

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: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet S Parts I-III Date/Time Prepared: 5/24/2013 7:29 am
--	----------------------	---	--

PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/24/2013 Time: 7:29 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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 WITHAM MEMORIAL HOSPITAL (150104) for the cost reporting period beginning 01/01/2012 and ending 12/31/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title V		Title XVII		HIT	Title XIX	
	1.00	2.00	Part A	Part B			
PART III - SETTLEMENT SUMMARY							
1.00 Hospital	0	-91,942		-68,002	106,554	-1,081,150	1.00
2.00 Subprovider - IPF	0	0		0		0	2.00
3.00 Subprovider - IRF	0	0		0		0	3.00
4.00 SUBPROVIDER I	0	0		0		0	4.00
5.00 Swing bed - SNF	0	0		0		0	5.00
6.00 Swing bed - NF	0	0		0		0	6.00
7.00 SKILLED NURSING FACILITY	0	0		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	-91,942		-68,002	106,554	-1,081,150	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.

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: 150104
 Period: From 01/01/2012 To 12/31/2012
 Worksheet S Parts I-III
 Date/Time Prepared: 5/24/2013 7:29 am

PART I - COST REPORT STATUS

Provider use only
 1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.
 Date: 5/24/2013 Time: 7:29 am

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

PART II - CERTIFICATION

MI SREPRESENTATION 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 WITHAM MEMORIAL HOSPITAL (150104) for the cost reporting period beginning 01/01/2012 and ending 12/31/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 5/24/2013 Time: 7:29 am
 B8vMXqoXMxxpZLbTrJe39uU: 1oS0m0
 qTmswOmbMXmgW2. 8Ae3W5JFYc. Ai DN
 jEzV0. 1PkL0I l 3uT
PI: Date: 5/24/2013 Time: 7:29 am
 C7yr6QqSl: VxbQa6yP. 9X. M1j Pf7RO
 8WgBx0VqAi ZoWUQMxphFegsW8zFv9.
 VH9c0FRSRX04YGyr

(Signed)

Officer or Administrator of Provider(s)

Title

Date

	Title V 1.00	Title XVII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-91,942	-68,002	106,554	-1,081,150	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
7.00 SKILLED NURSING FACILITY	0	0	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	-91,942	-68,002	106,554	-1,081,150	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: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/24/2013 7:28 am
---	--	----------------------	---	---

		1.00	2.00	3.00	4.00					
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 2605 N. LEBANON STREET	PO Box:		Zip Code: 46052-		County: BOONE			1.00	
2.00	City: LEBANON	State: IN							2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	WI THAM MEMORIAL HOSPITAL	150104	26900	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	WI THAM HOSPITAL GEROPSYCH	15S104	26900	4	01/01/2000	N	P	N	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2012	12/31/2012		20.00	
21.00	Type of Control (see instructions)					9		21.00		
Inpatient PPS Information										
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	450	457	0	0	1,024	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0		25.00	
						Urban/Rural	S	Date of Geogr		
						1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/24/2013 7:28 am		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.	Y	Y			39.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.					58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00				62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1 / (col. 1 + col. 2)) 3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 150104

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

Worksheet S-2
Part I
Date/Time Prepared:
5/24/2013 7:28 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/24/2013 7:28 am		
		1.00	2.00	3.00		
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y				70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N		0		71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N				75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		76.00
		1.00				
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
		V	XIX			
		1.00	2.00			
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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.	N	N	N	N	109.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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.	2				118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part I Date/Time Prepared: 5/24/2013 7:28 am	
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.00	List amounts of malpractice premiums and paid losses:	293,890	0		0
				1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		N		140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	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		144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N		145.00
				1.00	2.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150104			Period: From 01/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 5/24/2013 7:28 am																																					
								1.00																																				
Multi campus																																												
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00																																			
Health Information Technology (HIT) Incentive in the American Recovery and Reinvestment Act																																												
<table border="1"> <thead> <tr> <th></th> <th>Name</th> <th>County</th> <th>State</th> <th>Zip Code</th> <th>CBSA</th> <th>FTE/Campus</th> <th></th> </tr> <tr> <th></th> <th>0</th> <th>1.00</th> <th>2.00</th> <th>3.00</th> <th>4.00</th> <th>5.00</th> <th></th> </tr> </thead> <tbody> <tr> <td>166.00</td> <td colspan="6">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</td> <td>0.00</td> <td>166.00</td> </tr> <tr> <td colspan="8"></td> <td>1.00</td> <td></td> </tr> </tbody> </table>											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	
	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																																				
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00																																			
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00																																			
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							1.00	169.00																																			

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/24/2013 7:28 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		N		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.		N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
			Part A		Part B
			Y/N	Date	Y/N
			1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		Y	03/20/2013	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	1.00 N	2.00	3.00 N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA		SEVERS	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.	317-713-7946		TSEVERS@BLUEANDCO.COM	43.00

		Part B		
		Date		
		4.00		
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	03/20/2013		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HFS Supplemental Information		Provider CCN: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part IX Date/Time Prepared: 5/24/2013 7:28 am
		Title V 1.00	Title XIX 2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient 1.00	Outpatient 2.00	
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V 1.00	Title XIX 2.00	
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150104

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

Worksheet S-3
Part I
Date/Time Prepared:
5/24/2013 7:28 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	60	21,960	0.00	0	1.00
2.00 HMO						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		60	21,960	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,928	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		68	24,888	0.00	0	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	40.00	10	3,660		0	16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	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
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		78				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

Component	I/P Days / O/P Vi s i t s / Tri ps			Full Time Equival ents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payrol l	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	2,338	411	5,186			1.00
2.00 HMO	438	1,468				2.00
3.00 HMO IPF Subprovider	2	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	2,338	411	5,186			7.00
8.00 INTENSIVE CARE UNIT	636	0	1,513			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		0	916			13.00
14.00 Total (see instructions)	2,974	411	7,615	0.00	537.13	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	1,986	0	2,333	0.00	18.31	16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150104

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

Worksheet S-3
Part I
Date/Time Prepared:
5/24/2013 7:28 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title VIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	555.44	27.00
28.00 Observation Bed Days		381	1,621			28.00
29.00 Ambulance Trips	21,275					29.00
30.00 Employee discount days (see instruction)			86			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		52	71			32.00
33.00 LTCH non-covered days	0					33.00
Component	Full Time Equivalents	Discharges				
	Nonpaid Workers	Title V	Title XVIII	Title XIX		Total All Patients
	11.00	12.00	13.00	14.00		15.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)		0	889	168	2,280	1.00
2.00 HMO			132			2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	889	168	2,280	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	226	0	262	16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	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
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150104

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

Worksheet S-3
Part II
Date/Time Prepared:
5/24/2013 7:28 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	33,767,921	0	33,767,921	1,155,310.00	29.23
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		13,204,611	0	13,204,611	340,520.00	38.78
OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		477,901	0	477,901	8,581.00	55.69
12.00	Contract management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		7,457,051	0	7,457,051		
18.00	Wage-related costs (other) Wkst S-3, Part IV line 25		0	0	0		
19.00	Excluded areas		3,447,675	0	3,447,675		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits	4.00	101,575	0	101,575	8,658.00	11.73
27.00	Administrative & General	5.00	4,373,030	0	4,373,030	174,486.00	25.06
28.00	Administrative & General under contract (see inst.)		728,968	0	728,968	6,002.00	121.45
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	479,698	0	479,698	19,631.00	24.44
31.00	Laundry & Linen Service	8.00	26,625	0	26,625	2,581.00	10.32
32.00	Housekeeping	9.00	301,479	0	301,479	24,207.00	12.45
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	562,015	-323,760	238,255	12,464.00	19.12
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	323,760	323,760	24,142.00	13.41
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	441,224	0	441,224	11,629.00	37.94
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00
40.00	Pharmacy	15.00	391,091	0	391,091	12,311.00	31.77

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150104

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

Worksheet S-3
Part II
Date/Time Prepared:
5/24/2013 7:28 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col. 2 ± col. 3)	Paid Hours Related to Sal aries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
41.00	Medical Records & Medical Records Library	16.00	756,450	0	756,450	35,886.00	21.08	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: 150104

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

Worksheet S-3
Part III
Date/Time Prepared:
5/24/2013 7:28 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	34,496,889	0	34,496,889	1,161,312.00	29.71	1.00
2.00	Excluded area salaries (see instructions)	13,204,611	0	13,204,611	340,520.00	38.78	2.00
3.00	Subtotal salaries (line 1 minus line 2)	21,292,278	0	21,292,278	820,792.00	25.94	3.00
4.00	Subtotal other wages & related costs (see inst.)	477,901	0	477,901	8,581.00	55.69	4.00
5.00	Subtotal wage-related costs (see inst.)	7,457,051	0	7,457,051	0.00	35.02	5.00
6.00	Total (sum of lines 3 thru 5)	29,227,230	0	29,227,230	829,373.00	35.24	6.00
7.00	Total overhead cost (see instructions)	8,162,155	0	8,162,155	331,997.00	24.59	7.00

Provider CCN: 150104

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

Worksheet S-3
Part IV
Date/Time Prepared:
5/24/2013 7:28 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	1,603,889	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	6,176,975	8.00
9.00	Prescription Drug Plan	206,485	9.00
10.00	Dental, Hearing and Vision Plan	277,609	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	88,607	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)	138,785	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	231,386	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	2,153,851	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	27,789	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	10,905,376	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	90,655	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150104

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

Worksheet S-3
Part V
Date/Time Prepared:
5/24/2013 7:28 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	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			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet S-10 Date/Time Prepared: 5/24/2013 7:28 am
---	----------------------	---	--

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.253398	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		5,111,520	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			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		28,120,007	6.00
7.00	Medicaid cost (line 1 times line 6)		7,125,554	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)		2,014,034	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)		2,014,034	19.00
			1.00	
			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	Uninsured patients	Insured patients	Total (col. 1 + col. 2)
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,339,826	0	1,339,826
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	1,339,826	0	1,339,826
			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?			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)		13,357,457	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		38,435	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		13,319,022	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		3,375,014	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		4,714,840	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		6,728,874	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150104

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

Worksheet A
Date/Time Prepared:
5/24/2013 7:28 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		7,076,169	7,076,169	-608,363	6,467,806	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		0	0	3,593,986	3,593,986	2.00
3.00	00300 OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS	101,575	8,604,779	8,706,354	325,953	9,032,307	4.00
5.00	00500 ADMINISTRATION & GENERAL	4,373,030	11,167,820	15,540,850	-1,167,449	14,373,401	5.00
7.00	00700 OPERATION OF PLANT	479,698	2,510,537	2,990,235	-17,960	2,972,275	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	26,625	193,561	220,186	0	220,186	8.00
9.00	00900 HOUSEKEEPING	301,479	145,439	446,918	-3,370	443,548	9.00
10.00	01000 DIETARY	562,015	508,706	1,070,721	-640,759	429,962	10.00
11.00	01100 CAFETERIA	0	0	0	637,659	637,659	11.00
13.00	01300 NURSING ADMINISTRATION	441,224	45,210	486,434	-2,344	484,090	13.00
15.00	01500 PHARMACY	391,091	1,631,515	2,022,606	-575,154	1,447,452	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	756,450	309,807	1,066,257	-113,493	952,764	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	2,517,608	1,614,334	4,131,942	-121,408	4,010,534	30.00
31.00	03100 INTENSIVE CARE UNIT	915,697	269,552	1,185,249	-41,732	1,143,517	31.00
40.00	04000 SUBPROVIDER - I/PF	905,215	181,570	1,086,785	-6,699	1,080,086	40.00
41.00	04100 SUBPROVIDER - I/RF	0	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300 NURSERY	0	41,895	41,895	0	41,895	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,595,340	4,508,719	6,104,059	-2,367,572	3,736,487	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	954,082	2,602,421	3,556,503	-405,840	3,150,663	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501 ULTRA SOUND	234,445	340,209	574,654	-79,473	495,181	55.01
57.00	05700 CT SCAN	121,887	894,199	1,016,086	-521,955	494,131	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	268,218	945,341	1,213,559	-448,843	764,716	58.00
59.00	05900 CARDIAC CATHETERIZATION	142,165	498,336	640,501	-115,604	524,897	59.00
60.00	06000 LABORATORY	1,789,950	3,139,615	4,929,565	-70,279	4,859,286	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	166,736	166,736	0	166,736	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600 PHYSICAL THERAPY	920,456	185,093	1,105,549	-13,888	1,091,661	66.00
67.00	06700 OCCUPATIONAL THERAPY	256,530	143,788	400,318	-1,772	398,546	67.00
67.01	06701 AUDIOLOGY	110,180	164,818	274,998	-10,871	264,127	67.01
68.00	06800 SPEECH PATHOLOGY	40,059	31,944	72,003	-21	71,982	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901 CARDIOLOGY	757,495	180,336	937,831	-45,773	892,058	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	-2,339	-2,339	375,222	372,883	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,352,770	2,352,770	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	517,639	517,639	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	136,043	130,730	266,773	-7,551	259,222	90.01
90.02	09002 CLINIC	0	0	0	0	0	90.02
90.03	09003 DERMATOLOGY CLINIC	0	1,188	1,188	0	1,188	90.03
90.04	09004 ENT CLINIC	0	2,905	2,905	-2,885	20	90.04
90.05	09005 SURGERY CLINIC	0	710	710	-710	0	90.05
90.07	09007 UROLOGY CLINIC	0	3,333	3,333	-951	2,382	90.07
90.09	09009 GASTROENTEROLOGY CLINIC	52,797	4,626	57,423	0	57,423	90.09
90.11	09011 NEUROLOGY CLINIC	0	4,476	4,476	-3,323	1,153	90.11
90.12	09012 OPHTHAMOLOGY CLINIC	0	39,622	39,622	-20,977	18,645	90.12
90.13	09013 ALLERGY CLINIC	144,869	36,678	181,547	-794	180,753	90.13
90.14	09014 WOUND CARE	196,803	214,026	410,829	-8,135	402,694	90.14
91.00	09100 EMERGENCY	1,975,499	2,231,818	4,207,317	-193,129	4,014,188	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	1,208,710	322,458	1,531,168	-89,344	1,441,824	95.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	22,677,235	51,092,680	73,769,915	94,808	73,864,723	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	11,059,751	3,755,012	14,814,763	-94,808	14,719,955	192.00
194.00	07950 THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951 CAFE/BOUQUIN	0	0	0	0	0	194.01
194.02	07952 OTHER NONREIMBURSABLE COST CENTERS	30,935	95,597	126,532	0	126,532	194.02
200.00	TOTAL (SUM OF LINES 118-199)	33,767,921	54,943,289	88,711,210	0	88,711,210	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150104

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

Worksheet A
Date/Time Prepared:
5/24/2013 7:28 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-604,488	5,863,318	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	3,593,986	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	-2,779,829	6,252,478	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-957,881	13,415,520	5.00
7.00	00700	OPERATION OF PLANT	-738,826	2,233,449	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	220,186	8.00
9.00	00900	HOUSEKEEPING	-1,020	442,528	9.00
10.00	01000	DIETARY	-61,375	368,587	10.00
11.00	01100	CAFETERIA	-280,616	357,043	11.00
13.00	01300	NURSING ADMINISTRATION	0	484,090	13.00
15.00	01500	PHARMACY	0	1,447,452	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,325	949,439	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-833,862	3,176,672	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,143,517	31.00
40.00	04000	SUBPROVIDER - I PF	-31,185	1,048,901	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	41,895	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-3,345	3,733,142	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-108	3,150,555	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
55.01	05501	ULTRA SOUND	0	495,181	55.01
57.00	05700	CT SCAN	0	494,131	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	764,716	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	524,897	59.00
60.00	06000	LABORATORY	-251,450	4,607,836	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	166,736	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	1,091,661	66.00
67.00	06700	OCCUPATIONAL THERAPY	-6,634	391,912	67.00
67.01	06701	AUDIOLOGY	-168,510	95,617	67.01
68.00	06800	SPEECH PATHOLOGY	0	71,982	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	CARDIOLOGY	0	892,058	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-111,306	261,577	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,352,770	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-23,347	494,292	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	-34,580	224,642	90.01
90.02	09002	CLINIC	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	-1,188	0	90.03
90.04	09004	ENT CLINIC	0	20	90.04
90.05	09005	SURGERY CLINIC	0	0	90.05
90.07	09007	UROLOGY CLINIC	-2,382	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	-24,000	33,423	90.09
90.11	09011	NEUROLOGY CLINIC	-1,153	0	90.11
90.12	09012	OPHTHALMOLOGY CLINIC	0	18,645	90.12
90.13	09013	ALLERGY CLINIC	0	180,753	90.13
90.14	09014	WOUND CARE	0	402,694	90.14
91.00	09100	EMERGENCY	-1,471,620	2,542,568	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-4,196	1,437,628	95.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-8,396,226	65,468,497	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	14,719,955	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	126,532	194.02
200.00		TOTAL (SUM OF LINES 118-199)	-8,396,226	80,314,984	200.00

COST CENTERS USED IN COST REPORT		Provider CCN: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet Non-CMS W Date/Time Prepared: 5/24/2013 7:28 am
Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAPITAL RELATED COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
40.00	SUBPROVIDER - IPF	04000		40.00
41.00	SUBPROVIDER - IRF	04100		41.00
42.00	SUBPROVIDER	04200		42.00
43.00	NURSERY	04300		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
55.00	RADIOLOGY-THERAPEUTIC	05500		55.00
55.01	ULTRA SOUND	05501		55.01
57.00	CT SCAN	05700		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
63.00	BLOOD STORING, PROCESSING & TRANS.	06300		63.00
64.00	INTRAVENOUS THERAPY	06400		64.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
67.01	AUDIOLOGY	06701		67.01
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
69.01	CARDIOLOGY	06901		69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	09000		90.00
90.01	OTHER OUTPATIENT SERVICE COST CENTER	09001		90.01
90.02	CLINIC	09002		90.02
90.03	DERMATOLOGY CLINIC	09003		90.03
90.04	ENT CLINIC	09004		90.04
90.05	SURGERY CLINIC	09005		90.05
90.07	UROLOGY CLINIC	09007		90.07
90.09	GASTROENTEROLOGY CLINIC	09009		90.09
90.11	NEUROLOGY CLINIC	09011		90.11
90.12	OPHTHAMOLOGY CLINIC	09012		90.12
90.13	ALLERGY CLINIC	09013		90.13
90.14	WOUND CARE	09014		90.14
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	09500		95.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
194.00	THORNTOWN OFFICE BUILDING	07950		194.00
194.01	CAFE/BOUTIQUE	07951		194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS	07952		194.02
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 150104

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

Worksheet A-6

Date/Time Prepared:
5/24/2013 7:28 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - EMPLOYEE BENEFITS RECLASS						
1.00	EMPLOYEE BENEFITS	4.00	0	328,003	1.00	
	TOTALS		0	328,003		
B - INSURANCE RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	41,476	1.00	
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	356,378	2.00	
	TOTALS		0	397,854		
C - CAFETERIA RECLASS						
1.00	CAFETERIA	11.00	323,760	313,899	1.00	
	TOTALS		323,760	313,899		
D - MME DEPRECIATION RECLASS						
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	3,593,986	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	
27.00		0.00	0	0	27.00	
28.00		0.00	0	0	28.00	
29.00		0.00	0	0	29.00	
30.00		0.00	0	0	30.00	
31.00		0.00	0	0	31.00	
32.00		0.00	0	0	32.00	
33.00		0.00	0	0	33.00	
34.00		0.00	0	0	34.00	
35.00		0.00	0	0	35.00	
36.00		0.00	0	0	36.00	
	TOTALS		0	3,593,986		
E - DRUG RECLASS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	567,123	1.00	
	TOTALS		0	567,123		
F - MED SUPPLY IMPLANTS						
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	2,352,770	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
	TOTALS		0	2,352,770		
G - CHARGABLE MED SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	480,902	1.00	
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	73	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	

Provider CCN: 150104

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

Worksheet A-6
Date/Time Prepared:
5/24/2013 7:28 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
	TOTALS		0	480,975		
500.00	Grand Total: Increases		323,760	8,034,610		500.00

RECLASSIFICATIONS

Provider CCN: 150104

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

Worksheet A-6
Date/Time Prepared:
5/24/2013 7:28 am

Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - EMPLOYEE BENEFITS RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	328,003	0		1.00
	TOTALS		0	328,003			
B - INSURANCE RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	397,854	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	397,854			
C - CAFETERIA RECLASS							
1.00	DIETARY	10.00	323,760	313,899	0		1.00
	TOTALS		323,760	313,899			
D - MME DEPRECIATION RECLASS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,006,217	9		1.00
2.00	EMPLOYEE BENEFITS	4.00	0	2,050	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	441,592	0		3.00
4.00	OPERATION OF PLANT	7.00	0	17,960	0		4.00
5.00	HOUSEKEEPING	9.00	0	3,370	0		5.00
6.00	DIETARY	10.00	0	3,067	0		6.00
8.00	NURSING ADMINISTRATION	13.00	0	2,344	0		8.00
9.00	PHARMACY	15.00	0	3,517	0		9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	113,493	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	27,323	0		11.00
12.00	SUBPROVIDER - IPF	40.00	0	3,594	0		12.00
13.00	OPERATING ROOM	50.00	0	173,973	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	362,519	0		14.00
15.00	ULTRA SOUND	55.01	0	75,260	0		15.00
16.00	CT SCAN	57.00	0	518,931	0		16.00
17.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	446,531	0		17.00
18.00	CARDIAC CATHETERIZATION	59.00	0	22,328	0		18.00
19.00	LABORATORY	60.00	0	69,823	0		19.00
21.00	PHYSICAL THERAPY	66.00	0	11,344	0		21.00
22.00	OCCUPATIONAL THERAPY	67.00	0	1,280	0		22.00
23.00	AUDIOLOGY	67.01	0	10,871	0		23.00
24.00	SPEECH PATHOLOGY	68.00	0	21	0		24.00
25.00	CARDIOLOGY	69.01	0	44,956	0		25.00
26.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	894	0		26.00
27.00	OTHER OUTPATIENT SERVICE COST CENTER	90.01	0	7,047	0		27.00
28.00	ENT CLINIC	90.04	0	2,885	0		28.00
29.00	SURGERY CLINIC	90.05	0	710	0		29.00
30.00	NEUROLOGY CLINIC	90.11	0	3,323	0		30.00
31.00	OPHTHAMOLOGY CLINIC	90.12	0	20,977	0		31.00
32.00	ALLERGY CLINIC	90.13	0	789	0		32.00
33.00	WOUND CARE	90.14	0	168	0		33.00
34.00	EMERGENCY	91.00	0	18,315	0		34.00
35.00	AMBULANCE SERVICES	95.00	0	81,708	0		35.00
36.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	94,806	0		36.00
	TOTALS		0	3,593,986			
E - DRUG RECLASS							
1.00	PHARMACY	15.00	0	567,123	0		1.00
	TOTALS		0	567,123			
F - MED SUPPLY IMPLANTS							
1.00	ADULTS & PEDIATRICS	30.00	0	464	0		1.00
2.00	OPERATING ROOM	50.00	0	2,067,695	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	43,394	0		3.00
4.00	CARDIAC CATHETERIZATION	59.00	0	89,820	0		4.00
5.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	101,913	0		5.00
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	49,484	0		6.00
	TOTALS		0	2,352,770			
G - CHARGABLE MED SUPPLIES							
1.00	DIETARY	10.00	0	33	0		1.00
2.00	PHARMACY	15.00	0	4,514	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	93,621	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	41,732	0		4.00
5.00	SUBPROVIDER - IPF	40.00	0	3,105	0		5.00
6.00	OPERATING ROOM	50.00	0	125,904	0		6.00
7.00	ULTRA SOUND	55.01	0	4,213	0		7.00
8.00	CT SCAN	57.00	0	3,024	0		8.00
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	2,312	0		9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	3,456	0		10.00

Provider CCN: 150104

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

Worksheet A-6
Date/Time Prepared:
5/24/2013 7:28 am

Decreases								
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
11.00	LABORATORY	60.00	0	456	0		11.00	
12.00	PHYSICAL THERAPY	66.00	0	2,544	0		12.00	
13.00	OCCUPATIONAL THERAPY	67.00	0	492	0		13.00	
14.00	CARDIOLOGY	69.01	0	817	0		14.00	
15.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,873	0		15.00	
16.00	OTHER OUTPATIENT SERVICE COST CENTER	90.01	0	504	0		16.00	
17.00	UROLOGY CLINIC	90.07	0	951	0		17.00	
18.00	ALLERGY CLINIC	90.13	0	5	0		18.00	
19.00	WOUND CARE	90.14	0	7,967	0		19.00	
20.00	EMERGENCY	91.00	0	174,814	0		20.00	
21.00	AMBULANCE SERVICES	95.00	0	7,636	0		21.00	
22.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2	0		22.00	
	TOTALS		0	480,975				
500.00	Grand Total: Decreases		323,760	8,034,610			500.00	

Increases			Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary	
2.00	3.00	4.00	6.00	7.00	8.00	
A - EMPLOYEE BENEFITS RECLASS						
1.00	EMPLOYEE BENEFITS	4.00	ADMINISTRATIVE & GENERAL	5.00	0	1.00
	TOTALS		TOTALS		0	
B - INSURANCE RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	ADMINISTRATIVE & GENERAL	5.00	0	1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00		0.00	0	2.00
	TOTALS		TOTALS		0	
C - CAFETERIA RECLASS						
1.00	CAFETERIA	11.00	DIETARY	10.00	323,760	1.00
	TOTALS		TOTALS		323,760	
D - MME DEPRECIATION RECLASS						
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00		0.00	EMPLOYEE BENEFITS	4.00	0	2.00
3.00		0.00	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00		0.00	OPERATION OF PLANT	7.00	0	4.00
5.00		0.00	HOUSEKEEPING	9.00	0	5.00
6.00		0.00	DIETARY	10.00	0	6.00
8.00		0.00	NURSING ADMINISTRATION	13.00	0	8.00
9.00		0.00	PHARMACY	15.00	0	9.00
10.00		0.00	MEDICAL RECORDS & LIBRARY	16.00	0	10.00
11.00		0.00	ADULTS & PEDIATRICS	30.00	0	11.00
12.00		0.00	SUBPROVIDER - IPF	40.00	0	12.00
13.00		0.00	OPERATING ROOM	50.00	0	13.00
14.00		0.00	RADIOLOGY-DIAGNOSTIC	54.00	0	14.00
15.00		0.00	ULTRA SOUND	55.01	0	15.00
16.00		0.00	CT SCAN	57.00	0	16.00
17.00		0.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	17.00
18.00		0.00	CARDIAC CATHETERIZATION	59.00	0	18.00
19.00		0.00	LABORATORY	60.00	0	19.00
21.00		0.00	PHYSICAL THERAPY	66.00	0	21.00
22.00		0.00	OCCUPATIONAL THERAPY	67.00	0	22.00
23.00		0.00	AUDIOLOGY	67.01	0	23.00
24.00		0.00	SPEECH PATHOLOGY	68.00	0	24.00
25.00		0.00	CARDIOLOGY	69.01	0	25.00
26.00		0.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	26.00
27.00		0.00	OTHER OUTPATIENT SERVICE COST CENTER	90.01	0	27.00
28.00		0.00	DENT CLINIC	90.04	0	28.00
29.00		0.00	SURGERY CLINIC	90.05	0	29.00
30.00		0.00	NEUROLOGY CLINIC	90.11	0	30.00
31.00		0.00	OPHTHALMOLOGY CLINIC	90.12	0	31.00
32.00		0.00	ALLERGY CLINIC	90.13	0	32.00
33.00		0.00	WOUND CARE	90.14	0	33.00
34.00		0.00	EMERGENCY	91.00	0	34.00
35.00		0.00	AMBULANCE SERVICES	95.00	0	35.00
36.00		0.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	36.00
	TOTALS		TOTALS		0	
E - DRUG RECLASS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	PHARMACY	15.00	0	1.00
	TOTALS		TOTALS		0	
F - MED SUPPLY IMPLANTS						
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	ADULTS & PEDIATRICS	30.00	0	1.00
2.00		0.00	OPERATING ROOM	50.00	0	2.00
3.00		0.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3.00
4.00		0.00	CARDIAC CATHETERIZATION	59.00	0	4.00
5.00		0.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	5.00
6.00		0.00	DRUGS CHARGED TO PATIENTS	73.00	0	6.00
	TOTALS		TOTALS		0	
G - CHARGABLE MED SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	DIETARY	10.00	0	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	PHARMACY	15.00	0	2.00
3.00		0.00	ADULTS & PEDIATRICS	30.00	0	3.00
4.00		0.00	INTENSIVE CARE UNIT	31.00	0	4.00
5.00		0.00	SUBPROVIDER - IPF	40.00	0	5.00
6.00		0.00	OPERATING ROOM	50.00	0	6.00
7.00		0.00	ULTRA SOUND	55.01	0	7.00

Provider CCN: 150104

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

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
5/24/2013 7:28 am

	Increases			Decreases				
	Cost Center	Line #	Salary	Cost Center	Line #	Salary		
	2.00	3.00	4.00	6.00	7.00	8.00		
8.00		0.00		0	57.00	0		8.00
9.00		0.00		0	58.00	0		9.00
10.00		0.00		0	59.00	0		10.00
11.00		0.00		0	60.00	0		11.00
12.00		0.00		0	66.00	0		12.00
13.00		0.00		0	67.00	0		13.00
14.00		0.00		0	69.01	0		14.00
15.00		0.00		0	71.00	0		15.00
16.00		0.00		0	90.01	0		16.00
17.00		0.00		0	90.07	0		17.00
18.00		0.00		0	90.13	0		18.00
19.00		0.00		0	90.14	0		19.00
20.00		0.00		0	91.00	0		20.00
21.00		0.00		0	95.00	0		21.00
22.00		0.00		0	192.00	0		22.00
	TOTALS			TOTALS		0		
500.00	Grand Total : Increases		323,760	Grand Total : Decreases		323,760		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150104

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

Worksheet A-7
Part I
Date/Time Prepared:
5/24/2013 7:28 am

		Acquisitions			Disposals and Retirements		
		Beginning Balances	Purchases	Donation			Total
		1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	7,269,626	0	0	0	1.00	
2.00	Land Improvements	0	0	0	0	2.00	
3.00	Buildings and Fixtures	78,397,524	845,117	0	845,117	3.00	
4.00	Building Improvements	0	0	0	0	4.00	
5.00	Fixed Equipment	36,242,559	1,922,769	0	1,922,769	5.00	
6.00	Movable Equipment	0	0	0	0	6.00	
7.00	HIT designated Assets	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	121,909,709	2,767,886	0	2,767,886	8.00	
9.00	Reconciling Items	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	121,909,709	2,767,886	0	2,767,886	10.00	
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	7,269,626	0			1.00	
2.00	Land Improvements	0	0			2.00	
3.00	Buildings and Fixtures	79,043,761	0			3.00	
4.00	Building Improvements	0	0			4.00	
5.00	Fixed Equipment	38,010,676	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)	124,324,063	0			8.00	
9.00	Reconciling Items	0	0			9.00	
10.00	Total (line 8 minus line 9)	124,324,063	0			10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150104

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

Worksheet A-7
Part II
Date/Time Prepared:
5/24/2013 7:28 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	7,076,169	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	7,076,169	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	7,076,169				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	7,076,169				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150104

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

Worksheet A-7
Part III
Date/Time Prepared:
5/24/2013 7:28 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	79,043,761	0	79,043,761	0.675274	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	38,010,676	0	38,010,676	0.324726	0	2.00
3.00	Total (sum of lines 1-2)	117,054,437	0	117,054,437	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	6,069,952	-61,469	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	3,593,986	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	9,663,938	-61,469	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	-543,019	397,854	0	0	5,863,318	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	3,593,986	2.00
3.00	Total (sum of lines 1-2)	-543,019	397,854	0	0	9,457,304	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0			0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-4,934		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)		0			0.00	0	8.00
9.00 Parking lot (chapter 21)		0			0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-2,593,439				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0				0	12.00
13.00 Laundry and linen service		0			0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-193,717		CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employees and others		0			0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	0	16.00
17.00 Sale of drugs to other than patients		0			0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-3,325		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00	0	19.00
20.00 Vending machines	B	-3,623		DIETARY	10.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0		*** Cost Center Deleted ***	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0		PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0		*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.	
			Cost Center	Line #			
			1.00	2.00	3.00		
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00		32.00
33.00 HOSPITAL ADMIN SPONSORSHIPS/DONATION	A	-218,325	ADMINISTRATIVE & GENERAL		5.00		33.00
33.01 TOXICOLOGY SPONSORSHIPS	A	-50	LABORATORY		60.00		33.01
33.02 RENTAL REVENUE	B	-26,944	NEW CAP REL COSTS-BLDG & FIXT		1.00	10	33.02
33.03 MEDICAL STAFF FEES	B	-2,850	ADMINISTRATIVE & GENERAL		5.00		33.03
33.04 PATIENT ACCOUNTS	B	-45,637	ADMINISTRATIVE & GENERAL		5.00		33.04
33.05 MEALS ON WHEELS	B	-45,056	DIETARY		10.00		33.05
33.06 MED SURG MISC REV	B	-862	ADULTS & PEDIATRICS		30.00		33.06
33.07 DERMATOLOGY CLINIC RENT	A	-1,188	DERMATOLOGY CLINIC		90.03		33.07
33.08		0			0.00		33.08
33.09 UROLOGY CLINIC RENT	A	-2,382	UROLOGY CLINIC		90.07		33.09
33.10 GASTROENTEROLOGY CLINIC RENT	A	-24,000	GASTROENTEROLOGY CLINIC		90.09		33.10
33.11 NEUROLOGY CLINIC RENT	A	-1,153	NEUROLOGY CLINIC		90.11		33.11
33.12 AMBULANCE	B	-4,196	AMBULANCE SERVICES		95.00		33.12
33.13 RENTAL INCOME ANSON	B	-738,826	OPERATION OF PLANT		7.00		33.13
33.14 2005 PREMIUM AMORTIZATION	B	-134,258	NEW CAP REL COSTS-BLDG & FIXT		1.00	11	33.14
33.15 2010 PREMIUM AMORTIZATION	B	-24,133	NEW CAP REL COSTS-BLDG & FIXT		1.00	11	33.15
33.16 2005 BOND GAIN/LOSS ON INVESTMENT	B	-3,735	NEW CAP REL COSTS-BLDG & FIXT		1.00	11	33.16
33.17 2005 BOND INTEREST ON INVEST	B	-24,188	NEW CAP REL COSTS-BLDG & FIXT		1.00	11	33.17
33.18 2010 BOND INTEREST ON INVEST	B	-20,460	NEW CAP REL COSTS-BLDG & FIXT		1.00	11	33.18
33.19 LOSS ON INVESTMENT	B	-37,842	NEW CAP REL COSTS-BLDG & FIXT		1.00	11	33.19
33.20 GAIN/LOSS SHO INV	B	87,554	ADMINISTRATIVE & GENERAL		5.00		33.20
33.21 GAIN/LOSS CIHA	B	-53,062	ADMINISTRATIVE & GENERAL		5.00		33.21
33.22 GAIN/LOSS SHO RRG	B	48,470	ADMINISTRATIVE & GENERAL		5.00		33.22
33.23 HEARING AID COSTS	A	-168,510	AUDIOLOGY		67.01		33.23
33.24 PHYSICIAN RECRUITMENT	A	-32,691	ADMINISTRATIVE & GENERAL		5.00		33.24
33.25 BANK FEES	A	-129,869	ADMINISTRATIVE & GENERAL		5.00		33.25
33.26 LOBBYING EXPENSE-IHA DUES	A	-1,480	ADMINISTRATIVE & GENERAL		5.00		33.26
33.27 LOBBYING EXPENSE-AHA DUES	A	-4,093	ADMINISTRATIVE & GENERAL		5.00		33.27
33.28 NONREIMBURSABLE ADVERTISING COSTS	A	-360,856	ADMINISTRATIVE & GENERAL		5.00		33.28
33.29 PHYSICIAN CLINIC ANSON	B	-34,580	OTHER OUTPATIENT SERVICE COST CENTER		90.01		33.29
33.30 OPERATING ROOM PURCHASING DISCOUNTS	B	-3,345	OPERATING ROOM		50.00		33.30
33.31 CENTRAL SUPPLY PURCHASING DISCOUNTS	B	-111,306	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00		33.31
33.32 LAB PURCHASING DISCOUNTS	B	-400	LABORATORY		60.00		33.32
33.33 RADIOLOGY DIAGNOSTIC PURCHASING DISC	B	-108	RADIOLOGY-DIAGNOSTIC		54.00		33.33
33.34 PHARMACY ED	B	-23,347	DRUGS CHARGED TO PATIENTS		73.00		33.34
33.35 HEAD START	B	-12,696	DIETARY		10.00		33.35
33.36 HOUSEKEEPING	B	-1,020	HOUSEKEEPING		9.00		33.36
33.37 WELLNESS REVENUE	B	-46,079	EMPLOYEE BENEFITS		4.00		33.37
33.38 OTHER OPERATING REVENUE	B	-240,108	ADMINISTRATIVE & GENERAL		5.00		33.38
33.39 1208 N. LEBANON RENTAL INCOME	B	-8,500	NEW CAP REL COSTS-BLDG & FIXT		1.00	10	33.39
33.40 LEASE INCOME	B	-26,025	NEW CAP REL COSTS-BLDG & FIXT		1.00	10	33.40
33.41		0			0.00		33.41
33.42 INTEREST INCOME	B	-298,403	NEW CAP REL COSTS-BLDG & FIXT		1.00	11	33.42
33.43 CAFETERIA GUEST MEALS	A	-86,899	CAFETERIA		11.00		33.43
33.44		0			0.00		33.44
33.45 SELF INSURANCE CLAIMS PAID	A	-2,733,750	EMPLOYEE BENEFITS		4.00		33.45
33.46		0			0.00		33.46
33.47		0			0.00		33.47
33.48		0			0.00		33.48

Provider CCN: 150104

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

Worksheet A-8
 Date/Time Prepared:
 5/24/2013 7:28 am

33.49 33.50 50.00	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.				
				1.00	2.00			3.00	4.00	5.00
				Cost Center	Line #					
			0			0	33.49			
			0			0	33.50			
	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,396,226				50.00			

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150104

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

Worksheet A-8-2

Date/Time Prepared:
5/24/2013 7:28 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	833,000	833,000	0	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	64,228	0	64,228	154,100	446	2.00
3.00	60.00	LABORATORY	251,000	251,000	0	0	0	3.00
4.00	67.00	OCCUPATIONAL THERAPY	6,634	6,634	0	0	0	4.00
5.00	91.00	EMERGENCY	1,471,620	1,471,620	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,626,482	2,562,254	64,228		446	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	33,043	1,652	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			33,043	1,652	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	833,000		1.00
2.00	40.00	SUBPROVIDER - IPF	0	33,043	31,185	31,185		2.00
3.00	60.00	LABORATORY	0	0	0	251,000		3.00
4.00	67.00	OCCUPATIONAL THERAPY	0	0	0	6,634		4.00
5.00	91.00	EMERGENCY	0	0	0	1,471,620		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	33,043	31,185	2,593,439		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150104

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

Worksheet B
Part I
Date/Time Prepared:
5/24/2013 7:28 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	5,863,318	5,863,318				1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	3,593,986		3,593,986			2.00
4.00 00400 EMPLOYEE BENEFITS	6,252,478	13,335	8,174	6,273,987		4.00
5.00 00500 ADMINISTRATIVE & GENERAL	13,415,520	426,162	261,220	814,949	14,917,851	5.00
7.00 00700 OPERATION OF PLANT	2,233,449	558,317	342,227	89,396	3,223,389	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	220,186	0	0	4,962	225,148	8.00
9.00 00900 HOUSEKEEPING	442,528	64,291	39,408	56,183	602,410	9.00
10.00 01000 DIETARY	368,587	143,910	88,211	44,401	645,109	10.00
11.00 01100 CAFETERIA	357,043	0	0	60,335	417,378	11.00
13.00 01300 NURSING ADMINISTRATION	484,090	0	0	82,226	566,316	13.00
15.00 01500 PHARMACY	1,447,452	44,426	27,232	72,883	1,591,993	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	949,439	70,179	43,017	140,971	1,203,606	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	3,176,672	466,784	286,121	469,176	4,398,753	30.00
31.00 03100 INTENSIVE CARE UNIT	1,143,517	128,192	78,577	170,647	1,520,933	31.00
40.00 04000 SUBPROVIDER - IPF	1,048,901	146,774	89,967	168,694	1,454,336	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
43.00 04300 NURSERY	41,895	0	0	0	41,895	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	3,733,142	372,548	228,357	297,304	4,631,351	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	3,150,555	455,626	279,281	177,801	4,063,263	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01 05501 ULTRA SOUND	495,181	0	0	43,691	538,872	55.01
57.00 05700 CT SCAN	494,131	0	0	22,715	516,846	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	764,716	39,088	23,959	49,985	877,748	58.00
59.00 05900 CARDIAC CATHETERIZATION	524,897	32,947	20,195	26,494	604,533	59.00
60.00 06000 LABORATORY	4,607,836	212,485	130,245	333,572	5,284,138	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	166,736	0	0	0	166,736	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00 06600 PHYSICAL THERAPY	1,091,661	205,657	126,060	171,534	1,594,912	66.00
67.00 06700 OCCUPATIONAL THERAPY	391,912	0	0	47,806	439,718	67.00
67.01 06701 AUDIOLOGY	95,617	0	0	20,533	116,150	67.01
68.00 06800 SPEECH PATHOLOGY	71,982	0	0	7,465	79,447	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01 06901 CARDIOLOGY	892,058	21,194	12,991	141,165	1,067,408	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	261,577	0	0	0	261,577	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2,352,770	0	0	0	2,352,770	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	494,292	0	0	0	494,292	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER	224,642	87,569	53,677	25,353	391,241	90.01
90.02 09002 CLINIC	0	140,794	86,301	0	227,095	90.02
90.03 09003 DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04 09004 ENT CLINIC	20	0	0	0	20	90.04
90.05 09005 SURGERY CLINIC	0	0	0	0	0	90.05
90.07 09007 UROLOGY CLINIC	0	0	0	0	0	90.07
90.09 09009 GASTROENTEROLOGY CLINIC	33,423	0	0	9,839	43,262	90.09
90.11 09011 NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12 09012 OPHTHALMOLOGY CLINIC	18,645	0	0	0	18,645	90.12
90.13 09013 ALLERGY CLINIC	180,753	0	0	26,997	207,750	90.13
90.14 09014 WOUND CARE	402,694	80,283	49,211	36,676	568,864	90.14
91.00 09100 EMERGENCY	2,542,568	562,854	345,008	368,150	3,818,580	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	1,437,628	109,061	66,850	225,253	1,838,792	95.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	65,468,497	4,382,476	2,686,289	4,207,156	61,013,127	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	14,297	8,764	0	23,061	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	14,719,955	954,235	584,907	2,061,066	18,320,163	192.00
194.00 07950 THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01 07951 CAFE/BOUTIQUE	0	41,608	25,504	0	67,112	194.01
194.02 07952 OTHER NONREIMBURSABLE COST CENTERS	126,532	470,702	288,522	5,765	891,521	194.02
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)	80,314,984	5,863,318	3,593,986	6,273,987	80,314,984	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet B Part I Date/Time Prepared: 5/24/2013 7:28 am		
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
		5.00	7.00	8.00	9.00	10.00
GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400 EMPLOYEE BENEFITS					4.00
5.00	00500 ADMINISTRATIVE & GENERAL	14,917,851				5.00
7.00	00700 OPERATION OF PLANT	735,294	3,958,683			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	51,359	0	276,507		8.00
9.00	00900 HOUSEKEEPING	137,417	60,431	0	800,258	9.00
10.00	01000 DIETARY	147,157	135,271	0	49,619	977,156
11.00	01100 CAFETERIA	95,209	0	0	16,543	0
13.00	01300 NURSING ADMINISTRATION	129,183	0	0	7,480	0
15.00	01500 PHARMACY	363,153	41,759	0	15,105	0
16.00	01600 MEDICAL RECORDS & LIBRARY	274,557	65,966	0	33,087	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1,003,408	438,762	15,168	251,351	567,308
31.00	03100 INTENSIVE CARE UNIT	346,943	120,497	3,322	66,749	161,431
40.00	04000 SUBPROVIDER - IPF	331,751	137,963	2,727	79,374	248,417
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200 SUBPROVIDER	0	0	0	0	0
43.00	04300 NURSERY	9,557	0	1,264	0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1,056,467	350,183	42,294	14,817	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	926,879	428,274	22,773	67,037	0
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0
55.01	05501 ULTRA SOUND	122,923	0	7,476	4,316	0
57.00	05700 CT SCAN	117,899	0	29,526	6,617	0
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	200,225	36,741	13,863	6,330	0
59.00	05900 CARDIAC CATHETERIZATION	137,901	30,969	5,154	0	0
60.00	06000 LABORATORY	1,205,375	199,729	49,641	28,340	0
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	38,034	0	863	0	0
64.00	06400 INTRAVENOUS THERAPY	0	0	2,460	0	0
66.00	06600 PHYSICAL THERAPY	363,819	193,311	6,316	10,214	0
67.00	06700 OCCUPATIONAL THERAPY	100,305	0	946	4,891	0
67.01	06701 AUDIOLOGY	26,495	0	869	3,596	0
68.00	06800 SPEECH PATHOLOGY	18,123	0	394	2,158	0
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0
69.01	06901 CARDIOLOGY	243,489	19,921	11,394	21,722	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	59,669	0	4,438	0	0
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	536,695	0	6,132	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	112,754	0	13,576	15,680	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	1	0	0
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	89,247	82,312	0	38,553	0
90.02	09002 CLINIC	51,803	132,342	0	56,679	0
90.03	09003 DERMATOLOGY CLINIC	0	0	0	0	0
90.04	09004 ENT CLINIC	5	0	0	0	0
90.05	09005 SURGERY CLINIC	0	0	0	0	0
90.07	09007 UROLOGY CLINIC	0	0	131	0	0
90.09	09009 GASTROENTEROLOGY CLINIC	9,869	0	0	0	0
90.11	09011 NEUROLOGY CLINIC	0	0	849	0	0
90.12	09012 OPHTHALMOLOGY CLINIC	4,253	0	255	0	0
90.13	09013 ALLERGY CLINIC	47,390	0	2,009	0	0
90.14	09014 WOUND CARE	129,765	75,464	2,105	0	0
91.00	09100 EMERGENCY	871,064	529,065	24,575	0	0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	419,451	37,904	5,986	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	10,514,887	3,116,864	276,507	800,258	977,156
NONREIMBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	5,260	13,439	0	0	0
192.00	19200 PHYSICIANS' PRIVATE OFFICES	4,179,028	789,270	0	0	0
194.00	07950 THORNTOWN OFFICE BUILDING	0	0	0	0	0
194.01	07951 CAFE/BOUTIQUE	15,309	39,110	0	0	0
194.02	07952 OTHER NONREIMBURSABLE COST CENTERS	203,367	0	0	0	0
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118-201)	14,917,851	3,958,683	276,507	800,258	977,156

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150104

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

Worksheet B Part I Date/Time Prepared: 5/24/2013 7:28 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		11.00	13.00	15.00	16.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	529,130					11.00
13.00	01300	10,238	713,217				13.00
15.00	01500	20,475	0	2,032,485			15.00
16.00	01600	41,490	0	9	1,618,715		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	139,559	166,518	7,060	397,788	7,385,675	30.00
31.00	03100	11,315	52,384	1,520	82,708	2,367,802	31.00
40.00	04000	17,781	74,125	206	98,462	2,445,142	40.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	52,716	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	12,393	121,897	73,800	142,770	6,445,972	50.00
54.00	05400	15,087	0	3,569	382,032	5,908,914	54.00
55.00	05500	0	0	0	0	0	55.00
55.01	05501	1,616	0	1,382	41,354	717,939	55.01
57.00	05700	2,155	0	5,796	47,262	726,101	57.00
58.00	05800	5,388	0	34,310	25,600	1,200,205	58.00
59.00	05900	0	9,004	313	0	787,874	59.00
60.00	06000	44,184	0	440	39,385	6,851,232	60.00
63.00	06300	0	0	0	0	205,633	63.00
64.00	06400	0	0	0	0	2,460	64.00
66.00	06600	22,092	51,831	4,638	76,800	2,323,933	66.00
67.00	06700	9,160	14,964	37,128	33,477	640,589	67.00
67.01	06701	9,699	9,297	0	0	166,106	67.01
68.00	06800	10,238	2,106	0	0	112,466	68.00
69.00	06900	0	0	0	0	0	69.00
69.01	06901	22,092	48,235	2,398	73,846	1,510,505	69.01
71.00	07100	11,315	0	0	0	336,999	71.00
72.00	07200	0	0	0	0	2,895,597	72.00
73.00	07300	0	0	0	0	636,302	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	1	90.00
90.01	09001	18,320	16,825	534	165,416	802,448	90.01
90.02	09002	0	0	0	0	467,919	90.02
90.03	09003	0	0	0	0	0	90.03
90.04	09004	0	0	0	0	25	90.04
90.05	09005	0	0	28	0	28	90.05
90.07	09007	0	0	1,601	0	1,732	90.07
90.09	09009	0	5,188	33	0	58,352	90.09
90.11	09011	0	0	425	0	1,274	90.11
90.12	09012	0	0	0	0	23,153	90.12
90.13	09013	0	5,888	2,111	0	265,148	90.13
90.14	09014	0	13,972	7,743	0	797,913	90.14
91.00	09100	34,485	118,109	106,387	0	5,502,265	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	70,048	0	14,334	0	2,386,515	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		529,130	710,343	305,765	1,606,900	54,026,935	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	41,760	190.00
192.00	19200	0	2,427	1,726,720	11,815	25,029,423	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	121,531	194.01
194.02	07952	0	447	0	0	1,095,335	194.02
200.00						0	200.00
201.00		0	0	0	0	0	201.00
202.00		529,130	713,217	2,032,485	1,618,715	80,314,984	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet B Part I Date/Time Prepared: 5/24/2013 7:28 am
---	--	----------------------	---	---

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	7,385,675
31.00	03100	INTENSIVE CARE UNIT	0	2,367,802
40.00	04000	SUBPROVIDER - I/PF	0	2,445,142
41.00	04100	SUBPROVIDER - IRF	0	0
42.00	04200	SUBPROVIDER	0	0
43.00	04300	NURSERY	0	52,716
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	6,445,972
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,908,914
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0
55.01	05501	ULTRA SOUND	0	717,939
57.00	05700	CT SCAN	0	726,101
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,200,205
59.00	05900	CARDIAC CATHETERIZATION	0	787,874
60.00	06000	LABORATORY	0	6,851,232
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	205,633
64.00	06400	INTRAVENOUS THERAPY	0	2,460
66.00	06600	PHYSICAL THERAPY	0	2,323,933
67.00	06700	OCCUPATIONAL THERAPY	0	640,589
67.01	06701	AUDIOLOGY	0	166,106
68.00	06800	SPEECH PATHOLOGY	0	112,466
69.00	06900	ELECTROCARDIOLOGY	0	0
69.01	06901	CARDIOLOGY	0	1,510,505
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	336,999
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,895,597
73.00	07300	DRUGS CHARGED TO PATIENTS	0	636,302
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	1
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	802,448
90.02	09002	CLINIC	0	467,919
90.03	09003	DERMATOLOGY CLINIC	0	0
90.04	09004	ENT CLINIC	0	25
90.05	09005	SURGERY CLINIC	0	28
90.07	09007	UROLOGY CLINIC	0	1,732
90.09	09009	GASTROENTEROLOGY CLINIC	0	58,352
90.11	09011	NEUROLOGY CLINIC	0	1,274
90.12	09012	OPHTHAMOLOGY CLINIC	0	23,153
90.13	09013	ALLERGY CLINIC	0	265,148
90.14	09014	WOUND CARE	0	797,913
91.00	09100	EMERGENCY	0	5,502,265
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	2,386,515
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	54,026,935
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	41,760
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	25,029,423
194.00	07950	THORNTOWN OFFICE BUILDING	0	0
194.01	07951	CAFE/BOUTIQUE	0	121,531
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	1,095,335
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	80,314,984

COST ALLOCATION STATISTICS

Provider CCN: 150104

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

Worksheet Non-CMS W
Date/Time Prepared:
5/24/2013 7:28 am

Cost Center Description		Statistics Code	Statistics Description		
		1.00	2.00		
GENERAL SERVICE COST CENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE	FEET	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	3	SQUARE	FEET	2.00
4.00	EMPLOYEE BENEFITS	S	GROSS	SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-34	ACCUM.	COST	5.00
7.00	OPERATION OF PLANT	33	SQUARE	FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	C	GROSS	CHARGES	8.00
9.00	HOUSEKEEPING	9	HOURS OF	SERVICE	9.00
10.00	DIETARY	10	MEALS	SERVED	10.00
11.00	CAFETERIA	11	MEALS	SERVED	11.00
13.00	NURSING ADMINISTRATION	13	DIRECT	NRSING HRS	13.00
15.00	PHARMACY	15	COSTED	REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	16	TIME	SPENT	16.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150104

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2013 7:28 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	0	13,335	8,174	21,509	21,509 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	426,162	261,220	687,382	2,794 5.00
7.00 00700	OPERATION OF PLANT	0	558,317	342,227	900,544	307 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	17 8.00
9.00 00900	HOUSEKEEPING	0	64,291	39,408	103,699	193 9.00
10.00 01000	DIETARY	0	143,910	88,211	232,121	152 10.00
11.00 01100	CAFETERIA	0	0	0	0	207 11.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	282 13.00
15.00 01500	PHARMACY	0	44,426	27,232	71,658	250 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	70,179	43,017	113,196	483 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	466,784	286,121	752,905	1,609 30.00
31.00 03100	INTENSIVE CARE UNIT	0	128,192	78,577	206,769	585 31.00
40.00 04000	SUBPROVIDER - IPF	0	146,774	89,967	236,741	578 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
43.00 04300	NURSERY	0	0	0	0	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	372,548	228,357	600,905	1,019 50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	455,626	279,281	734,907	610 54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0 55.00
55.01 05501	ULTRA SOUND	0	0	0	0	150 55.01
57.00 05700	CT SCAN	0	0	0	0	78 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	39,088	23,959	63,047	171 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	32,947	20,195	53,142	91 59.00
60.00 06000	LABORATORY	0	212,485	130,245	342,730	1,144 60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
66.00 06600	PHYSICAL THERAPY	0	205,657	126,060	331,717	588 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	164 67.00
67.01 06701	AUDIOLOGY	0	0	0	0	70 67.01
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	26 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
69.01 06901	CARDIOLOGY	0	21,194	12,991	34,185	484 69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0 90.00
90.01 09001	OTHER OUTPATIENT SERVICE COST CENTER	0	87,569	53,677	141,246	87 90.01
90.02 09002	CLINIC	0	140,794	86,301	227,095	0 90.02
90.03 09003	DERMATOLOGY CLINIC	0	0	0	0	0 90.03
90.04 09004	ENT CLINIC	0	0	0	0	0 90.04
90.05 09005	SURGERY CLINIC	0	0	0	0	0 90.05
90.07 09007	UROLOGY CLINIC	0	0	0	0	0 90.07
90.09 09009	GASTROENTEROLOGY CLINIC	0	0	0	0	34 90.09
90.11 09011	NEUROLOGY CLINIC	0	0	0	0	0 90.11
90.12 09012	OPHTHAMOLOGY CLINIC	0	0	0	0	0 90.12
90.13 09013	ALLERGY CLINIC	0	0	0	0	93 90.13
90.14 09014	WOUND CARE	0	80,283	49,211	129,494	126 90.14
91.00 09100	EMERGENCY	0	562,854	345,008	907,862	1,262 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	109,061	66,850	175,911	772 95.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	4,382,476	2,686,289	7,068,765	14,426 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	14,297	8,764	23,061	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	954,235	584,907	1,539,142	7,063 192.00
194.00 07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0 194.00
194.01 07951	CAFE/BOUTIQUE	0	41,608	25,504	67,112	0 194.01
194.02 07952	OTHER NONREIMBURSABLE COST CENTERS	0	470,702	288,522	759,224	20 194.02
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	5,863,318	3,593,986	9,457,304	21,509 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150104

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2013 7:28 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	690,176					5.00
7.00	00700 OPERATION OF PLANT	34,020	934,871				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	2,376	0	2,393			8.00
9.00	00900 HOUSEKEEPING	6,358	14,271	0	124,521		9.00
10.00	01000 DIETARY	6,808	31,945	0	7,721	278,747	10.00
11.00	01100 CAFETERIA	4,405	0	0	2,574	0	11.00
13.00	01300 NURSING ADMINISTRATION	5,977	0	0	1,164	0	13.00
15.00	01500 PHARMACY	16,802	9,862	0	2,350	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	12,703	15,578	0	5,148	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	46,424	103,617	129	39,109	161,833	30.00
31.00	03100 INTENSIVE CARE UNIT	16,052	28,456	28	10,386	46,050	31.00
40.00	04000 SUBPROVIDER - IPF	15,349	32,581	23	12,351	70,864	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
43.00	04300 NURSERY	442	0	11	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	48,879	82,698	359	2,306	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	42,884	101,140	193	10,431	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501 ULTRA SOUND	5,687	0	63	672	0	55.01
57.00	05700 CT SCAN	5,455	0	250	1,030	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	9,264	8,677	118	985	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	6,380	7,314	44	0	0	59.00
60.00	06000 LABORATORY	55,769	47,167	469	4,410	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1,760	0	7	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	21	0	0	64.00
66.00	06600 PHYSICAL THERAPY	16,833	45,652	54	1,589	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	4,641	0	8	761	0	67.00
67.01	06701 AUDIOLOGY	1,226	0	7	560	0	67.01
68.00	06800 SPEECH PATHOLOGY	838	0	3	336	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901 CARDIOLOGY	11,265	4,705	97	3,380	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,761	0	38	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	24,831	0	52	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	5,217	0	115	2,440	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	4,129	19,439	0	5,999	0	90.01
90.02	09002 CLINIC	2,397	31,253	0	8,819	0	90.02
90.03	09003 DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004 ENT CLINIC	0	0	0	0	0	90.04
90.05	09005 SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007 UROLOGY CLINIC	0	0	1	0	0	90.07
90.09	09009 GASTROENTEROLOGY CLINIC	457	0	0	0	0	90.09
90.11	09011 NEUROLOGY CLINIC	0	0	7	0	0	90.11
90.12	09012 OPHTHALMOLOGY CLINIC	197	0	2	0	0	90.12
90.13	09013 ALLERGY CLINIC	2,193	0	17	0	0	90.13
90.14	09014 WOUND CARE	6,004	17,821	18	0	0	90.14
91.00	09100 EMERGENCY	40,301	124,942	208	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	19,407	8,951	51	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	486,491	736,069	2,393	124,521	278,747	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	243	3,174	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	193,325	186,392	0	0	0	192.00
194.00	07950 THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951 CAFE/BOUTIQUE	708	9,236	0	0	0	194.01
194.02	07952 OTHER NONREIMBURSABLE COST CENTERS	9,409	0	0	0	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	690,176	934,871	2,393	124,521	278,747	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150104

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2013 7:28 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	15.00	16.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	7,186					11.00
13.00	01300	NURSING ADMINISTRATION	139	7,562				13.00
15.00	01500	PHARMACY	278	0	101,200			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	563	0	0	147,671		16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,897	1,767	352	36,289	1,145,931	30.00
31.00	03100	INTENSIVE CARE UNIT	154	555	76	7,545	316,656	31.00
40.00	04000	SUBPROVIDER - IPF	241	786	10	8,982	378,506	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
43.00	04300	NURSERY	0	0	0	0	453	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	168	1,292	3,675	13,025	754,326	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	205	0	178	34,852	925,400	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	22	0	69	3,773	10,436	55.01
57.00	05700	CT SCAN	29	0	289	4,312	11,443	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	73	0	1,708	2,335	86,378	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	95	16	0	67,082	59.00
60.00	06000	LABORATORY	600	0	22	3,593	455,904	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	1,767	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	21	64.00
66.00	06600	PHYSICAL THERAPY	300	550	231	7,006	404,520	66.00
67.00	06700	OCCUPATIONAL THERAPY	124	159	1,849	3,054	10,760	67.00
67.01	06701	AUDIOLOGY	132	99	0	0	2,094	67.01
68.00	06800	SPEECH PATHOLOGY	139	22	0	0	1,364	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	300	511	119	6,737	61,783	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	154	0	0	0	2,953	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	24,883	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	7,772	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	249	178	27	15,090	186,444	90.01
90.02	09002	CLINIC	0	0	0	0	269,564	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	1	0	1	90.05
90.07	09007	UROLOGY CLINIC	0	0	80	0	81	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	55	2	0	548	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	21	0	28	90.11
90.12	09012	OPHTHALMOLOGY CLINIC	0	0	0	0	199	90.12
90.13	09013	ALLERGY CLINIC	0	62	105	0	2,470	90.13
90.14	09014	WOUND CARE	0	148	386	0	153,997	90.14
91.00	09100	EMERGENCY	468	1,252	5,297	0	1,081,592	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	951	0	714	0	206,757	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,186	7,531	15,227	146,593	6,572,113	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	26,478	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	26	85,973	1,078	2,012,999	192.00
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00
194.01	07951	CAFE/BOUTIQUE	0	0	0	0	77,056	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	5	0	0	768,658	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	7,186	7,562	101,200	147,671	9,457,304	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150104

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2013 7:28 am

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400 EMPLOYEE BENEFITS			4.00
5.00	00500 ADMINISTRATIVE & GENERAL			5.00
7.00	00700 OPERATION OF PLANT			7.00
8.00	00800 LAUNDRY & LINEN SERVICE			8.00
9.00	00900 HOUSEKEEPING			9.00
10.00	01000 DIETARY			10.00
11.00	01100 CAFETERIA			11.00
13.00	01300 NURSING ADMINISTRATION			13.00
15.00	01500 PHARMACY			15.00
16.00	01600 MEDICAL RECORDS & LIBRARY			16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	0	1,145,931	30.00
31.00	03100 INTENSIVE CARE UNIT	0	316,656	31.00
40.00	04000 SUBPROVIDER - I/PF	0	378,506	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	42.00
43.00	04300 NURSERY	0	453	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	754,326	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	925,400	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
55.01	05501 ULTRA SOUND	0	10,436	55.01
57.00	05700 CT SCAN	0	11,443	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	86,378	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	67,082	59.00
60.00	06000 LABORATORY	0	455,904	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	1,767	63.00
64.00	06400 INTRAVENOUS THERAPY	0	21	64.00
66.00	06600 PHYSICAL THERAPY	0	404,520	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	10,760	67.00
67.01	06701 AUDIOLOGY	0	2,094	67.01
68.00	06800 SPEECH PATHOLOGY	0	1,364	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
69.01	06901 CARDIOLOGY	0	61,783	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,953	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	24,883	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	7,772	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	186,444	90.01
90.02	09002 CLINIC	0	269,564	90.02
90.03	09003 DERMATOLOGY CLINIC	0	0	90.03
90.04	09004 ENT CLINIC	0	0	90.04
90.05	09005 SURGERY CLINIC	0	1	90.05
90.07	09007 UROLOGY CLINIC	0	81	90.07
90.09	09009 GASTROENTEROLOGY CLINIC	0	548	90.09
90.11	09011 NEUROLOGY CLINIC	0	28	90.11
90.12	09012 OPHTHAMOLOGY CLINIC	0	199	90.12
90.13	09013 ALLERGY CLINIC	0	2,470	90.13
90.14	09014 WOUND CARE	0	153,997	90.14
91.00	09100 EMERGENCY	0	1,081,592	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0	206,757	95.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	6,572,113	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	26,478	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	2,012,999	192.00
194.00	07950 THORNTOWN OFFICE BUILDING	0	0	194.00
194.01	07951 CAFE/BOUTIQUE	0	77,056	194.01
194.02	07952 OTHER NONREIMBURSABLE COST CENTERS	0	768,658	194.02
200.00	Cross Foot Adjustments	0	0	200.00
201.00	Negative Cost Centers	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	9,457,304	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150104

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

Worksheet B-1

Date/Time Prepared:
5/24/2013 7:28 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)		
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00	5A	5.00		
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	255,907					1.00	
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP		255,907				2.00	
4.00 00400 EMPLOYEE BENEFITS	582	582	33,666,346			4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	18,600	18,600	4,373,030	-14,917,851	65,397,133	5.00	
7.00 00700 OPERATION OF PLANT	24,368	24,368	479,698	0	3,223,389	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	0	0	26,625	0	225,148	8.00	
9.00 00900 HOUSEKEEPING	2,806	2,806	301,479	0	602,410	9.00	
10.00 01000 DIETARY	6,281	6,281	238,255	0	645,109	10.00	
11.00 01100 CAFETERIA	0	0	323,760	0	417,378	11.00	
13.00 01300 NURSING ADMINISTRATION	0	0	441,224	0	566,316	13.00	
15.00 01500 PHARMACY	1,939	1,939	391,091	0	1,591,993	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	3,063	3,063	756,450	0	1,203,606	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	20,373	20,373	2,517,608	0	4,398,753	30.00	
31.00 03100 INTENSIVE CARE UNIT	5,595	5,595	915,697	0	1,520,933	31.00	
40.00 04000 SUBPROVIDER - IPF	6,406	6,406	905,215	0	1,454,336	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	
43.00 04300 NURSERY	0	0	0	0	41,895	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	16,260	16,260	1,595,340	0	4,631,351	50.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	19,886	19,886	954,082	0	4,063,263	54.00	
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00	
55.01 05501 ULTRA SOUND	0	0	234,445	0	538,872	55.01	
57.00 05700 CT SCAN	0	0	121,887	0	516,846	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1,706	1,706	268,218	0	877,748	58.00	
59.00 05900 CARDIAC CATHETERIZATION	1,438	1,438	142,165	0	604,533	59.00	
60.00 06000 LABORATORY	9,274	9,274	1,789,950	0	5,284,138	60.00	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	166,736	63.00	
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
66.00 06600 PHYSICAL THERAPY	8,976	8,976	920,456	0	1,594,912	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0	0	256,530	0	439,718	67.00	
67.01 06701 AUDIOLOGY	0	0	110,180	0	116,150	67.01	
68.00 06800 SPEECH PATHOLOGY	0	0	40,059	0	79,447	68.00	
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
69.01 06901 CARDIOLOGY	925	925	757,495	0	1,067,408	69.01	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	261,577	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	2,352,770	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	494,292	73.00	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0	0	0	0	0	90.00	
90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER	3,822	3,822	136,043	0	391,241	90.01	
90.02 09002 CLINIC	6,145	6,145	0	0	227,095	90.02	
90.03 09003 DERMATOLOGY CLINIC	0	0	0	0	0	90.03	
90.04 09004 ENT CLINIC	0	0	0	0	20	90.04	
90.05 09005 SURGERY CLINIC	0	0	0	0	0	90.05	
90.07 09007 UROLOGY CLINIC	0	0	0	0	0	90.07	
90.09 09009 GASTROENTEROLOGY CLINIC	0	0	52,797	0	43,262	90.09	
90.11 09011 NEUROLOGY CLINIC	0	0	0	0	0	90.11	
90.12 09012 OPHTHAMOLOGY CLINIC	0	0	0	0	18,645	90.12	
90.13 09013 ALLERGY CLINIC	0	0	144,869	0	207,750	90.13	
90.14 09014 WOUND CARE	3,504	3,504	196,803	0	568,864	90.14	
91.00 09100 EMERGENCY	24,566	24,566	1,975,499	0	3,818,580	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
OTHER REIMBURSABLE COST CENTERS							
95.00 09500 AMBULANCE SERVICES	4,760	4,760	1,208,710	0	1,838,792	95.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	191,275	191,275	22,575,660	-14,917,851	46,095,276	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	624	624	0	0	23,061	190.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	41,648	41,648	11,059,751	0	18,320,163	192.00	
194.00 07950 THORNTOWN OFFICE BUILDING	0	0	0	0	0	194.00	
194.01 07951 CAFE/BOUIQUE	1,816	1,816	0	0	67,112	194.01	
194.02 07952 OTHER NONREIMBURSABLE COST CENTERS	20,544	20,544	30,935	0	891,521	194.02	
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)	5,863,318	3,593,986	6,273,987	14,917,851	202.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	22.911909	14.044110	0.186358	0.228112	203.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150104

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

Worksheet B-1
Date/Time Prepared:
5/24/2013 7:28 am

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
		1.00	2.00	4.00				
204.00	Cost to be allocated (per Wkst. B, Part II)			21,509	5A	690,176	204.00	
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000639		0.010554	205.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150104

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

Worksheet B-1

Date/Time Prepared:
5/24/2013 7:28 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (GROSS CHARGES)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	183,813				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	213,209,619			8.00
9.00	00900	HOUSEKEEPING	2,806	0	139,073		9.00
10.00	01000	DIETARY	6,281	0	8,623	34,206	10.00
11.00	01100	CAFETERIA	0	0	2,875	0	982
13.00	01300	NURSING ADMINISTRATION	0	0	1,300	0	19
15.00	01500	PHARMACY	1,939	0	2,625	0	38
16.00	01600	MEDICAL RECORDS & LIBRARY	3,063	0	5,750	0	77
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	20,373	11,694,523	43,681	19,859	259
31.00	03100	INTENSIVE CARE UNIT	5,595	2,561,516	11,600	5,651	21
40.00	04000	SUBPROVIDER - IPF	6,406	2,102,894	13,794	8,696	33
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	974,207	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	16,260	32,609,244	2,575	0	23
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,886	17,557,989	11,650	0	28
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
55.01	05501	ULTRA SOUND	0	5,764,395	750	0	3
57.00	05700	CT SCAN	0	22,765,133	1,150	0	4
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,706	10,688,656	1,100	0	10
59.00	05900	CARDIAC CATHETERIZATION	1,438	3,974,041	0	0	0
60.00	06000	LABORATORY	9,274	38,291,746	4,925	0	82
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	665,203	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	1,896,923	0	0	0
66.00	06600	PHYSICAL THERAPY	8,976	4,869,413	1,775	0	41
67.00	06700	OCCUPATIONAL THERAPY	0	729,165	850	0	17
67.01	06701	AUDIOLOGY	0	670,260	625	0	18
68.00	06800	SPEECH PATHOLOGY	0	304,049	375	0	19
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
69.01	06901	CARDIOLOGY	925	8,785,136	3,775	0	41
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,422,021	0	0	21
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,727,782	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,466,849	2,725	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	863	0	0	0
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	3,822	0	6,700	0	34
90.02	09002	CLINIC	6,145	0	9,850	0	0
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	0
90.04	09004	ENT CLINIC	0	0	0	0	0
90.05	09005	SURGERY CLINIC	0	0	0	0	0
90.07	09007	UROLOGY CLINIC	0	101,214	0	0	0
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	0
90.11	09011	NEUROLOGY CLINIC	0	654,582	0	0	0
90.12	09012	OPHTHALMOLOGY CLINIC	0	196,334	0	0	0
90.13	09013	ALLERGY CLINIC	0	1,549,217	0	0	0
90.14	09014	WOUND CARE	3,504	1,623,232	0	0	0
91.00	09100	EMERGENCY	24,566	18,947,885	0	0	64
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,760	4,615,147	0	0	130
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	144,725	213,209,619	139,073	34,206	982
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	624	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	36,648	0	0	0	0
194.00	07950	THORNTOWN OFFICE BUILDING	0	0	0	0	0
194.01	07951	CAFE/BOUTIQUE	1,816	0	0	0	0
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	3,958,683	276,507	800,258	977,156	529,130
203.00		Unit cost multiplier (Wkst. B, Part I)	21.536469	0.001297	5.754230	28.566801	538.828921
204.00		Cost to be allocated (per Wkst. B, Part II)	934,871	2,393	124,521	278,747	7,186

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150104

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

Worksheet B-1

Date/Time Prepared:
5/24/2013 7:28 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (GROSS CHARGES)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	5.085990	0.000011	0.895364	8.149067	7.317719	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150104

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

Worksheet B-1

Date/Time Prepared:
5/24/2013 7:28 am

Cost Center Description		NURSING ADMINISTRATIVE (DIRECT NURSING HRS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		13.00	15.00	16.00	
GENERAL SERVICE COST CENTERS					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400 EMPLOYEE BENEFITS				4.00
5.00	00500 ADMINISTRATIVE & GENERAL				5.00
7.00	00700 OPERATION OF PLANT				7.00
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00	00900 HOUSEKEEPING				9.00
10.00	01000 DIETARY				10.00
11.00	01100 CAFETERIA				11.00
13.00	01300 NURSING ADMINISTRATION	337,928			13.00
15.00	01500 PHARMACY	0	928,163		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	4	41,100	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	78,897	3,224	10,100	30.00
31.00	03100 INTENSIVE CARE UNIT	24,820	694	2,100	31.00
40.00	04000 SUBPROVIDER - IPF	35,121	94	2,500	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	42.00
43.00	04300 NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	57,756	33,702	3,625	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	1,630	9,700	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
55.01	05501 ULTRA SOUND	0	631	1,050	55.01
57.00	05700 CT SCAN	0	2,647	1,200	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	15,668	650	58.00
59.00	05900 CARDIAC CATHETERIZATION	4,266	143	0	59.00
60.00	06000 LABORATORY	0	201	1,000	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
66.00	06600 PHYSICAL THERAPY	24,558	2,118	1,950	66.00
67.00	06700 OCCUPATIONAL THERAPY	7,090	16,955	850	67.00
67.01	06701 AUDIOLOGY	4,405	0	0	67.01
68.00	06800 SPEECH PATHOLOGY	998	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
69.01	06901 CARDIOLOGY	22,854	1,095	1,875	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	7,972	244	4,200	90.01
90.02	09002 CLINIC	0	0	0	90.02
90.03	09003 DERMATOLOGY CLINIC	0	0	0	90.03
90.04	09004 ENT CLINIC	0	0	0	90.04
90.05	09005 SURGERY CLINIC	0	13	0	90.05
90.07	09007 UROLOGY CLINIC	0	731	0	90.07
90.09	09009 GASTROENTEROLOGY CLINIC	2,458	15	0	90.09
90.11	09011 NEUROLOGY CLINIC	0	194	0	90.11
90.12	09012 OPHTHAMOLOGY CLINIC	0	0	0	90.12
90.13	09013 ALLERGY CLINIC	2,790	964	0	90.13
90.14	09014 WOUND CARE	6,620	3,536	0	90.14
91.00	09100 EMERGENCY	55,961	48,583	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0	6,546	0	95.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1-117)	336,566	139,632	40,800	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	1,150	788,531	300	192.00
194.00	07950 THORNTOWN OFFICE BUILDING	0	0	0	194.00
194.01	07951 CAFE/BOUTIQUE	0	0	0	194.01
194.02	07952 OTHER NONREIMBURSABLE COST CENTERS	212	0	0	194.02
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)	713,217	2,032,485	1,618,715	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	2.110559	2.189793	39.384793	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150104

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

Worksheet B-1

Date/Time Prepared:
5/24/2013 7:28 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURSING HRS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		13.00	15.00	16.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	7,562	101,200	147,671	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.022378	0.109033	3.592968	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150104

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2013 7:28 am

		Title XVIII			Hospital		PPS		
Cost Center Description	Therapy Limit Adj.	Costs			Charges				
		Total Costs	RCE Disallowance	Total Costs	Inpatient				
		1.00	2.00	3.00	4.00	5.00		6.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	7,385,675		7,385,675	0	7,385,675	9,130,826	30.00
31.00	03100	INTENSIVE CARE UNIT	2,367,802		2,367,802	0	2,367,802	2,561,516	31.00
40.00	04000	SUBPROVIDER - IPF	2,445,142		2,445,142	31,185	2,476,327	2,102,894	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
43.00	04300	NURSERY	52,716		52,716	0	52,716	974,207	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	6,445,972		6,445,972	0	6,445,972	5,205,880	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,908,914		5,908,914	0	5,908,914	1,304,735	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	0	55.00
55.01	05501	ULTRASOUND	717,939		717,939	0	717,939	521,183	55.01
57.00	05700	CT SCAN	726,101		726,101	0	726,101	3,105,822	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,200,205		1,200,205	0	1,200,205	620,136	58.00
59.00	05900	CARDIAC CATHETERIZATION	787,874		787,874	0	787,874	1,640,595	59.00
60.00	06000	LABORATORY	6,851,232		6,851,232	0	6,851,232	7,741,136	60.00
63.00	06300	BLOOD STORAGE, PROCESSING & TRANS.	205,633		205,633	0	205,633	361,934	63.00
64.00	06400	INTRAVENOUS THERAPY	2,460		2,460	0	2,460	800,219	64.00
66.00	06600	PHYSICAL THERAPY	2,323,933	0	2,323,933	0	2,323,933	507,557	66.00
67.00	06700	OCCUPATIONAL THERAPY	640,589	0	640,589	0	640,589	186,010	67.00
67.01	06701	AUDIOLOGY	166,106	0	166,106	0	166,106	0	67.01
68.00	06800	SPEECH PATHOLOGY	112,466	0	112,466	0	112,466	36,271	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	0	69.00
69.01	06901	CARDIOLOGY	1,510,505		1,510,505	0	1,510,505	3,143,619	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	336,999		336,999	0	336,999	1,529,064	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,895,597		2,895,597	0	2,895,597	2,045,823	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	636,302		636,302	0	636,302	5,455,722	73.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	1		1	0	1	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	802,448		802,448	0	802,448	0	90.01
90.02	09002	CLINIC	467,919		467,919	0	467,919	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0		0	0	0	0	90.03
90.04	09004	ENT CLINIC	25		25	0	25	0	90.04
90.05	09005	SURGERY CLINIC	28		28	0	28	0	90.05
90.07	09007	UROLOGY CLINIC	1,732		1,732	0	1,732	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	58,352		58,352	0	58,352	0	90.09
90.11	09011	NEUROLOGY CLINIC	1,274		1,274	0	1,274	1,276	90.11
90.12	09012	OPHTHALMOLOGY CLINIC	23,153		23,153	0	23,153	0	90.12
90.13	09013	ALLERGY CLINIC	265,148		265,148	0	265,148	0	90.13
90.14	09014	WOUND CARE	797,913		797,913	0	797,913	4,945	90.14
91.00	09100	EMERGENCY	5,502,265		5,502,265	0	5,502,265	2,489,005	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,758,801		1,758,801	0	1,758,801	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	2,386,515		2,386,515	0	2,386,515	42,294	95.00
200.00		Subtotal (see instructions)	55,785,736	0	55,785,736	31,185	55,816,921	51,512,669	200.00
201.00		Less Observation Beds	1,758,801		1,758,801		1,758,801		201.00
202.00		Total (see instructions)	54,026,935	0	54,026,935	31,185	54,058,120	51,512,669	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150104

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2013 7:28 am

			Title XVIII		Hospital		PPS	
Cost Center Description	Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio			
	Outpatient	Total (col. 6 + col. 7)						
	7.00	8.00				9.00	10.00	11.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,130,826					30.00
31.00	03100	INTENSIVE CARE UNIT	2,561,516					31.00
40.00	04000	SUBPROVIDER - IPF	2,102,894					40.00
41.00	04100	SUBPROVIDER - IRF	0					41.00
42.00	04200	SUBPROVIDER	0					42.00
43.00	04300	NURSERY	974,207					43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	27,403,364	32,609,244	0.197673	0.000000	0.197673	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,253,254	17,557,989	0.336537	0.000000	0.336537	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0.000000	55.00
55.01	05501	ULTRA SOUND	5,243,212	5,764,395	0.124547	0.000000	0.124547	55.01
57.00	05700	CT SCAN	19,659,311	22,765,133	0.031895	0.000000	0.031895	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	10,068,520	10,688,656	0.112288	0.000000	0.112288	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,333,446	3,974,041	0.198255	0.000000	0.198255	59.00
60.00	06000	LABORATORY	30,550,610	38,291,746	0.178922	0.000000	0.178922	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	303,269	665,203	0.309128	0.000000	0.309128	63.00
64.00	06400	INTRAVENOUS THERAPY	1,096,704	1,896,923	0.001297	0.000000	0.001297	64.00
66.00	06600	PHYSICAL THERAPY	4,361,856	4,869,413	0.477251	0.000000	0.477251	66.00
67.00	06700	OCCUPATIONAL THERAPY	543,155	729,165	0.878524	0.000000	0.878524	67.00
67.01	06701	AUDIOLOGY	670,260	670,260	0.247823	0.000000	0.247823	67.01
68.00	06800	SPEECH PATHOLOGY	267,778	304,049	0.369894	0.000000	0.369894	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0.000000	69.00
69.01	06901	CARDIOLOGY	5,641,517	8,785,136	0.171939	0.000000	0.171939	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,892,957	3,422,021	0.098480	0.000000	0.098480	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,681,959	4,727,782	0.612464	0.000000	0.612464	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,011,127	10,466,849	0.060792	0.000000	0.060792	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	863	863	0.001159	0.000000	0.001159	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0.000000	90.01
90.02	09002	CLINIC	0	0	0.000000	0.000000	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0.000000	0.000000	0.000000	90.03
90.04	09004	ENT CLINIC	0	0	0.000000	0.000000	0.000000	90.04
90.05	09005	SURGERY CLINIC	0	0	0.000000	0.000000	0.000000	90.05
90.07	09007	UROLOGY CLINIC	101,214	101,214	0.017112	0.000000	0.017112	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0.000000	0.000000	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	653,306	654,582	0.001946	0.000000	0.001946	90.11
90.12	09012	OPHTHAMOLOGY CLINIC	196,334	196,334	0.117927	0.000000	0.117927	90.12
90.13	09013	ALLERGY CLINIC	1,549,217	1,549,217	0.171150	0.000000	0.171150	90.13
90.14	09014	WOUND CARE	1,618,287	1,623,232	0.491558	0.000000	0.491558	90.14
91.00	09100	EMERGENCY	16,458,880	18,947,885	0.290389	0.000000	0.290389	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,563,697	2,563,697	0.686041	0.000000	0.686041	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	4,572,853	4,615,147	0.517105	0.000000	0.517105	95.00
200.00		Subtotal (see instructions)	161,696,950	213,209,619				200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	161,696,950	213,209,619				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150104

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2013 7:28 am

		Title XIX			Hospital		Cost		
Cost Center Description	Therapy Limit Adj.	Costs			Charges				
		Total Costs	RCE Disallowance	Total Costs	Inpatient				
		1.00	2.00	3.00	4.00	5.00		6.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	7,385,675		7,385,675	0	0	9,130,826	30.00
31.00	03100	INTENSIVE CARE UNIT	2,367,802		2,367,802	0	0	2,561,516	31.00
40.00	04000	SUBPROVIDER - IPF	2,445,142		2,445,142	0	0	2,102,894	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
43.00	04300	NURSERY	52,716		52,716	0	0	974,207	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	6,445,972		6,445,972	0	0	5,205,880	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,908,914		5,908,914	0	0	1,304,735	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	0	55.00
55.01	05501	ULTRASOUND	717,939		717,939	0	0	521,183	55.01
57.00	05700	CT SCAN	726,101		726,101	0	0	3,105,822	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,200,205		1,200,205	0	0	620,136	58.00
59.00	05900	CARDIAC CATHETERIZATION	787,874		787,874	0	0	1,640,595	59.00
60.00	06000	LABORATORY	6,851,232		6,851,232	0	0	7,741,136	60.00
63.00	06300	BLOOD STORAGE, PROCESSING & TRANS.	205,633		205,633	0	0	361,934	63.00
64.00	06400	INTRAVENOUS THERAPY	2,460		2,460	0	0	800,219	64.00
66.00	06600	PHYSICAL THERAPY	2,323,933	0	2,323,933	0	0	507,557	66.00
67.00	06700	OCCUPATIONAL THERAPY	640,589	0	640,589	0	0	186,010	67.00
67.01	06701	AUDIOLOGY	166,106	0	166,106	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	112,466	0	112,466	0	0	36,271	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	0	69.00
69.01	06901	CARDIOLOGY	1,510,505		1,510,505	0	0	3,143,619	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	336,999		336,999	0	0	1,529,064	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,895,597		2,895,597	0	0	2,045,823	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	636,302		636,302	0	0	5,455,722	73.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	1		1	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	802,448		802,448	0	0	0	90.01
90.02	09002	CLINIC	467,919		467,919	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0		0	0	0	0	90.03
90.04	09004	ENT CLINIC	25		25	0	0	0	90.04
90.05	09005	SURGERY CLINIC	28		28	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	1,732		1,732	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	58,352		58,352	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	1,274		1,274	0	0	1,276	90.11
90.12	09012	OPHTHALMOLOGY CLINIC	23,153		23,153	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	265,148		265,148	0	0	0	90.13
90.14	09014	WOUND CARE	797,913		797,913	0	0	4,945	90.14
91.00	09100	EMERGENCY	5,502,265		5,502,265	0	0	2,489,005	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,758,801		1,758,801	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	2,386,515		2,386,515	0	0	42,294	95.00
200.00		Subtotal (see instructions)	55,785,736	0	55,785,736	0	0	51,512,669	200.00
201.00		Less Observation Beds	1,758,801		1,758,801	0	0		201.00
202.00		Total (see instructions)	54,026,935	0	54,026,935	0	0	51,512,669	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150104

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2013 7:28 am

			Title XIX		Hospital		Cost	
Cost Center Description	Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio			
	Outpatient	Total (col. 6 + col. 7)						
	7.00	8.00				9.00	10.00	11.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,130,826					30.00
31.00	03100	INTENSIVE CARE UNIT	2,561,516					31.00
40.00	04000	SUBPROVIDER - IPF	2,102,894					40.00
41.00	04100	SUBPROVIDER - IRF	0					41.00
42.00	04200	SUBPROVIDER	0					42.00
43.00	04300	NURSERY	974,207					43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	27,403,364	32,609,244	0.197673	0.000000	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,253,254	17,557,989	0.336537	0.000000	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0.000000	55.00
55.01	05501	ULTRA SOUND	5,243,212	5,764,395	0.124547	0.000000	0.000000	55.01
57.00	05700	CT SCAN	19,659,311	22,765,133	0.031895	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	10,068,520	10,688,656	0.112288	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,333,446	3,974,041	0.198255	0.000000	0.000000	59.00
60.00	06000	LABORATORY	30,550,610	38,291,746	0.178922	0.000000	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	303,269	665,203	0.309128	0.000000	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	1,096,704	1,896,923	0.001297	0.000000	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	4,361,856	4,869,413	0.477251	0.000000	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	543,155	729,165	0.878524	0.000000	0.000000	67.00
67.01	06701	AUDIOLOGY	670,260	670,260	0.247823	0.000000	0.000000	67.01
68.00	06800	SPEECH PATHOLOGY	267,778	304,049	0.369894	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0.000000	69.00
69.01	06901	CARDIOLOGY	5,641,517	8,785,136	0.171939	0.000000	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,892,957	3,422,021	0.098480	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,681,959	4,727,782	0.612464	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,011,127	10,466,849	0.060792	0.000000	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	863	863	0.001159	0.000000	0.000000	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0.000000	90.01
90.02	09002	CLINIC	0	0	0.000000	0.000000	0.000000	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0.000000	0.000000	0.000000	90.03
90.04	09004	ENT CLINIC	0	0	0.000000	0.000000	0.000000	90.04
90.05	09005	SURGERY CLINIC	0	0	0.000000	0.000000	0.000000	90.05
90.07	09007	UROLOGY CLINIC	101,214	101,214	0.017112	0.000000	0.000000	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0.000000	0.000000	0.000000	90.09
90.11	09011	NEUROLOGY CLINIC	653,306	654,582	0.001946	0.000000	0.000000	90.11
90.12	09012	OPHTHAMOLOGY CLINIC	196,334	196,334	0.117927	0.000000	0.000000	90.12
90.13	09013	ALLERGY CLINIC	1,549,217	1,549,217	0.171150	0.000000	0.000000	90.13
90.14	09014	WOUND CARE	1,618,287	1,623,232	0.491558	0.000000	0.000000	90.14
91.00	09100	EMERGENCY	16,458,880	18,947,885	0.290389	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,563,697	2,563,697	0.686041	0.000000	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	4,572,853	4,615,147	0.517105	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	161,696,950	213,209,619				200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	161,696,950	213,209,619				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part I Date/Time Prepared: 5/24/2013 7:28 am
		Title XVIII	Hospital	PPS

Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,145,931	0	1,145,931	6,807	168.35	30.00
31.00	INTENSIVE CARE UNIT	316,656		316,656	1,513	209.29	31.00
40.00	SUBPROVIDER - IPF	378,506	0	378,506	2,333	162.24	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	453		453	916	0.49	43.00
200.00	Total (lines 30-199)	1,841,546		1,841,546	11,569		200.00

Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
	6.00	7.00	

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,338	393,602				30.00
31.00	INTENSIVE CARE UNIT	636	133,108				31.00
40.00	SUBPROVIDER - IPF	1,986	322,209				40.00
41.00	SUBPROVIDER - IRF	0	0				41.00
42.00	SUBPROVIDER	0	0				42.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30-199)	4,960	848,919				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part II Date/Time Prepared: 5/24/2013 7:28 am
--	--	----------------------	---	--

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)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	754,326	32,609,244	0.023132	2,120,014	49,040	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	925,400	17,557,989	0.052705	832,992	43,903	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
55.01	05501 ULTRA SOUND	10,436	5,764,395	0.001810	119,557	216	55.01
57.00	05700 CT SCAN	11,443	22,765,133	0.000503	1,392,550	700	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	86,378	10,688,656	0.008081	275,032	2,223	58.00
59.00	05900 CARDIAC CATHETERIZATION	67,082	3,974,041	0.016880	560,819	9,467	59.00
60.00	06000 LABORATORY	455,904	38,291,746	0.011906	3,643,141	43,375	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1,767	665,203	0.002656	166,321	442	63.00
64.00	06400 INTRAVENOUS THERAPY	21	1,896,923	0.000011	488,677	5	64.00
66.00	06600 PHYSICAL THERAPY	404,520	4,869,413	0.083074	275,900	22,920	66.00
67.00	06700 OCCUPATIONAL THERAPY	10,760	729,165	0.014757	125,967	1,859	67.00
67.01	06701 AUDIOLOGY	2,094	670,260	0.003124	0	0	67.01
68.00	06800 SPEECH PATHOLOGY	1,364	304,049	0.004486	24,077	108	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	06901 RADIOLOGY	61,783	8,785,136	0.007033	1,794,922	12,624	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,953	3,422,021	0.000863	577,427	498	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	24,883	4,727,782	0.005263	869,297	4,575	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7,772	10,466,849	0.000743	2,573,351	1,912	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	863	0.000000	0	0	90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	186,444	0	0.000000	0	0	90.01
90.02	09002 CLINIC	269,564	0	0.000000	0	0	90.02
90.03	09003 DERMATOLOGY CLINIC	0	0	0.000000	0	0	90.03
90.04	09004 ENT CLINIC	0	0	0.000000	0	0	90.04
90.05	09005 SURGERY CLINIC	1	0	0.000000	0	0	90.05
90.07	09007 UROLOGY CLINIC	81	101,214	0.000800	0	0	90.07
90.09	09009 GASTROENTEROLOGY CLINIC	548	0	0.000000	0	0	90.09
90.11	09011 NEUROLOGY CLINIC	28	654,582	0.000043	0	0	90.11
90.12	09012 OPHTHALMOLOGY CLINIC	199	196,334	0.001014	0	0	90.12
90.13	09013 ALLERGY CLINIC	2,470	1,549,217	0.001594	0	0	90.13
90.14	09014 WOUND CARE	153,997	1,623,232	0.094871	2,635	250	90.14
91.00	09100 EMERGENCY	1,081,592	18,947,885	0.057082	1,160,156	66,224	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	272,889	2,563,697	0.106444	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	4,796,699	193,825,029		17,002,835	260,341	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part III Date/Time Prepared: 5/24/2013 7:28 am
---	----------------------	---	---

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	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	200.00
Cost Center Description		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
		6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,807	0.00	2,338	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,513	0.00	636	0	31.00
40.00	04000	SUBPROVIDER - IPF	2,333	0.00	1,986	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0	41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0	42.00
43.00	04300	NURSERY	916	0.00	0	0	43.00
200.00		Total (lines 30-199)	11,569		4,960	0	200.00
Cost Center Description		PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost				
		12.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0			30.00
31.00	03100	INTENSIVE CARE UNIT	0	0			31.00
40.00	04000	SUBPROVIDER - IPF	0	0			40.00
41.00	04100	SUBPROVIDER - IRF	0	0			41.00
42.00	04200	SUBPROVIDER	0	0			42.00
43.00	04300	NURSERY	0	0			43.00
200.00		Total (lines 30-199)	0	0			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150104

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2013 7:28 am

Cost Center Description		Title XVIII			Hospital	PPS	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
55.01	05501	ULTRA SOUND	0	0	0	0	55.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
67.01	06701	AUDIOLOGY	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	CARDIOLOGY	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0	0	90.03
90.04	09004	ENT CLINIC	0	0	0	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0	0	90.05
90.07	09007	UROLOGY CLINIC	0	0	0	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	0	0	0	90.11
90.12	09012	OPHTHAMOLOGY CLINIC	0	0	0	0	90.12
90.13	09013	ALLERGY CLINIC	0	0	0	0	90.13
90.14	09014	WOUND CARE	0	0	0	0	90.14
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150104

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2013 7:28 am

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	PPS
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)			
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	32,609,244	0.000000	0.000000	2,120,014	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,557,989	0.000000	0.000000	832,992	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
55.01	05501	ULTRA SOUND	0	5,764,395	0.000000	0.000000	119,557	55.01
57.00	05700	CT SCAN	0	22,765,133	0.000000	0.000000	1,392,550	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	10,688,656	0.000000	0.000000	275,032	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,974,041	0.000000	0.000000	560,819	59.00
60.00	06000	LABORATORY	0	38,291,746	0.000000	0.000000	3,643,141	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	665,203	0.000000	0.000000	166,321	63.00
64.00	06400	INTRAVENOUS THERAPY	0	1,896,923	0.000000	0.000000	488,677	64.00
66.00	06600	PHYSICAL THERAPY	0	4,869,413	0.000000	0.000000	275,900	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	729,165	0.000000	0.000000	125,967	67.00
67.01	06701	AUDIOLOGY	0	670,260	0.000000	0.000000	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	304,049	0.000000	0.000000	24,077	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
69.01	06901	CARDIOLOGY	0	8,785,136	0.000000	0.000000	1,794,922	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,422,021	0.000000	0.000000	577,427	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,727,782	0.000000	0.000000	869,297	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,466,849	0.000000	0.000000	2,573,351	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	863	0.000000	0.000000	0	90.00
90.01	09001	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	90.01
90.02	09002	CLINIC	0	0	0.000000	0.000000	0	90.02
90.03	09003	DERMATOLOGY CLINIC	0	0	0.000000	0.000000	0	90.03
90.04	09004	ENT CLINIC	0	0	0.000000	0.000000	0	90.04
90.05	09005	SURGERY CLINIC	0	0	0.000000	0.000000	0	90.05
90.07	09007	UROLOGY CLINIC	0	101,214	0.000000	0.000000	0	90.07
90.09	09009	GASTROENTEROLOGY CLINIC	0	0	0.000000	0.000000	0	90.09
90.11	09011	NEUROLOGY CLINIC	0	654,582	0.000000	0.000000	0	90.11
90.12	09012	OPHTHAMOLOGY CLINIC	0	196,334	0.000000	0.000000	0	90.12
90.13	09013	ALLERGY CLINIC	0	1,549,217	0.000000	0.000000	0	90.13
90.14	09014	WOUND CARE	0	1,623,232	0.000000	0.000000	2,635	90.14
91.00	09100	EMERGENCY	0	18,947,885	0.000000	0.000000	1,160,156	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,563,697	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0					95.00
200.00		Total (lines 50-199)	0	193,825,029			17,002,835	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150104

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2013 7:28 am

Cost Center Description		Title XVIII			Hospital		PPS
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	7,472,053	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	5,808,386	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501 ULTRA SOUND	0	601,516	0	0	0	55.01
57.00	05700 CT SCAN	0	5,210,983	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	2,944,700	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	979,287	0	0	0	59.00
60.00	06000 LABORATORY	0	446,371	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	105,793	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	198,798	0	0	0	64.00
66.00	06600 PHYSICAL THERAPY	0	6,376	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	50	0	0	0	67.00
67.01	06701 AUDIOLOGY	0	0	0	0	0	67.01
68.00	06800 SPEECH PATHOLOGY	0	84,506	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901 CARDIOLOGY	0	1,438,576	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	372,039	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	966,844	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,477,273	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002 CLINIC	0	0	0	0	0	90.02
90.03	09003 DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004 ENT CLINIC	0	0	0	0	0	90.04
90.05	09005 SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007 UROLOGY CLINIC	0	42,742	0	0	0	90.07
90.09	09009 GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011 NEUROLOGY CLINIC	0	1,232	0	0	0	90.11
90.12	09012 OPHTHALMOLOGY CLINIC	0	94,045	0	0	0	90.12
90.13	09013 ALLERGY CLINIC	0	0	0	0	0	90.13
90.14	09014 WOUND CARE	0	374,992	0	0	0	90.14
91.00	09100 EMERGENCY	0	2,816,979	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	680,768	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00	Total (lines 50-199)	0	32,124,309	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150104

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2013 7:28 am

Cost Center Description		PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	Title XVIII	Hospital	PPS
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0			54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0			55.00
55.01	05501 ULTRA SOUND	0	0			55.01
57.00	05700 CT SCAN	0	0			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0			59.00
60.00	06000 LABORATORY	0	0			60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0			63.00
64.00	06400 INTRAVENOUS THERAPY	0	0			64.00
66.00	06600 PHYSICAL THERAPY	0	0			66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0			67.00
67.01	06701 AUDIOLOGY	0	0			67.01
68.00	06800 SPEECH PATHOLOGY	0	0			68.00
69.00	06900 ELECTROCARDIOLOGY	0	0			69.00
69.01	06901 CARDIOLOGY	0	0			69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0			90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0			90.01
90.02	09002 CLINIC	0	0			90.02
90.03	09003 DERMATOLOGY CLINIC	0	0			90.03
90.04	09004 ENT CLINIC	0	0			90.04
90.05	09005 SURGERY CLINIC	0	0			90.05
90.07	09007 UROLOGY CLINIC	0	0			90.07
90.09	09009 GASTROENTEROLOGY CLINIC	0	0			90.09
90.11	09011 NEUROLOGY CLINIC	0	0			90.11
90.12	09012 OPHTHAMOLOGY CLINIC	0	0			90.12
90.13	09013 ALLERGY CLINIC	0	0			90.13
90.14	09014 WOUND CARE	0	0			90.14
91.00	09100 EMERGENCY	0	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/24/2013 7:28 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.197673	7,472,053	96	83	1,477,023	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.336537	5,808,386	15	0	1,954,737	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01 05501 ULTRA SOUND	0.124547	601,516	0	0	74,917	55.01
57.00 05700 CT SCAN	0.031895	5,210,983	0	5,750	166,204	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.112288	2,944,700	0	0	330,654	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.198255	979,287	3	487	194,149	59.00
60.00 06000 LABORATORY	0.178922	446,371	0	0	79,866	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.309128	105,793	0	0	32,704	63.00
64.00 06400 INTRAVENOUS THERAPY	0.001297	198,798	0	0	258	64.00
66.00 06600 PHYSICAL THERAPY	0.477251	6,376	0	0	3,043	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.878524	50	0	0	44	67.00
67.01 06701 AUDIOLOGY	0.247823	0	0	0	0	67.01
68.00 06800 SPEECH PATHOLOGY	0.369894	84,506	0	0	31,258	68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01 06901 CARDIOLOGY	0.171939	1,438,576	2	0	247,347	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.098480	372,039	7	0	36,638	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.612464	966,844	0	0	592,157	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.060792	1,477,273	0	7,749	89,806	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.001159	0	0	0	0	90.00
90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.01
90.02 09002 CLINIC	0.000000	0	0	0	0	90.02
90.03 09003 DERMATOLOGY CLINIC	0.000000	0	0	0	0	90.03
90.04 09004 ENT CLINIC	0.000000	0	0	0	0	90.04
90.05 09005 SURGERY CLINIC	0.000000	0	0	0	0	90.05
90.07 09007 UROLOGY CLINIC	0.017112	42,742	0	0	731	90.07
90.09 09009 GASTROENTEROLOGY CLINIC	0.000000	0	0	0	0	90.09
90.11 09011 NEUROLOGY CLINIC	0.001946	1,232	0	0	2	90.11
90.12 09012 OPHTHAMOLOGY CLINIC	0.117927	94,045	0	0	11,090	90.12
90.13 09013 ALLERGY CLINIC	0.171150	0	0	0	0	90.13
90.14 09014 WOUND CARE	0.491558	374,992	0	1,322	184,330	90.14
91.00 09100 EMERGENCY	0.290389	2,816,979	0	0	818,020	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.686041	680,768	0	0	467,035	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0.517105	0	0	0	0	95.00
200.00	Subtotal (see instructions)	32,124,309	123	15,391	6,792,013	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0		201.00
202.00	Net Charges (line 200 +/- line 201)	32,124,309	123	15,391	6,792,013	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/24/2013 7:28 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	19	16		50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	5	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01 05501 ULTRA SOUND	0	0		55.01
57.00 05700 CT SCAN	0	183		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	1	97		59.00
60.00 06000 LABORATORY	0	0		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
67.01 06701 AUDIOLOGY	0	0		67.01
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
69.01 06901 CARDIOLOGY	0	0		69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	471		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0		90.01
90.02 09002 CLINIC	0	0		90.02
90.03 09003 DERMATOLOGY CLINIC	0	0		90.03
90.04 09004 ENT CLINIC	0	0		90.04
90.05 09005 SURGERY CLINIC	0	0		90.05
90.07 09007 UROLOGY CLINIC	0	0		90.07
90.09 09009 GASTROENTEROLOGY CLINIC	0	0		90.09
90.11 09011 NEUROLOGY CLINIC	0	0		90.11
90.12 09012 OPHTHAMOLOGY CLINIC	0	0		90.12
90.13 09013 ALLERGY CLINIC	0	0		90.13
90.14 09014 WOUND CARE	0	650		90.14
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0			95.00
200.00	Subtotal (see instructions)	26	1,417	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	26	1,417	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150104 Component CCN: 15S104		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part II Date/Time Prepared: 5/24/2013 7:28 am	
				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	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	754,326	32,609,244	0.023132	6,354	147	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	925,400	17,557,989	0.052705	30,041	1,583	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
55.01	05501 ULTRA SOUND	10,436	5,764,395	0.001810	4,372	8	55.01
57.00	05700 CT SCAN	11,443	22,765,133	0.000503	30,787	15	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	86,378	10,688,656	0.008081	17,575	142	58.00
59.00	05900 CARDIAC CATHETERIZATION	67,082	3,974,041	0.016880	2,556	43	59.00
60.00	06000 LABORATORY	455,904	38,291,746	0.011906	517,866	6,166	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1,767	665,203	0.002656	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	21	1,896,923	0.000011	2,526	0	64.00
66.00	06600 PHYSICAL THERAPY	404,520	4,869,413	0.083074	34,646	2,878	66.00
67.00	06700 OCCUPATIONAL THERAPY	10,760	729,165	0.014757	4,683	69	67.00
67.01	06701 AUDIOLOGY	2,094	670,260	0.003124	0	0	67.01
68.00	06800 SPEECH PATHOLOGY	1,364	304,049	0.004486	3,846	17	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	06901 CARDIOLOGY	61,783	8,785,136	0.007033	56,226	395	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,953	3,422,021	0.000863	17,031	15	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	24,883	4,727,782	0.005263	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7,772	10,466,849	0.000743	408,885	304	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	863	0.000000	0	0	90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	186,444	0	0.000000	0	0	90.01
90.02	09002 CLINIC	269,564	0	0.000000	0	0	90.02
90.03	09003 DERMATOLOGY CLINIC	0	0	0.000000	0	0	90.03
90.04	09004 ENT CLINIC	0	0	0.000000	0	0	90.04
90.05	09005 SURGERY CLINIC	1	0	0.000000	0	0	90.05
90.07	09007 UROLOGY CLINIC	81	101,214	0.000800	0	0	90.07
90.09	09009 GASTROENTEROLOGY CLINIC	548	0	0.000000	0	0	90.09
90.11	09011 NEUROLOGY CLINIC	28	654,582	0.000043	0	0	90.11
90.12	09012 OPHTHAMOLOGY CLINIC	199	196,334	0.001014	0	0	90.12
90.13	09013 ALLERGY CLINIC	2,470	1,549,217	0.001594	0	0	90.13
90.14	09014 WOUND CARE	153,997	1,623,232	0.094871	6	1	90.14
91.00	09100 EMERGENCY	1,081,592	18,947,885	0.057082	9,086	519	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2,563,697	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	4,523,810	193,825,029		1,146,486	12,302	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150104
Component CCN: 15S104

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2013 7:28 am

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	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501 ULTRA SOUND	0	0	0	0	0	55.01
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
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	06701 AUDIOLOGY	0	0	0	0	0	67.01
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901 CARDIOLOGY	0	0	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002 CLINIC	0	0	0	0	0	90.02
90.03	09003 DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004 ENT CLINIC	0	0	0	0	0	90.04
90.05	09005 SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007 UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009 GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011 NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012 OPHTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013 ALLERGY CLINIC	0	0	0	0	0	90.13
90.14	09014 WOUND CARE	0	0	0	0	0	90.14
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
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
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: 150104 Component CCN: 15S104	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/24/2013 7:28 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient	
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 ÷ col. 7)	Ratio of Cost to Charges (col. 6 ÷ col. 7)	Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	32,609,244	0.000000	0.000000	6,354	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	17,557,989	0.000000	0.000000	30,041	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
55.01 05501 ULTRA SOUND	0	5,764,395	0.000000	0.000000	4,372	55.01
57.00 05700 CT SCAN	0	22,765,133	0.000000	0.000000	30,787	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	10,688,656	0.000000	0.000000	17,575	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	3,974,041	0.000000	0.000000	2,556	59.00
60.00 06000 LABORATORY	0	38,291,746	0.000000	0.000000	517,866	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	665,203	0.000000	0.000000	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	1,896,923	0.000000	0.000000	2,526	64.00
66.00 06600 PHYSICAL THERAPY	0	4,869,413	0.000000	0.000000	34,646	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	729,165	0.000000	0.000000	4,683	67.00
67.01 06701 AUDIOLOGY	0	670,260	0.000000	0.000000	0	67.01
68.00 06800 SPEECH PATHOLOGY	0	304,049	0.000000	0.000000	3,846	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
69.01 06901 CARDIOLOGY	0	8,785,136	0.000000	0.000000	56,226	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,422,021	0.000000	0.000000	17,031	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	4,727,782	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	10,466,849	0.000000	0.000000	408,885	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	863	0.000000	0.000000	0	90.00
90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	90.01
90.02 09002 CLINIC	0	0	0.000000	0.000000	0	90.02
90.03 09003 DERMATOLOGY CLINIC	0	0	0.000000	0.000000	0	90.03
90.04 09004 ENT CLINIC	0	0	0.000000	0.000000	0	90.04
90.05 09005 SURGERY CLINIC	0	0	0.000000	0.000000	0	90.05
90.07 09007 UROLOGY CLINIC	0	101,214	0.000000	0.000000	0	90.07
90.09 09009 GASTROENTEROLOGY CLINIC	0	0	0.000000	0.000000	0	90.09
90.11 09011 NEUROLOGY CLINIC	0	654,582	0.000000	0.000000	0	90.11
90.12 09012 OPHTHAMOLOGY CLINIC	0	196,334	0.000000	0.000000	0	90.12
90.13 09013 ALLERGY CLINIC	0	1,549,217	0.000000	0.000000	0	90.13
90.14 09014 WOUND CARE	0	1,623,232	0.000000	0.000000	6	90.14
91.00 09100 EMERGENCY	0	18,947,885	0.000000	0.000000	9,086	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2,563,697	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	193,825,029			1,146,486	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150104 Component CCN: 15S104	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/24/2013 7:28 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	30	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	318	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501 ULTRA SOUND	0	0	0	0	0	55.01
57.00	05700 CT SCAN	0	1,800	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	3	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	06701 AUDIOLOGY	0	0	0	0	0	67.01
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901 CARDIOLOGY	0	31	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	22	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.01
90.02	09002 CLINIC	0	0	0	0	0	90.02
90.03	09003 DERMATOLOGY CLINIC	0	0	0	0	0	90.03
90.04	09004 ENT CLINIC	0	0	0	0	0	90.04
90.05	09005 SURGERY CLINIC	0	0	0	0	0	90.05
90.07	09007 UROLOGY CLINIC	0	0	0	0	0	90.07
90.09	09009 GASTROENTEROLOGY CLINIC	0	0	0	0	0	90.09
90.11	09011 NEUROLOGY CLINIC	0	0	0	0	0	90.11
90.12	09012 OPHTHAMOLOGY CLINIC	0	0	0	0	0	90.12
90.13	09013 ALLERGY CLINIC	0	0	0	0	0	90.13
90.14	09014 WOUND CARE	0	0	0	0	0	90.14
91.00	09100 EMERGENCY	0	1,291	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	3,503	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150104
Component CCN: 15S104

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2013 7:28 am
PPS

Title XVII I

Subprovider -
IPF

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
55.01	05501 ULTRA SOUND	0	0	55.01
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
67.01	06701 AUDIOLOGY	0	0	67.01
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
69.01	06901 CARDIOLOGY	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0	90.01
90.02	09002 CLINIC	0	0	90.02
90.03	09003 DERMATOLOGY CLINIC	0	0	90.03
90.04	09004 ENT CLINIC	0	0	90.04
90.05	09005 SURGERY CLINIC	0	0	90.05
90.07	09007 UROLOGY CLINIC	0	0	90.07
90.09	09009 GASTROENTEROLOGY CLINIC	0	0	90.09
90.11	09011 NEUROLOGY CLINIC	0	0	90.11
90.12	09012 OPHTHAMOLOGY CLINIC	0	0	90.12
90.13	09013 ALLERGY CLINIC	0	0	90.13
90.14	09014 WOUND CARE	0	0	90.14
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES			95.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/24/2013 7:28 am	
		Component CCN: 15S104	Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.197673	30	0	6
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.336537	318	0	107
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0
55.01	05501 ULTRA SOUND	0.124547	0	0	0
57.00	05700 CT SCAN	0.031895	1,800	0	57
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.112288	0	0	0
59.00	05900 CARDIAC CATHETERIZATION	0.198255	3	0	1
60.00	06000 LABORATORY	0.178922	0	0	0
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.309128	0	0	0
64.00	06400 INTRAVENOUS THERAPY	0.001297	0	0	0
66.00	06600 PHYSICAL THERAPY	0.477251	0	0	0
67.00	06700 OCCUPATIONAL THERAPY	0.878524	0	0	0
67.01	06701 AUDIOLOGY	0.247823	0	0	0
68.00	06800 SPEECH PATHOLOGY	0.369894	0	0	0
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0
69.01	06901 CARDIOLOGY	0.171939	31	0	5
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.098480	8	0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.612464	0	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0.060792	22	0	1
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.001159	0	0	0
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0
90.02	09002 CLINIC	0.000000	0	0	0
90.03	09003 DERMATOLOGY CLINIC	0.000000	0	0	0
90.04	09004 ENT CLINIC	0.000000	0	0	0
90.05	09005 SURGERY CLINIC	0.000000	0	0	0
90.07	09007 UROLOGY CLINIC	0.017112	0	0	0
90.09	09009 GASTROENTEROLOGY CLINIC	0.000000	0	0	0
90.11	09011 NEUROLOGY CLINIC	0.001946	0	0	0
90.12	09012 OPHTHAMOLOGY CLINIC	0.117927	0	0	0
90.13	09013 ALLERGY CLINIC	0.171150	0	0	0
90.14	09014 WOUND CARE	0.491558	0	0	0
91.00	09100 EMERGENCY	0.290389	1,291	0	375
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.686041	0	0	0
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.517105		0	
200.00	Subtotal (see instructions)		3,503	0	553
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	201.00
202.00	Net Charges (line 200 +/- line 201)		3,503	0	553

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150104	Period: From 01/01/2012	Worksheet D Part V Date/Time Prepared: 5/24/2013 7:28 am
	Component CCN: 15S104	To 12/31/2012	
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
55.01 05501 ULTRASOUND	0	0	55.01
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	64.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
67.01 06701 AUDIOLOGY	0	0	67.01
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
69.01 06901 CARDIOLOGY	0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
90.01 09001 OTHER OUTPATIENT SERVICE COST CENTER	0	0	90.01
90.02 09002 CLINIC	0	0	90.02
90.03 09003 DERMATOLOGY CLINIC	0	0	90.03
90.04 09004 ENT CLINIC	0	0	90.04
90.05 09005 SURGERY CLINIC	0	0	90.05
90.07 09007 UROLOGY CLINIC	0	0	90.07
90.09 09009 GASTROENTEROLOGY CLINIC	0	0	90.09
90.11 09011 NEUROLOGY CLINIC	0	0	90.11
90.12 09012 OPHTHALMOLOGY CLINIC	0	0	90.12
90.13 09013 ALLERGY CLINIC	0	0	90.13
90.14 09014 WOUND CARE	0	0	90.14
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS			
95.00 09500 AMBULANCE SERVICES	0	0	95.00
200.00 Subtotal (see instructions)	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/24/2013 7:28 am
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,807	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,807	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)		5,186	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)		2,338	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		7,385,675	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)		7,385,675	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		12,553,046	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		12,553,046	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.588357	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		2,420.56	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)		7,385,675	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,085.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,536,753	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)		2,536,753	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/24/2013 7:28 am	
Cost Center Description			Title XVIII		Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,367,802	1,513	1,564.97	636	995,321
44.00	CORONARY CARE UNIT					43.00
45.00	BURN INTENSIVE CARE UNIT					44.00
46.00	SURGICAL INTENSIVE CARE UNIT					45.00
47.00	OTHER SPECIAL CARE (SPECIFY)					46.00
	Cost Center Description					47.00
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				3,248,433	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				6,780,507	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)				526,710	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				260,341	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				787,051	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				5,993,456	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)				1,621	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,085.01	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				1,758,801	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150104		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/24/2013 7:28 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,145,931	7,385,675	0.155156	1,758,801	272,889	90.00
91.00	Nursing School cost	0	7,385,675	0.000000	1,758,801	0	91.00
92.00	Allied health cost	0	7,385,675	0.000000	1,758,801	0	92.00
93.00	All other Medical Education	0	7,385,675	0.000000	1,758,801	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Component CCN: 15S104		Date/Time Prepared: 5/24/2013 7:28 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,333	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,333	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)		2,333	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)		1,986	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,476,327	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)		2,476,327	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,102,894	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,102,894	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.177581	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)		901.37	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)		2,476,327	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,061.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,108,000	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)		2,108,000	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150104		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1	
		Component CCN: 15S104				Date/Time Prepared: 5/24/2013 7:28 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					168,948		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,276,948		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)					322,209		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					12,302		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					334,511		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					1,942,437		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: 150104 Component CCN: 15S104		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/24/2013 7:28 am	
		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	378,506	2,476,327	0.152850	0	0	90.00
91.00	Nursing School cost	0	2,476,327	0.000000	0	0	91.00
92.00	Allied health cost	0	2,476,327	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,476,327	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/24/2013 7:28 am
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,807	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,807	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)		5,186	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)		411	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)		916	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		7,385,675	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)		7,385,675	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		11,550,178	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		11,550,178	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.639443	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		2,227.18	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)		7,385,675	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,085.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		445,939	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)		445,939	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/24/2013 7:28 am
Title XIX			Hospital		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)	52,716	916	57.55	0	0
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	2,367,802	1,513	1,564.97	0	0
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)					243,559
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					689,498
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
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00 Total Program excludable cost (sum of lines 50 and 51)					0
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
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
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
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
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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
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
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					1,621
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,085.01
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,758,801

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150104		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/24/2013 7:28 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	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: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/24/2013 7:28 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,757,608		30.00
31.00	03100 INTENSIVE CARE UNIT		1,144,644		31.00
40.00	04000 SUBPROVIDER - IPF		651		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.197673	2,120,014	419,070	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.336537	832,992	280,333	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501 ULTRA SOUND	0.124547	119,557	14,890	55.01
57.00	05700 CT SCAN	0.031895	1,392,550	44,415	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.112288	275,032	30,883	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.198255	560,819	111,185	59.00
60.00	06000 LABORATORY	0.178922	3,643,141	651,838	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.309128	166,321	51,414	63.00
64.00	06400 INTRAVENOUS THERAPY	0.001297	488,677	634	64.00
66.00	06600 PHYSICAL THERAPY	0.477251	275,900	131,674	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.878524	125,967	110,665	67.00
67.01	06701 AUDIOLOGY	0.247823	0	0	67.01
68.00	06800 SPEECH PATHOLOGY	0.369894	24,077	8,906	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901 CARDIOLOGY	0.171939	1,794,922	308,617	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.098480	577,427	56,865	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.612464	869,297	532,413	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.060792	2,573,351	156,439	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.001159	0	0	90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002 CLINIC	0.000000	0	0	90.02
90.03	09003 DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004 ENT CLINIC	0.000000	0	0	90.04
90.05	09005 SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007 UROLOGY CLINIC	0.017112	0	0	90.07
90.09	09009 GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011 NEUROLOGY CLINIC	0.001946	0	0	90.11
90.12	09012 OPHTHAMOLOGY CLINIC	0.117927	0	0	90.12
90.13	09013 ALLERGY CLINIC	0.171150	0	0	90.13
90.14	09014 WOUND CARE	0.491558	2,635	1,295	90.14
91.00	09100 EMERGENCY	0.290389	1,160,156	336,897	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.686041	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		17,002,835	3,248,433	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)		17,002,835		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3	
		Component CCN: 15S104		Date/Time Prepared: 5/24/2013 7:28 am	
		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	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		1,790,240		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.197673	6,354	1,256	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.336537	30,041	10,110	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501 ULTRA SOUND	0.124547	4,372	545	55.01
57.00	05700 CT SCAN	0.031895	30,787	982	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.112288	17,575	1,973	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.198255	2,556	507	59.00
60.00	06000 LABORATORY	0.178922	517,866	92,658	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.309128	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.001297	2,526	3	64.00
66.00	06600 PHYSICAL THERAPY	0.477251	34,646	16,535	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.878524	4,683	4,114	67.00
67.01	06701 AUDIOLOGY	0.247823	0	0	67.01
68.00	06800 SPEECH PATHOLOGY	0.369894	3,846	1,423	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901 CARDIOLOGY	0.171939	56,226	9,667	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.098480	17,031	1,677	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.612464	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.060792	408,885	24,857	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.001159	0	0	90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002 CLINIC	0.000000	0	0	90.02
90.03	09003 DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004 ENT CLINIC	0.000000	0	0	90.04
90.05	09005 SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007 UROLOGY CLINIC	0.017112	0	0	90.07
90.09	09009 GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011 NEUROLOGY CLINIC	0.001946	0	0	90.11
90.12	09012 OPHTHAMOLOGY CLINIC	0.117927	0	0	90.12
90.13	09013 ALLERGY CLINIC	0.171150	0	0	90.13
90.14	09014 WOUND CARE	0.491558	6	3	90.14
91.00	09100 EMERGENCY	0.290389	9,086	2,638	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.686041	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		1,146,486	168,948	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)		1,146,486		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/24/2013 7:28 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,361,439		30.00
31.00	03100 INTENSIVE CARE UNIT		94,948		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
43.00	04300 NURSERY		225,097		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.197673	249,678	49,355	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.336537	51,704	17,400	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
55.01	05501 ULTRA SOUND	0.124547	25,348	3,157	55.01
57.00	05700 CT SCAN	0.031895	118,102	3,767	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.112288	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.198255	42,865	8,498	59.00
60.00	06000 LABORATORY	0.178922	404,230	72,326	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.309128	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.001297	51,434	67	64.00
66.00	06600 PHYSICAL THERAPY	0.477251	11,429	5,455	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.878524	3,451	3,032	67.00
67.01	06701 AUDIOLOGY	0.247823	0	0	67.01
68.00	06800 SPEECH PATHOLOGY	0.369894	245	91	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	06901 CARDIOLOGY	0.171939	123,670	21,264	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.098480	133,588	13,156	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.612464	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.060792	278,538	16,933	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.001159	0	0	90.00
90.01	09001 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.01
90.02	09002 CLINIC	0.000000	0	0	90.02
90.03	09003 DERMATOLOGY CLINIC	0.000000	0	0	90.03
90.04	09004 ENT CLINIC	0.000000	0	0	90.04
90.05	09005 SURGERY CLINIC	0.000000	0	0	90.05
90.07	09007 UROLOGY CLINIC	0.017112	0	0	90.07
90.09	09009 GASTROENTEROLOGY CLINIC	0.000000	0	0	90.09
90.11	09011 NEUROLOGY CLINIC	0.001946	0	0	90.11
90.12	09012 OPHTHAMOLOGY CLINIC	0.117927	0	0	90.12
90.13	09013 ALLERGY CLINIC	0.171150	0	0	90.13
90.14	09014 WOUND CARE	0.491558	0	0	90.14
91.00	09100 EMERGENCY	0.290389	100,065	29,058	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.686041	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		1,594,347	243,559	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)		1,594,347		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/24/2013 7:28 am
		Title XVIIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments			5,063,849 1.00
2.00	Outlier payments for discharges. (see instructions)			0 2.00
2.01	Outlier reconciliation amount			0 2.01
3.00	Managed Care Simulated Payments			0 3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			63.57 4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)			0.00 5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00 6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00 7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00 7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.			0.00 8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00 8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)			0.00 8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			0.00 9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			0.00 10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00 11.00
12.00	Current year allowable FTE (see instructions)			0.00 12.00
13.00	Total allowable FTE count for the prior year.			0.00 13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			0.00 14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00 15.00
16.00	Adjustment for residents in initial years of the program			0.00 16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00 17.00
18.00	Adjusted rolling average FTE count			0.00 18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000 19.00
20.00	Prior year resident to bed ratio (see instructions)			0.000000 20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000 21.00
22.00	IME payment adjustment (see instructions)			0 22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).			0.00 23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00 24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			0.00 25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000 26.00
27.00	IME payments adjustment. (see instructions)			0.000000 27.00
28.00	IME Adjustment (see instructions)			0 28.00
29.00	Total IME payment (sum of lines 22 and 28)			0 29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			3.65 30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)			24.85 31.00
32.00	Sum of lines 30 and 31			28.50 32.00
33.00	Allowable disproportionate share percentage (see instructions)			12.00 33.00
34.00	Disproportionate share adjustment (see instructions)			607,662 34.00
Additional payment for high percentage of ESRD beneficiary discharges				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)			0 40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0 41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)			0.00 42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0 43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)			0.000000 44.00
45.00	Average weekly cost for dialysis treatments (see instructions)			0.00 45.00
46.00	Total additional payment (line 45 times line 44 times line 41)			0 46.00
47.00	Subtotal (see instructions)			5,671,511 47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)			0 48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)			5,671,511 49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)			406,558 50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)			0 51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).			0 52.00
53.00	Nursing and Allied Health Managed Care payment			0 53.00
54.00	Special add-on payments for new technologies			0 54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)			0 55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)			0 56.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/24/2013 7:28 am
		Title XVIII	Hospital	PPS
		1.00		
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).			0 57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)			0 58.00
59.00	Total (sum of amounts on lines 49 through 58)			6,078,069 59.00
60.00	Primary payer payments			0 60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			6,078,069 61.00
62.00	Deductibles billed to program beneficiaries			761,708 62.00
63.00	Coinurance billed to program beneficiaries			6,936 63.00
64.00	Allowable bad debts (see instructions)			14,399 64.00
65.00	Adjusted reimbursable bad debts (see instructions)			10,079 65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			-17,149 66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			5,319,504 67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)			0 68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)			0 69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 70.00
70.93	HVBP incentive payment (see instructions)			933 70.93
70.94	Hospital readmissions reduction adjustment (see instructions)			0 70.94
70.95	Recovery of Accelerated Depreciation			0 70.95
70.96	Low Volume Payment-1			441,413 70.96
70.97	Low Volume Payment-2			155,297 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)			5,917,147 71.00
72.00	Interim payments			6,009,089 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)			-91,942 74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			50,000 75.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)			0 90.00
91.00	Capital outlier from Worksheet L, Part I, line 2			0 91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0 92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0 93.00
94.00	The rate used to calculate the Time Value of Money			0.00 94.00
95.00	Time Value of Money for operating expenses(see instructions)			0 95.00
96.00	Time Value of Money for capital related expenses (see instructions)			0 96.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150104

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/24/2013 7:28 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01		
		0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00	5,063,849	0	3,884,863	1,178,986	1.00	
2.00	Outlier payments for discharges (see instructions)	2.00	0	0	0	0	2.00	
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00	
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00	
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	5.00	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00	
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	Amount from Worksheet E Part A, line 27 (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	7.00	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00	
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00	
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200	10.00	
11.00	Disproportionate share adjustment (see instructions)	34.00	607,662	0	466,184	141,478	11.00	
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00	
13.00	Subtotal (see instructions)	47.00	5,671,511	0	4,351,047	1,320,464	13.00	
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	48.00	0	0	0	0	14.00	
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49.00	5,671,511	0	4,351,047	1,320,464	15.00	
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50.00	406,558	0	312,933	93,625	16.00	
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00	
19.00	SUBTOTAL			0	4,663,980	1,414,089	19.00	
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00		
20.00	Capital DRG other than outlier	1.00	406,558	0	312,933	93,625	20.00	
21.00	Capital DRG outlier payments	2.00	0	0	0	0	21.00	
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	22.00	
23.00	Indirect medical education adjustment (line 20 times line 22)	6.00	0	0	0	0	23.00	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	24.00	
25.00	Disproportionate share adjustment (line 20 times line 24)	11.00	0	0	0	0	25.00	
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	12.00	406,558	0	312,933	93,625	26.00	
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00		
27.00	Low volume adjustment factor				0.094643	0.109821	27.00	
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.96			441,413		28.00	
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				155,297	29.00	

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150104

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/24/2013 7:28 am

Title XVII I

Hospital

PPS

		Total (Col 2 through 4)		
		5.00		
1.00	DRG amounts other than outlier payments	5,063,849		1.00
2.00	Outlier payments for discharges (see instructions)	0		2.00
3.00	Operating outlier reconciliation	0		3.00
4.00	Managed care simulated payments	0		4.00
Indirect Medical Education Adjustment				
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)			5.00
6.00	IME payment adjustment (see instructions)	0		6.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
7.00	Amount from Worksheet E Part A, line 27 (see instructions)			7.00
8.00	IME adjustment (see instructions)	0		8.00
9.00	Total IME payment (sum of lines 6 and 8)	0		9.00
Disproportionate Share Adjustment				
10.00	Allowable disproportionate share percentage (see instructions)			10.00
11.00	Disproportionate share adjustment (see instructions)	607,662		11.00
Additional payment for high percentage of ESRD beneficiary discharges				
12.00	Total ESRD additional payment (see instructions)	0		12.00
13.00	Subtotal (see instructions)	5,671,511		13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	5,671,511		15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	406,558		16.00
17.00	Special add-on payments for new technologies	0		17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	0		18.00
19.00	SUBTOTAL	6,078,069		19.00
		5.00		
20.00	Capital DRG other than outlier	406,558		20.00
21.00	Capital DRG outlier payments	0		21.00
22.00	Indirect medical education percentage (see instructions)			22.00
23.00	Indirect medical education adjustment (line 20 times line 22)	0		23.00
24.00	Allowable disproportionate share percentage (see instructions)			24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	0		25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	406,558		26.00
		5.00		
27.00	Low volume adjustment factor			27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	441,413		28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	155,297		29.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/24/2013 7:28 am
		Title XVII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			1,443 1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)			6,792,013 2.00
3.00	PPS payments			5,640,550 3.00
4.00	Outlier payment (see instructions)			3,604 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)			1,443 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			15,514 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)			15,514 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			15,514 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			14,071 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)			1,443 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)			5,644,154 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			19 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,360,110 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)			4,285,468 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			4,285,468 30.00
31.00	Primary payer payments			326 31.00
32.00	Subtotal (line 30 minus line 31)			4,285,142 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			40,509 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			28,356 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			30,878 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			4,313,498 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.98	AB Re-billing demo amount (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			4,313,498 40.00
41.00	Interim payments			4,381,500 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)			-68,002 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0 112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150104 Component CCN: 15S104	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/24/2013 7:28 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		553	2.00
3.00	PPS payments		466	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		466	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		132	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)		334	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		334	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		334	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		334	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	AB Re-billing demo amount (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		334	40.00
41.00	Interim payments		334	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)		0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 150104		Period: From 01/01/2012 To 12/31/2012		Worksheet E-1 Part I Date/Time Prepared: 5/24/2013 7:28 am	
		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		5,717,112		4,284,788	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		155,297		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	12/31/2012	136,680	12/31/2012	96,712	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)		136,680		96,712	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)		6,009,089		4,381,500	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		91,942		68,002	6.02	
7.00	Total Medicare program liability (see instructions)		5,917,147		4,313,498	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: 150104
Component CCN: 15S104

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

Worksheet E-1
Part I
Date/Time Prepared:
5/24/2013 7:28 am

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,664,977		334	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,664,977		334	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,664,977		334	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 150104

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

Worksheet E-1
Part II
Date/Time Prepared:
5/24/2013 7:28 am

		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			2,280 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			2,974 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2			438 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			6,699 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			213,209,619 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			5,287,437 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			1,162,682 8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			1,056,128 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)			106,554 32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			0 108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150104 Component CCN: 15S104	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part II Date/Time Prepared: 5/24/2013 7:28 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			1,759,109 1.00
2.00	Net IPF PPS Outlier Payments			61,591 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)			6.374317 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)			1,820,700 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)			1,820,700 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,820,700 18.00
19.00	Deductibles			152,544 19.00
20.00	Subtotal (line 18 minus line 19)			1,668,156 20.00
21.00	Coinsurance			3,179 21.00
22.00	Subtotal (line 20 minus line 21)			1,664,977 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			0 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)			1,664,977 26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			1,664,977 31.00
32.00	Interim payments			1,664,977 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)			0 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			61,591 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: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part VII Date/Time Prepared: 5/24/2013 7:28 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital /SNF/NF services		689,498		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)		689,498	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)		689,498	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		1,680,584		8.00
9.00	Ancillary service charges		1,594,347	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)		3,274,931	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		3,274,931	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		2,585,433	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)		689,498	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		689,498	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		689,498	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)		689,498	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		689,498	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)		689,498	0	40.00
41.00	Interim payments		1,770,648	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		-1,081,150	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

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

Provider CCN: 150104

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

Worksheet G

Date/Time Prepared:
5/24/2013 7:28 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	25,677,008	0	0	0	1.00
2.00	Temporary investments	20,969,498	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	20,295,743	0	0	0	4.00
5.00	Other receivable	2,510,737	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	4,187,619	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	2,975,000	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)	76,615,605	0	0	0	11.00
FIXED ASSETS						
12.00	Land	7,269,626	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	112,070,407	0	0	0	15.00
16.00	Accumulated depreciation	-43,680,667	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	75,659,366	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	-291,891	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	12,391,672	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	12,099,781	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	164,374,752	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	16,215,525	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,740,291	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	9,512,123	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	31,467,939	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	68,420,201	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	68,420,201	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	99,888,140	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	64,486,612	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	64,486,612	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	164,374,752	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150104

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

Worksheet G-1

Date/Time Prepared:
5/24/2013 7:28 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		56,863,698		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		7,622,914				2.00
3.00	Total (sum of line 1 and line 2)		64,486,612		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		64,486,612		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		64,486,612		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150104

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/24/2013 7:28 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	12,553,046		12,553,046	1.00
2.00	SUBPROVIDER - IPF	2,102,894		2,102,894	2.00
3.00	SUBPROVIDER - IRF	0		0	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)	14,655,940		14,655,940	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	2,953,984		2,953,984	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)	2,953,984		2,953,984	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	17,609,924		17,609,924	17.00
18.00	Ancillary services	34,489,546	140,075,104	174,564,650	18.00
19.00	Outpatient services	2,556,130	25,483,819	28,039,949	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	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PPO, MISC	2,912	31,469,319	31,472,231	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	54,658,512	197,028,242	251,686,754	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		88,711,210		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)		88,711,210		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150104

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

Worksheet G-3

Date/Time Prepared:
5/24/2013 7:28 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	251,686,754	1.00
2.00	Less contractual allowances and discounts on patients' accounts	137,075,383	2.00
3.00	Net patient revenues (line 1 minus line 2)	114,611,371	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	88,711,210	4.00
5.00	Net income from service to patients (line 3 minus line 4)	25,900,161	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	5,492,755	24.00
25.00	Total other income (sum of lines 6-24)	5,492,755	25.00
26.00	Total (line 5 plus line 25)	31,392,916	26.00
27.00	OTHER EXPENSES (SPECIFY)	23,770,002	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	23,770,002	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	7,622,914	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150104	Period: From 01/01/2012 To 12/31/2012	Worksheet L Parts I-III Date/Time Prepared: 5/24/2013 7:28 am
		Title XVIIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		406,558	1.00
2.00	Capital DRG outlier payments		0	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		18.54	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		406,558	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00