	11,045,240	0.022049	27,248	601 54.00
57.00	05700	CT SCAN	3,060	4,351,312	0.000703	68,442	48 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,579	2,727,001	0.000946	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0 59.00
60.00	06000	LABORATORY	88,612	24,241,132	0.003655	384,461	1,405 60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	21,483	3,151,575	0.006817	38,427	262 65.00
66.00	06600	PHYSICAL THERAPY	142,410	3,557,450	0.040031	10,252	410 66.00
67.00	06700	OCCUPATIONAL THERAPY	3,343	1,329,745	0.002514	1,740	4 67.00
68.00	06800	SPEECH PATHOLOGY	917	454,612	0.002017	756	2 68.00
69.00	06900	ELECTROCARDIOLOGY	24,810	6,478,544	0.003830	3,950	15 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	49,327	9,812,697	0.005027	87,006	437 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,691	4,969,515	0.003359	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	50,008	14,192,820	0.003523	957,683	3,374 73.00
76.00	03020	ONCOLOGY	21,867	1,389,193	0.015741	0	0 76.00
76.01	03021	WOUND CARE CENTER	83,690	2,918,942	0.028671	0	0 76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0 89.00
90.00	09000	CLINIC	0	0	0.000000	0	0 90.00
91.00	09100	EMERGENCY	88,162	12,177,333	0.007240	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	653,378	0.000000	0	0 92.00
200.00		Total (lines 50-199)	1,145,946	128,040,056		1,579,965	6,558 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150129 Component CCN: 15S129	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part IV Date/Time Prepared: 1/31/2013 2:24 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
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
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 PATIENTS	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
76.00	03020 ONCOLOGY	0	0	0	0	0	76.00
76.01	03021 WOUND CARE CENTER	0	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
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
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: 150129 Component CCN: 15S129	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part IV Date/Time Prepared: 1/31/2013 2:24 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	24,589,567	0.000000	0.000000	0	50.00
53.00 05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	11,045,240	0.000000	0.000000	27,248	54.00
57.00 05700 CT SCAN	0	4,351,312	0.000000	0.000000	68,442	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	2,727,001	0.000000	0.000000	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00 06000 LABORATORY	0	24,241,132	0.000000	0.000000	384,461	60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00 06500 RESPIRATORY THERAPY	0	3,151,575	0.000000	0.000000	38,427	65.00
66.00 06600 PHYSICAL THERAPY	0	3,557,450	0.000000	0.000000	10,252	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	1,329,745	0.000000	0.000000	1,740	67.00
68.00 06800 SPEECH PATHOLOGY	0	454,612	0.000000	0.000000	756	68.00
69.00 06900 ELECTROCARDIOLOGY	0	6,478,544	0.000000	0.000000	3,950	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,812,697	0.000000	0.000000	87,006	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	4,969,515	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	14,192,820	0.000000	0.000000	957,683	73.00
76.00 03020 ONCOLOGY	0	1,389,193	0.000000	0.000000	0	76.00
76.01 03021 WOUND CARE CENTER	0	2,918,942	0.000000	0.000000	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00 09000 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00 09100 EMERGENCY	0	12,177,333	0.000000	0.000000	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	653,378	0.000000	0.000000	0	92.00
200.00 Total (lines 50-199)	0	128,040,056			1,579,965	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150129 Component CCN: 15S129	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part IV Date/Time Prepared: 1/31/2013 2:24 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)	
		11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00	03020 ONCOLOGY	0	0	0	76.00
76.01	03021 WOUND CARE CENTER	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150129 Component CCN: 15T129		Period: From 09/01/2011 To 08/31/2012		Worksheet D Part II Date/Time Prepared: 1/31/2013 2:24 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	305,445	24,589,567	0.012422	37,968	472	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	243,542	11,045,240	0.022049	116,166	2,561	54.00
57.00	05700	CT SCAN	3,060	4,351,312	0.000703	17,827	13	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,579	2,727,001	0.000946	17,082	16	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	88,612	24,241,132	0.003655	666,219	2,435	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	21,483	3,151,575	0.006817	132,821	905	65.00
66.00	06600	PHYSICAL THERAPY	142,410	3,557,450	0.040031	696,795	27,893	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,343	1,329,745	0.002514	739,295	1,859	67.00
68.00	06800	SPEECH PATHOLOGY	917	454,612	0.002017	205,771	415	68.00
69.00	06900	ELECTROCARDIOLOGY	24,810	6,478,544	0.003830	111,955	429	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	49,327	9,812,697	0.005027	341,351	1,716	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,691	4,969,515	0.003359	846	3	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	50,008	14,192,820	0.003523	1,065,898	3,755	73.00
76.00	03020	ONCOLOGY	21,867	1,389,193	0.015741	0	0	76.00
76.01	03021	WOUND CARE CENTER	83,690	2,918,942	0.028671	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	88,162	12,177,333	0.007240	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	653,378	0.000000	0	0	92.00
200.00		Total (lines 50-199)	1,145,946	128,040,056		4,149,994	42,472	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150129 Component CCN: 15T129	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part IV Date/Time Prepared: 1/31/2013 2:24 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
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
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 PATIENTS	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
76.00	03020 ONCOLOGY	0	0	0	0	0	76.00
76.01	03021 WOUND CARE CENTER	0	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
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
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: 150129 Component CCN: 15T129	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part IV Date/Time Prepared: 1/31/2013 2:24 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	24,589,567	0.000000	0.000000	37,968	50.00
53.00 05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	11,045,240	0.000000	0.000000	116,166	54.00
57.00 05700 CT SCAN	0	4,351,312	0.000000	0.000000	17,827	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	2,727,001	0.000000	0.000000	17,082	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00 06000 LABORATORY	0	24,241,132	0.000000	0.000000	666,219	60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00 06500 RESPIRATORY THERAPY	0	3,151,575	0.000000	0.000000	132,821	65.00
66.00 06600 PHYSICAL THERAPY	0	3,557,450	0.000000	0.000000	696,795	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	1,329,745	0.000000	0.000000	739,295	67.00
68.00 06800 SPEECH PATHOLOGY	0	454,612	0.000000	0.000000	205,771	68.00
69.00 06900 ELECTROCARDIOLOGY	0	6,478,544	0.000000	0.000000	111,955	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,812,697	0.000000	0.000000	341,351	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	4,969,515	0.000000	0.000000	846	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	14,192,820	0.000000	0.000000	1,065,898	73.00
76.00 03020 ONCOLOGY	0	1,389,193	0.000000	0.000000	0	76.00
76.01 03021 WOUND CARE CENTER	0	2,918,942	0.000000	0.000000	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00 09000 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00 09100 EMERGENCY	0	12,177,333	0.000000	0.000000	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	653,378	0.000000	0.000000	0	92.00
200.00 Total (lines 50-199)	0	128,040,056			4,149,994	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150129 Component CCN: 15T129	Period: From 09/01/2011 To 08/31/2012	Worksheet D Part IV Date/Time Prepared: 1/31/2013 2:24 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)	
		11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00	03020 ONCOLOGY	0	0	0	76.00
76.01	03021 WOUND CARE CENTER	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet D-1 Date/Time Prepared: 1/31/2013 2:24 pm
Cost Center Description		Title XVIII	Hospital	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)		5,710	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,710	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)		5,223	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)		2,794	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)		5,499,363	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)		5,499,363	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		7,401,256	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		7,401,256	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.743031	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,417.05	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)		5,499,363	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)		963.11	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,690,929	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,690,929	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150129		Period: From 09/01/2011 To 08/31/2012		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 1/31/2013 2:24 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)		
	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	1,737,669	658	2,640.83	374	987,670		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)					3,375,138		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					7,053,737		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)					225,074		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					122,422		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					347,496		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					6,706,241		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)					487		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					963.11		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					469,035		89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet D-1

Date/Time Prepared:  
1/31/2013 2:24 pm

Cost Center Description		Cost	Title XVIII		Hospital		
			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	381,971	5,499,363	0.069457	469,035	32,578	90.00
91.00	Nursing School cost	0	5,499,363	0.000000	469,035	0	91.00
92.00	Allied health cost	0	5,499,363	0.000000	469,035	0	92.00
93.00	All other Medical Education	0	5,499,363	0.000000	469,035	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet D-1
		Component CCN: 15S129		Date/Time Prepared: 1/31/2013 2:24 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)		3,067	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,067	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)		3,067	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)		2,692	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)		2,475,168	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)		2,475,168	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		4,396,836	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		4,396,836	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.562943	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,433.60	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)		2,475,168	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)		807.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,172,525	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,172,525	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150129		Period: From 09/01/2011 To 08/31/2012		Worksheet D-1		
		Component CCN: 15S129				Date/Time Prepared: 1/31/2013 2:24 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)							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)					317,269		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,489,794		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)					131,585		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					6,558		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					138,143		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,351,651		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: 150129 Component CCN: 15S129		Period: From 09/01/2011 To 08/31/2012		Worksheet D-1 Date/Time Prepared: 1/31/2013 2:24 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	149,916	2,475,168	0.060568	0	0	90.00
91.00	Nursing School cost	0	2,475,168	0.000000	0	0	91.00
92.00	Allied health cost	0	2,475,168	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,475,168	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet D-1
		Component CCN: 15T129		Date/Time Prepared: 1/31/2013 2:24 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)		2,705	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,705	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)		2,705	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)		1,554	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)		2,718,777	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)		2,718,777	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		3,020,226	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		3,020,226	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.900190	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,116.53	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)		2,718,777	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)		1,005.09	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,561,910	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)		1,561,910	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet D-1			
		Component CCN: 15T129		Date/Time Prepared: 1/31/2013 2:24 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)					42.00	
Intensive Care Type Inpatient Hospital Units							
43.00	0	0	0.00	0	0	43.00	
44.00	INTENSIVE CARE UNIT					44.00	
45.00	CORONARY CARE UNIT					45.00	
46.00	BURN INTENSIVE CARE UNIT					46.00	
47.00	SURGICAL INTENSIVE CARE UNIT					47.00	
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)					997,068	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,558,978	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)					88,360	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					42,472	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					130,832	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,428,146	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: 150129 Component CCN: 15T129		Period: From 09/01/2011 To 08/31/2012		Worksheet D-1 Date/Time Prepared: 1/31/2013 2:24 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	153,793	2,718,777	0.056567	0	0	90.00
91.00	Nursing School cost	0	2,718,777	0.000000	0	0	91.00
92.00	Allied health cost	0	2,718,777	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,718,777	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet D-1 Date/Time Prepared: 1/31/2013 2:24 pm
Cost Center Description		Title XIX	Hospital	Cost
		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)		5,710	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,710	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)		5,223	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)		221	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)		5,499,363	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)		5,499,363	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		7,401,256	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		7,401,256	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.743031	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,417.05	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)		5,499,363	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)		963.11	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		212,847	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)		212,847	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150129		Period: From 09/01/2011 To 08/31/2012		Worksheet D-1	
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)	1.00	2.00	3.00	4.00	5.00	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	1,731,154	658	2,630.93	33	86,821	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							
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					222,303	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					521,971	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)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
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)					487	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					963.11	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					469,035	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet D-1

Date/Time Prepared:  
1/31/2013 2:24 pm

Cost Center Description	Cost	Title XIX		Hospital	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: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet D-1
		Component CCN: 15T129		Date/Time Prepared: 1/31/2013 2:24 pm
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,705	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,705	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)		2,705	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)		134	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)		2,718,777	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)		2,718,777	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		3,020,226	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		3,020,226	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.900190	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,116.53	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)		2,718,777	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)		1,005.09	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		134,682	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)		134,682	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150129		Period: From 09/01/2011 To 08/31/2012		Worksheet D-1	
		Component CCN: 15T129				Date/Time Prepared: 1/31/2013 2:24 pm	
		Title XIX		Subprovider - IRF		Cost	
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	0	0	0.00	0	0		43.00
44.00							44.00
45.00							45.00
46.00							46.00
47.00							47.00
	Cost Center Description						
					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					103,568	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					238,250	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)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
	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: 150129 Component CCN: 15T129		Period: From 09/01/2011 To 08/31/2012		Worksheet D-1 Date/Time Prepared: 1/31/2013 2:24 pm	
		Title XIX		Subprovider - IRF		Cost	
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: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet D-3 Date/Time Prepared: 1/31/2013 2:24 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		2,717,051	30.00
31.00	03100	INTENSIVE CARE UNIT		651,252	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.157494	2,087,846	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156378	1,447,059	54.00
57.00	05700	CT SCAN	0.071493	558,373	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.096380	144,910	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.136581	3,485,905	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.244240	731,352	65.00
66.00	06600	PHYSICAL THERAPY	0.431337	172,271	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.242357	107,865	67.00
68.00	06800	SPEECH PATHOLOGY	0.195217	30,862	68.00
69.00	06900	ELECTROCARDIOLOGY	0.114007	1,126,175	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.186623	1,753,433	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.342228	1,728,452	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.234463	3,244,927	73.00
76.00	03020	ONCOLOGY	0.191489	5,981	76.00
76.01	03021	WOUND CARE CENTER	0.215752	17,267	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.185613	920,429	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.717862	29,611	92.00
200.00		Total (sum of lines 50-94 and 96-98)		17,592,718	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)		17,592,718	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150129 Component CCN: 15S129	Period: From 09/01/2011 To 08/31/2012	Worksheet D-3 Date/Time Prepared: 1/31/2013 2:24 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		3,862,110	40.00
41.00	04100 SUBPROVIDER - IRF		0	41.00
42.00	04200 SUBPROVIDER		0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.157494	0	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.156378	27,248	54.00
57.00	05700 CT SCAN	0.071493	68,442	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.096380	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000 LABORATORY	0.136581	384,461	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.244240	38,427	65.00
66.00	06600 PHYSICAL THERAPY	0.431337	10,252	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.242357	1,740	67.00
68.00	06800 SPEECH PATHOLOGY	0.195217	756	68.00
69.00	06900 ELECTROCARDIOLOGY	0.114007	3,950	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.186623	87,006	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.342228	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.234463	957,683	73.00
76.00	03020 ONCOLOGY	0.191489	0	76.00
76.01	03021 WOUND CARE CENTER	0.215752	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000 CLINIC	0.000000	0	90.00
91.00	09100 EMERGENCY	0.185613	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.717862	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,579,965	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net Charges (line 200 minus line 201)		1,579,965	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet D-3
		Component CCN: 15T129		Date/Time Prepared: 1/31/2013 2:24 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		120,733	31.00
40.00	04000 SUBPROVIDER - IPF		0	40.00
41.00	04100 SUBPROVIDER - IRF		1,473,648	41.00
42.00	04200 SUBPROVIDER		0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.157494	37,968	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.156378	116,166	54.00
57.00	05700 CT SCAN	0.071493	17,827	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.096380	17,082	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000 LABORATORY	0.136581	666,219	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.244240	132,821	65.00
66.00	06600 PHYSICAL THERAPY	0.431337	696,795	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.242357	739,295	67.00
68.00	06800 SPEECH PATHOLOGY	0.195217	205,771	68.00
69.00	06900 ELECTROCARDIOLOGY	0.114007	111,955	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.186623	341,351	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.342228	846	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.234463	1,065,898	73.00
76.00	03020 ONCOLOGY	0.191489	0	76.00
76.01	03021 WOUND CARE CENTER	0.215752	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000 CLINIC	0.000000	0	90.00
91.00	09100 EMERGENCY	0.185613	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.717862	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		4,149,994	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)		4,149,994	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet D-3 Date/Time Prepared: 1/31/2013 2:24 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		222,704	30.00
31.00	03100	INTENSIVE CARE UNIT		18,652	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.157494	149,088	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156378	89,850	54.00
57.00	05700	CT SCAN	0.071493	36,083	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.096380	13,309	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.136581	283,301	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.244240	43,909	65.00
66.00	06600	PHYSICAL THERAPY	0.431072	5,918	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.242357	4,796	67.00
68.00	06800	SPEECH PATHOLOGY	0.195217	2,632	68.00
69.00	06900	ELECTROCARDIOLOGY	0.114007	62,682	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.186623	161,221	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.342228	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.234463	264,092	73.00
76.00	03020	ONCOLOGY	0.191489	0	76.00
76.01	03021	WOUND CARE CENTER	0.215752	7,050	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.185613	127,713	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.717862	4,017	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,255,661	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		1,255,661	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150129 Component CCN: 15T129	Period: From 09/01/2011 To 08/31/2012	Worksheet D-3 Date/Time Prepared: 1/31/2013 2:24 pm
		Title XIX	Subprovider - IRF	Cost
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		132,135	41.00
42.00	04200 SUBPROVIDER		0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.157494	1,422	224 50.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.156378	11,624	1,818 54.00
57.00	05700 CT SCAN	0.071493	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.096380	2,154	208 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000 LABORATORY	0.136581	72,557	9,910 60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0 60.01
65.00	06500 RESPIRATORY THERAPY	0.244240	8,764	2,141 65.00
66.00	06600 PHYSICAL THERAPY	0.431072	65,605	28,280 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.242357	70,308	17,040 67.00
68.00	06800 SPEECH PATHOLOGY	0.195217	18,181	3,549 68.00
69.00	06900 ELECTROCARDIOLOGY	0.114007	9,806	1,118 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.186623	30,970	5,780 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.342228	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.234463	142,122	33,322 73.00
76.00	03020 ONCOLOGY	0.191489	932	178 76.00
76.01	03021 WOUND CARE CENTER	0.215752	0	0 76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0 88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0 89.00
90.00	09000 CLINIC	0.000000	0	0 90.00
91.00	09100 EMERGENCY	0.185613	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.717862	0	0 92.00
200.00	Total (sum of lines 50-94 and 96-98)		434,445	103,568 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net Charges (line 200 minus line 201)		434,445	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet E Part A Date/Time Prepared: 1/31/2013 2:24 pm
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER PPS</b>				
1.00	DRG Amounts Other than Outlier Payments		3,728,079	1.00
2.00	Outlier payments for discharges. (see instructions)		250,176	2.00
2.01	Outlier reconciliation amount		0	2.01
3.00	Managed Care Simulated Payments		1,011,588	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		40.67	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)		3.44	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.		0.85	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.		7.00	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)		11.29	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		8.49	10.00
11.00	FTE count for residents in dental and podiatric programs.		3.01	11.00
12.00	Current year allowable FTE (see instructions)		11.50	12.00
13.00	Total allowable FTE count for the prior year.		7.63	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.		5.61	14.00
15.00	Sum of lines 12 through 14 divided by 3.		8.25	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		8.25	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.202852	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.177442	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.177442	21.00
22.00	IME payment adjustment (see instructions)		437,609	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)		437,609	29.00
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		0.00	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		0.00	31.00
32.00	Sum of lines 30 and 31		0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00
34.00	Disproportionate share adjustment (see instructions)		0	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)		4,415,864	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet E Part A Date/Time Prepared: 1/31/2013 2:24 pm
		Title XVIII	Hospital	PPS
		before 1/1	on/after 1/1	
		1.00	1.01	
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	4,415,864		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)	356,480		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).	301,240		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
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)	5,073,584		59.00
60.00	Primary payer payments	0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	5,073,584		61.00
62.00	Deductibles billed to program beneficiaries	432,236		62.00
63.00	Coinsurance billed to program beneficiaries	18,497		63.00
64.00	Allowable bad debts (see instructions)	22,053		64.00
65.00	Adjusted reimbursable bad debts (see instructions)	15,437		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	3,015		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	4,638,288		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
70.95	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)	4,638,288		71.00
72.00	Interim payments	4,561,307		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)	76,981		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2	0		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: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet E Part B Date/Time Prepared: 1/31/2013 2:24 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		203	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		3,711,992	2.00
3.00	PPS payments		3,051,364	3.00
4.00	Outlier payment (see instructions)		48,027	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)		203	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		864	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)		864	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)		864	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		661	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)		203	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)		3,099,391	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)		681,220	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		2,418,374	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		92,398	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,510,772	30.00
31.00	Primary payer payments		62	31.00
32.00	Subtotal (line 30 minus line 31)		2,510,710	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)		67,588	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		47,312	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		37,696	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		2,558,022	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		2,558,022	40.00
41.00	Interim payments		2,566,882	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)		-8,860	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet E-1  
Part I  
Date/Time Prepared:  
1/31/2013 2:24 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		4,166,837		2,418,267	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	05/03/2012	79,476	05/03/2012	11,671	3.01	
3.02		07/06/2012	3,452	07/06/2012	359	3.02	
3.03		08/31/2012	135,715	08/31/2012	48,129	3.03	
3.04		08/31/2012	175,827	08/31/2012	88,456	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)		394,470		148,615	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)		4,561,307		2,566,882	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		76,981		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		8,860	6.02	
7.00	Total Medicare program liability (see instructions)		4,638,288		2,558,022	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: 150129  
Component CCN: 15S129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet E-1  
Part I  
Date/Time Prepared:  
1/31/2013 2:24 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		2,159,346		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)		2,159,346		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		328		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,159,674		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: 150129  
Component CCN: 15T129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet E-1  
Part I  
Date/Time Prepared:  
1/31/2013 2:24 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		2,427,703			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)					0 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	05/03/2012	70,056			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)		-70,056			0 3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,357,647			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)					0 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)					0 6.00
6.01	SETTLEMENT TO PROVIDER		0			0 6.01
6.02	SETTLEMENT TO PROGRAM		14,174			0 6.02
7.00	Total Medicare program liability (see instructions)		2,343,473			0 7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					0 8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet E-1  
Part II  
Date/Time Prepared:  
1/31/2013 2:24 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			1,188 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			3,168 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			852 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			5,881 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			142,858,374 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			2,147,112 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			0 8.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)			0 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet E-3 Part II Date/Time Prepared: 1/31/2013 2:24 pm
		Component CCN: 15S129		
		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)			2,331,089 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			8.379781 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)			2,331,089 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)			2,331,089 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			2,331,089 18.00
19.00	Deductibles			165,096 19.00
20.00	Subtotal (line 18 minus line 19)			2,165,993 20.00
21.00	Coinsurance			6,647 21.00
22.00	Subtotal (line 20 minus line 21)			2,159,346 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			469 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			328 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			2,159,674 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)			2,159,674 31.00
32.00	Interim payments			2,159,346 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)			328 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			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150129 Component CCN: 15T129	Period: From 09/01/2011 To 08/31/2012	Worksheet E-3 Part III Date/Time Prepared: 1/31/2013 2:24 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)			1,852,968 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0267 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			125,589 3.00
4.00	Outlier Payments			421,291 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)			7.390710 10.00
11.00	Medical Education Adjustment Factor {{{(1 + (line 9/line 10)) raised to the power of .6876 -1}}.			0.000000 11.00
12.00	Medical Education Adjustment (line 1 multiplied by line 11).			0 12.00
13.00	Total PPS Payment (sum of lines 1, 3, 4 and 12)			2,399,848 13.00
14.00	Nursing and Allied Health Managed Care payment (see instruction)			0 14.00
15.00	Organ acquisition			0 15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 16.00
17.00	Subtotal (see instructions)			2,399,848 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			2,399,848 19.00
20.00	Deductibles			25,264 20.00
21.00	Subtotal (line 19 minus line 20)			2,374,584 21.00
22.00	Coinsurance			31,111 22.00
23.00	Subtotal (line 21 minus line 22)			2,343,473 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			0 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			2,343,473 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			2,343,473 32.00
33.00	Interim payments			2,357,647 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)			-14,174 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4			421,291 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: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet E-3 Part VII Date/Time Prepared: 1/31/2013 2:24 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		521,971		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		521,971	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		521,971	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		241,356		8.00
9.00	Ancillary service charges		1,255,661	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		1,497,017	0	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		1,497,017	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		975,046	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		521,971	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		521,971	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		521,971	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		521,971	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		521,971	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		521,971	0	40.00
41.00	Interim payments		604,580	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		-82,609	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet E-3 Part VII Date/Time Prepared: 1/31/2013 2:24 pm
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>				
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient hospital/SNF/NF services	238,250		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	238,250	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	238,250	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable Charges</b>				
8.00	Routine service charges	132,135		8.00
9.00	Ancillary service charges	434,445	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	566,580	0	12.00
<b>CUSTOMARY CHARGES</b>				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	566,580	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	328,330	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	238,250	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	238,250	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	238,250	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	238,250	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	238,250	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	238,250	0	40.00
41.00	Interim payments	215,819	0	41.00
42.00	Balance due provider/program (line 40 minus 41)	22,431	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet E-4 Date/Time Prepared: 1/31/2013 2:24 pm	
		Title XVII	Hospital	PPS	
				1.00	
<b>COMPUTATION OF TOTAL DIRECT GME AMOUNT</b>					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			1.42	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.85	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			7.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 plus line 4.02 plus applicable subscripts)			9.27	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			9.33	6.00
7.00	Enter the lesser of line 5 or line 6			9.27	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	6.66	2.67	9.33	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	6.62	2.65	9.27	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		3.01		10.00
11.00	Total weighted FTE count	6.62	5.66		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	1.99	3.46		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	1.11	2.48		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	3.24	3.87		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	3.24	3.87		17.00
18.00	Per resident amount	77,865.00	77,865.00		18.00
19.00	Approved amount for resident costs	252,283	301,338	553,621	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.06	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			553,621	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
<b>COMPUTATION OF PROGRAM PATIENT LOAD</b>					
26.00	Inpatient Days	7,414	1,015		26.00
27.00	Total Inpatient Days (see instructions)	11,653	11,653		27.00
28.00	Ratio of inpatient days to total inpatient days	0.636231	0.087102		28.00
29.00	Program direct GME amount	352,231	48,221		29.00
30.00	Reduction for direct GME payments for Medicare managed care		6,814		30.00
31.00	Net Program direct GME amount			393,638	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet E-4 Date/Time Prepared: 1/31/2013 2:24 pm
		Title XVIII	Hospital	PPS
				1.00
<b>DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)</b>				
32.00	Renal dialysis direct medical education costs (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Worksheet C, Part I, column 8, sum of lines 74 and 94)		0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
<b>APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY</b>				
<b>Part A Reasonable Cost</b>				
37.00	Reasonable cost (see instructions)		12,102,509	37.00
38.00	Organ acquisition costs (Worksheet D-4, Part III, column 1, line 69)		0	38.00
39.00	Cost of teaching physicians (Worksheet D-5, Part II, column 3, line 20)		0	39.00
40.00	Primary payer payments (see instructions)		0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		12,102,509	41.00
<b>Part B Reasonable Cost</b>				
42.00	Reasonable cost (see instructions)		3,712,195	42.00
43.00	Primary payer payments (see instructions)		62	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		3,712,133	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		15,814,642	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.765272	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.234728	47.00
<b>ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B</b>				
48.00	Total program GME payment (line 31)		393,638	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (Title XVIII only) (see instructions)		301,240	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		92,398	50.00

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

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet G

Date/Time Prepared:  
1/31/2013 2:24 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	1,581,424	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	7,760,757	0	0	0	4.00
5.00	Other receivable	714,807	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	593,630	0	0	0	7.00
8.00	Prepaid expenses	371,642	0	0	0	8.00
9.00	Other current assets	522,707	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	11,544,967	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	2,250,000	0	0	0	12.00
13.00	Land improvements	683,019	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	28,638,991	0	0	0	15.00
16.00	Accumulated depreciation	-16,688,512	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	20,431,310	0	0	0	23.00
24.00	Accumulated depreciation	-12,119,818	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	23,194,990	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	18,014,002	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	18,014,002	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	52,753,959	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	2,788,295	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,783,962	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	486,574	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	19,500	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,078,331	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	6,047,177	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)	6,047,177	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	13,125,508	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	39,628,451				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)	39,628,451	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	52,753,959	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet G-1

Date/Time Prepared:  
1/31/2013 2:24 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		41,731,567	
2.00	Net income (loss) (From Wkst. G-3, line 29)		-1,657,987			2.00
3.00	Total (sum of line 1 and line 2)		40,073,580		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		40,073,580		0	11.00
12.00	MISC ADJ	445,129		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		445,129		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		39,628,451		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet G-1

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
1/31/2013 2:24 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	6,141,414		6,141,414	1.00
2.00	SUBPROVIDER - IPF	4,396,836		4,396,836	2.00
3.00	SUBPROVIDER - IRF	3,020,226		3,020,226	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	13,558,476		13,558,476	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	1,913,220		1,913,220	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)	1,913,220		1,913,220	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	15,471,696		15,471,696	17.00
18.00	Ancillary services	36,810,497	78,398,848	115,209,345	18.00
19.00	Outpatient services	2,538,506	9,638,827	12,177,333	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	DIETARY	18,032	690	18,722	27.00
27.01	PHYSICIAN PRIVATE OFFICE	0	188,251	188,251	27.01
27.02	PRO FEES	561,608	4,166,525	4,728,133	27.02
27.03	PHYSICIAN SERVICE REVENUE	0	20,006,690	20,006,690	27.03
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	55,400,339	112,399,831	167,800,170	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		63,830,866		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)		63,830,866		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150129

Period:  
From 09/01/2011  
To 08/31/2012

Worksheet G-3

Date/Time Prepared:  
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	167,800,170	1.00
2.00	Less contractual allowances and discounts on patients' accounts	110,550,141	2.00
3.00	Net patient revenues (line 1 minus line 2)	57,250,029	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	63,830,866	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-6,580,837	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	INTEREST INCOME	214,953	24.00
24.01	OTHER OPERATING REVENUE	3,947,963	24.01
24.02	GAIN ON SALE OF ASSETS	5,826	24.02
24.03	GAIN ON HII	754,108	24.03
25.00	Total other income (sum of lines 6-24)	4,922,850	25.00
26.00	Total (line 5 plus line 25)	-1,657,987	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)	-1,657,987	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150129	Period: From 09/01/2011 To 08/31/2012	Worksheet L Parts I-III Date/Time Prepared: 1/31/2013 2:24 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		300,481	1.00
2.00	Capital DRG outlier payments		9,154	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		16.07	3.00
4.00	Number of interns & residents (see instructions)		8.25	4.00
5.00	Indirect medical education percentage (see instructions)		15.59	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		46,845	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		356,480	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