

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: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet S Parts I-III Date/Time Prepared: 11/27/2012 12:38 pm
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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: 11/27/2012 Time: 12:38 pm

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

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 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 MEMORIAL HOSP & HEALTH CARE CTR for the cost reporting period beginning 07/01/2011 and ending 06/30/2012 and to the best of my knowledge and belief, it is a true, correct and complete statement 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 identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-116,574	-84,915	0	0	1.00
2.00 Subprovider - IPF	0	42,569	0		0	2.00
3.00 Subprovider - IRF	0	17,392	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0				0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		1,363		0	10.00
10.01 RURAL HEALTH CLINIC II II	0		2,841		0	10.01
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00 CMHC I	0		0		0	12.00
200.00 Total	0	-56,613	-80,711	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/27/2012 12:35 pm				
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 800 WEST 9TH STREET			PO Box:						1.00	
2.00	City: JASPER			State: IN		Zip Code: 47546		County: DUBOIS		2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		
		Hospital and Hospital-Based Component Identification:									
3.00	Hospital		MEMORIAL HOSP & HEALTH CARE CTR	150115	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF		MEMORIAL HOSP & HCC (PSYCH)	15S115	99915	4	07/01/1985	N	P	O	4.00
5.00	Subprovider - IRF		MEMORIAL HOSP & HCC (REHAB)	15T115	99915	5	07/01/2005	N	P	O	5.00
6.00	Subprovider - (Other)							N	N	N	6.00
7.00	Swing Beds - SNF							N	N	N	7.00
8.00	Swing Beds - NF							N	N	N	8.00
9.00	Hospital-Based SNF		MEMORIAL HOSP & HEALTH CARE CTR	155305	99915		08/04/1987	N	P	O	9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA		MEMORIAL HOSP & HEALTH CARE CTR	157222	99915		08/28/1991	N	P	N	12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC		FRENCH LICK FAMILY MEDICINE	158507	99915		06/19/2009	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC 1		LOOGOOTEE FAMILY MEDICINE	158508	99915		12/14/2009	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FOHC							N	N	N	16.00
17.00	Hospital-Based (CMHC) 1										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
						From:		To:			
						1.00		2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2011		06/30/2012		20.00	
21.00	Type of Control (see instructions)					1				21.00	
Inpatient PPS Information											
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y		N		22.00	
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "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 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 days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		943	247	0	0	1,725	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 days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.		39	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.							2		26.00	
27.00	For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification in column 2.							2		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: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/27/2012 12:35 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		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 the special exceptions payment pursuant to 42 CFR Section §412.348(g)? 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)	N	0.00	0.00	61.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00	
		Program Name 1.00	Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet S-2
Part I
Date/Time Prepared:
11/27/2012 12:35 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. Use subscripted lines 65.01 through 65.50 for each additional primary care program. 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. (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	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

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		1.00	2.00	3.00		
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	N	0		71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y				75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N	N	0		76.00
		1.00				
Long Term Care Hospital PPS						
80.00	Are you a long term care hospital (LTCH)? Enter in column 1 "Y" for yes and "N" for no. LTCHs can only exist as independent/freestanding facilities. An independent or freestanding facility may exist as an unrelated hospital within a hospital, it must meet the separateness (from the host/co-located provider) requirements identified in 42 CFR 412.22(e.)		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.		N			86.00
		V			XIX	
		1.00			2.00	
Title V or XIX Inpatient Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)					107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00
		1.00			2.00 3.00	
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.	Y				116.00

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		1.00	2.00	3.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	Enter the total amount of malpractice premiums paid in column 1, enter the total amount of paid losses in column 2, and enter the total amount of self insurance paid in column 3.	955,163	0	0	118.01
		1.00	2.00		
118.02	Indicate if malpractice premiums and paid losses are reported in other than the Administrative and General cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	If this is an SCH (or EACH), regardless of bed size, or is rural hospital with 100 or fewer beds that qualifies for the outpatient hold harmless provision in accordance with ACA, section 3121, as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108; the Temporary Payroll Tax Cut Continuation Act of 2011, section 308; and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002, enter "Y" for yes or "N" for no in column 1 or column 2, respectively. Note that for SCHs (and EACHs) the outpatient hold harmless provision is effective for services rendered from January 1, 2010 through February 29, 2012 regardless of bed size and from March 1, 2012 through December 31, 2012 to all SCHs (and EACHs) with 100 or fewer beds. These responses impact the TOPs calculation on Worksheet E, Part B, line 8.	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:		141.00
142.00	Street:	PO Box:			142.00
143.00	City:	State:	Zip Code:		143.00
		1.00	2.00		
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150115		Period: From 07/01/2011 To 06/30/2012		Worksheet S-2 Part I Date/Time Prepared: 11/27/2012 12:35 pm	
		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	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC	N	N	N	N	161.00	
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part II Date/Time Prepared: 11/27/2012 12:35 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A			
		Description	Y/N	Date	
		0	1.00	2.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/26/2012		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N			20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part II Date/Time Prepared: 11/27/2012 12:35 pm
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		Part A		
		Description	Y/N	Date
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	N	21.00
				1.00
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.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
				Y/N
				Date
				1.00
				2.00
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	40.00
				1.00
				2.00
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.	RENEE	ESSLINGER	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(317) 383-4253	RESSLINGER@BKD.COM	43.00

		Part B		
		Y/N	Date	
		3.00	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)	Y	10/26/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
		3.00		
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.	MANAGING CONSULTANT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
11/27/2012 12:35 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours		
	Line Number					
	1.00	2.00	3.00	4.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	85	31,110	0.00		1.00
2.00 HMO						2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						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)		85	31,110	0.00		7.00
8.00 INTENSIVE CARE UNIT	31.00	26	9,516	0.00		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00					13.00
14.00 Total (see instructions)		111	40,626	0.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	40.00	9	3,294			16.00
17.00 SUBPROVIDER - IRF	41.00	8	2,928			17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	20	7,320			19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00					26.00
26.01 RURAL HEALTH CLINIC II	88.01					26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00					26.25
27.00 Total (sum of lines 14-26)		148				27.00
28.00 Observation Bed Days						28.00
28.01 SUBPROVIDER - IPF	40.00					28.01
28.02 SUBPROVIDER - IRF	41.00					28.02
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
11/27/2012 12:35 pm

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	5,927	611	12,586		1.00
2.00 HMO		516	1,795			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		2	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	5,927	611	12,586		7.00
8.00 INTENSIVE CARE UNIT	0	3,293	238	5,039		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		94	1,988		13.00
14.00 Total (see instructions)	0	9,220	943	19,613		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF	0	802	553	2,209		16.00
17.00 SUBPROVIDER - IRF	0	1,346	39	1,642		17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0	3,956	143	4,907		19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	4,846	1,465	9,598		22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE		0	0	0		24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0	933	0	3,658		26.00
26.01 RURAL HEALTH CLINIC II	0	2,345	0	6,746		26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		308	1,568		28.00
28.01 SUBPROVIDER - IPF				18		28.01
28.02 SUBPROVIDER - IRF				0		28.02
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				0		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			177	352		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
11/27/2012 12:35 pm

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	2,626	1.00
2.00 HMO					0	2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						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	1,010.12	0.00	0	2,626	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	15.59	0.00	0	108	16.00
17.00 SUBPROVIDER - IRF	0.00	12.30	0.00	0	99	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00	25.19	0.00			19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00	14.94	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00	0.00	0.00			24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00	3.52	0.00			26.00
26.01 RURAL HEALTH CLINIC II	0.00	6.01	0.00			26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00 Total (sum of lines 14-26)	0.00	1,087.67	0.00			27.00
28.00 Observation Bed Days						28.00
28.01 SUBPROVIDER - IPF						28.01
28.02 SUBPROVIDER - IRF						28.02
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
11/27/2012 12:35 pm

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	498	5,430		1.00
2.00 HMO				2.00
3.00 HMO IPF				3.00
4.00 HMO IRF				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)	498	5,430		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF	74	339		16.00
17.00 SUBPROVIDER - IRF	2	124		17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
26.00 RURAL HEALTH CLINIC				26.00
26.01 RURAL HEALTH CLINIC II				26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
28.01 SUBPROVIDER - IPF				28.01
28.02 SUBPROVIDER - IRF				28.02
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: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet S-3 Part II Date/Time Prepared: 11/27/2012 12:35 pm
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	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
	1.00	2.00	3.00	4.00	5.00	
PART II - WAGE DATA						
SALARIES						
1.00	Total salaries (see instructions)	200.00	65,172,641	0	65,172,641	2,302,660.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00
3.00	Non-physician anesthetist Part B		1,723,911	0	1,723,911	15,213.00
4.00	Physician-Part A - Administrative		0	0	0	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00
5.00	Physician-Part B		13,238,582	0	13,238,582	86,436.00
6.00	Non-physician-Part B		0	0	0	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00
8.00	Home office personnel		0	0	0	0.00
9.00	SNF	44.00	1,118,188	16,182	1,134,370	52,387.00
10.00	Excluded area salaries (see instructions)		18,169,249	139,882	18,309,131	528,170.00
OTHER WAGES & RELATED COSTS						
11.00	Contract labor (see instructions)		1,994	0	1,994	38.00
12.00	Contract management and administrative services		0	0	0	0.00
13.00	Contract labor: Physician-Part A - Administrative		1,311,906	0	1,311,906	5,586.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00
16.00	Home office and Contract Physicians Part A - Administrative		0	0	0	0.00
WAGE-RELATED COSTS						
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24		7,375,632	0	7,375,632	
18.00	Wage-related costs (other)Wkst S-3, Part IV Line 25		0	0	0	
19.00	Excluded areas		4,600,406	0	4,600,406	
20.00	Non-physician anesthetist Part A		0	0	0	
21.00	Non-physician anesthetist Part B		411,184	0	411,184	
22.00	Physician Part A - Administrative		0	0	0	
22.01	Physician Part A - Teaching		0	0	0	
23.00	Physician Part B		3,157,644	0	3,157,644	
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	1,306,670	-773,267	533,403	19,010.00
27.00	Administrative & General	5.00	6,505,089	244,530	6,749,619	293,950.00
28.00	Administrative & General under contract (see inst.)		852,837	0	852,837	3,888.00
29.00	Maintenance & Repairs	6.00	1,499,072	21,907	1,520,979	67,715.00
30.00	Operation of Plant	7.00	0	0	0	0.00
31.00	Laundry & Linen Service	8.00	220,656	4,847	225,503	20,087.00
32.00	Housekeeping	9.00	947,081	17,367	964,448	83,046.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00
34.00	Dietary	10.00	1,022,332	-698,491	323,841	21,115.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00
36.00	Cafeteria	11.00	0	718,013	718,013	49,819.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00
38.00	Nursing Administration	13.00	729,039	6,870	735,909	24,537.00
39.00	Central Services and Supply	14.00	216,794	4,316	221,110	16,620.00
40.00	Pharmacy	15.00	1,275,211	12,717	1,287,928	37,797.00
41.00	Medical Records & Medical Records Library	16.00	806,034	14,284	820,318	44,963.00
42.00	Social Service	17.00	0	0	0	0.00
43.00	Other General Service	18.00	0	0	0	0.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet S-3
Part II
Date/Time Prepared:
11/27/2012 12:35 pm

		Average Hourly Wage (col. 4 ÷ col. 5)	
		6.00	
PART II - WAGE DATA			
SALARIES			
1.00	Total salaries (see instructions)	28.30	1.00
2.00	Non-physician anesthetist Part A	0.00	2.00
3.00	Non-physician anesthetist Part B	113.32	3.00
4.00	Physician-Part A - Administrative	0.00	4.00
4.01	Physicians - Part A - Teaching	0.00	4.01
5.00	Physician-Part B	153.16	5.00
6.00	Non-physician-Part B	0.00	6.00
7.00	Interns & residents (in an approved program)	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)	0.00	7.01
8.00	Home office personnel	0.00	8.00
9.00	SNF	21.65	9.00
10.00	Excluded area salaries (see instructions)	34.67	10.00
OTHER WAGES & RELATED COSTS			
11.00	Contract labor (see instructions)	52.47	11.00
12.00	Contract management and administrative services	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative	234.86	13.00
14.00	Home office salaries & wage-related costs	0.00	14.00
15.00	Home office: Physician Part A - Administrative	0.00	15.00
16.00	Home office and Contract Physicians Part A - Administrative	0.00	16.00
WAGE-RELATED COSTS			
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24		17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV Line 25		18.00
19.00	Excluded areas		19.00
20.00	Non-physician anesthetist Part A		20.00
21.00	Non-physician anesthetist Part B		21.00
22.00	Physician Part A - Administrative		22.00
22.01	Physician Part A - Teaching		22.01
23.00	Physician Part B		23.00
24.00	Wage-related costs (RHC/FQHC)		24.00
25.00	Interns & residents (in an approved program)		25.00
OVERHEAD COSTS - DIRECT SALARIES			
26.00	Employee Benefits	28.06	26.00
27.00	Administrative & General	22.96	27.00
28.00	Administrative & General under contract (see inst.)	219.35	28.00
29.00	Maintenance & Repairs	22.46	29.00
30.00	Operation of Plant	0.00	30.00
31.00	Laundry & Linen Service	11.23	31.00
32.00	Housekeeping	11.61	32.00
33.00	Housekeeping under contract (see instructions)	0.00	33.00
34.00	Dietary	15.34	34.00
35.00	Dietary under contract (see instructions)	0.00	35.00
36.00	Cafeteria	14.41	36.00
37.00	Maintenance of Personnel	0.00	37.00
38.00	Nursing Administration	29.99	38.00
39.00	Central Services and Supply	13.30	39.00
40.00	Pharmacy	34.07	40.00
41.00	Medical Records & Medical Records Library	18.24	41.00
42.00	Social Service	0.00	42.00
43.00	Other General Service	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 150115		Period: From 07/01/2011 To 06/30/2012		Worksheet S-3 Part III Date/Time Prepared: 11/27/2012 12:35 pm	
	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4		
	1.00	2.00	3.00	4.00	5.00		
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	51,062,985	0	51,062,985	2,204,899.00		1.00
2.00	Excluded area salaries (see instructions)	19,287,437	156,064	19,443,501	580,557.00		2.00
3.00	Subtotal salaries (line 1 minus line 2)	31,775,548	-156,064	31,619,484	1,624,342.00		3.00
4.00	Subtotal other wages & related costs (see inst.)	1,313,900	0	1,313,900	5,624.00		4.00
5.00	Subtotal wage-related costs (see inst.)	7,375,632	0	7,375,632	0.00		5.00
6.00	Total (sum of lines 3 thru 5)	40,465,080	-156,064	40,309,016	1,629,966.00		6.00
7.00	Total overhead cost (see instructions)	15,380,815	-426,907	14,953,908	682,547.00		7.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet S-3 Part III Date/Time Prepared: 11/27/2012 12:35 pm
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		Average Hourly Wage (col. 4 ÷ col. 5)	
		6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY			
1.00	Net salaries (see instructions)	23.16	1.00
2.00	Excluded area salaries (see instructions)	33.49	2.00
3.00	Subtotal salaries (line 1 minus line 2)	19.47	3.00
4.00	Subtotal other wages & related costs (see inst.)	233.62	4.00
5.00	Subtotal wage-related costs (see inst.)	23.33	5.00
6.00	Total (sum of lines 3 thru 5)	24.73	6.00
7.00	Total overhead cost (see instructions)	21.91	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet S-3 Part IV Date/Time Prepared: 11/27/2012 12:35 pm
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		180,972	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)		906,625	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		3,936,637	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		27,246	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)		96,465	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		191,863	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		2,001,386	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		13,686	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		20,752	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		7,375,632	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet S-3 Part V Date/Time Prepared: 11/27/2012 12:35 pm
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Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	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	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 150115 Component CCN: 157222		Period: From 07/01/2011 To 06/30/2012		Worksheet S-4 Date/Time Prepared: 11/27/2012 12:35 pm PPS	
0.00 County				DUBOIS		0.00	
		1.00					
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	3,153	451	1,272	4,876	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	280.00	51.00	144.00	522.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.00	0.00	1.00	4.00
5.00	Other Administrative Personnel			2.94	0.00	2.94	5.00
6.00	Direct Nursing Service			5.73	0.00	5.73	6.00
7.00	Nursing Supervisor			1.03	0.00	1.03	7.00
8.00	Physical Therapy Service			1.19	0.00	1.19	8.00
9.00	Physical Therapy Supervisor			0.26	0.00	0.26	9.00
10.00	Occupational Therapy Service			0.37	0.00	0.37	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.04	0.00	0.04	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.02	0.00	0.02	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			2.34	0.00	2.34	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99915			20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	1,874	105	75	22	2,076	21.00
22.00	Skilled Nursing Visit Charges	327,702	17,750	14,415	3,861	363,728	22.00
23.00	Physical Therapy Visits	1,186	3	25	10	1,224	23.00
24.00	Physical Therapy Visit Charges	215,852	546	4,550	1,820	222,768	24.00
25.00	Occupational Therapy Visits	259	1	3	1	264	25.00
26.00	Occupational Therapy Visit Charges	47,138	182	546	182	48,048	26.00
27.00	Speech Pathology Visits	30	0	1	0	31	27.00
28.00	Speech Pathology Visit Charges	5,460	0	182	0	5,642	28.00
29.00	Medical Social Service Visits	2	0	0	0	2	29.00
30.00	Medical Social Service Visit Charges	432	0	0	0	432	30.00
31.00	Home Health Aide Visits	1,199	35	6	9	1,249	31.00
32.00	Home Health Aide Visit Charges	94,721	2,765	474	711	98,671	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,550	144	110	42	4,846	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	691,305	21,243	20,167	6,574	739,289	35.00
36.00	Total Number of Episodes (standard/non outlier)	275		38	3	316	36.00
37.00	Total Number of Outlier Episodes		3		0	3	37.00
38.00	Total Non-Routine Medical Supply Charges	26,318	3,328	560	728	30,934	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet S-7
Date/Time Prepared:
11/27/2012 12:35 pm

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

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
				1.00	2.00
3.00	RUX	0	0	0	3.00
4.00	RUL	0	0	0	4.00
5.00	RVX	0	0	0	5.00
6.00	RVL	0	0	0	6.00
7.00	RHX	14	0	14	7.00
8.00	RHL	10	0	10	8.00
9.00	RMX	2	0	2	9.00
10.00	RML	59	0	59	10.00
11.00	RLX	0	0	0	11.00
12.00	RUC	29	0	29	12.00
13.00	RUB	0	0	0	13.00
14.00	RUA	0	0	0	14.00
15.00	RVC	179	0	179	15.00
16.00	RVB	208	0	208	16.00
17.00	RVA	677	0	677	17.00
18.00	RHC	742	0	742	18.00
19.00	RHB	483	0	483	19.00
20.00	RHA	786	0	786	20.00
21.00	RMC	169	0	169	21.00
22.00	RMB	213	0	213	22.00
23.00	RMA	182	0	182	23.00
24.00	RLB	0	0	0	24.00
25.00	RLA	0	0	0	25.00
26.00	ES3	0	0	0	26.00
27.00	ES2	0	0	0	27.00
28.00	ES1	0	0	0	28.00
29.00	HE2	0	0	0	29.00
30.00	HE1	14	0	14	30.00
31.00	HD2	0	0	0	31.00
32.00	HD1	0	0	0	32.00
33.00	HC2	28	0	28	33.00
34.00	HC1	39	0	39	34.00
35.00	HB2	0	0	0	35.00
36.00	HB1	35	0	35	36.00
37.00	LE2	0	0	0	37.00
38.00	LE1	0	0	0	38.00
39.00	LD2	0	0	0	39.00
40.00	LD1	33	0	33	40.00
41.00	LC2	0	0	0	41.00
42.00	LC1	4	0	4	42.00
43.00	LB2	0	0	0	43.00
44.00	LB1	4	0	4	44.00
45.00	CE2	9	0	9	45.00
46.00	CE1	0	0	0	46.00
47.00	CD2	3	0	3	47.00
48.00	CD1	6	0	6	48.00
49.00	CC2	0	0	0	49.00
50.00	CC1	3	0	3	50.00
51.00	CB2	0	0	0	51.00
52.00	CB1	1	0	1	52.00
53.00	CA2	0	0	0	53.00
54.00	CA1	16	0	16	54.00
55.00	SE3	0	0	0	55.00
56.00	SE2	0	0	0	56.00
57.00	SE1	0	0	0	57.00
58.00	SSC	0	0	0	58.00
59.00	SSB	0	0	0	59.00
60.00	SSA	0	0	0	60.00
61.00	IB2	0	0	0	61.00
62.00	IB1	0	0	0	62.00
63.00	IA2	0	0	0	63.00
64.00	IA1	0	0	0	64.00
65.00	BB2	0	0	0	65.00
66.00	BB1	0	0	0	66.00
67.00	BA2	0	0	0	67.00
68.00	BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet S-7

Date/Time Prepared:
11/27/2012 12:35 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	8	0	8	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		3,956	0	3,956	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	

201.00	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	99915	99915	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	1,204,362			207.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 150115 Component CCN: 158507	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 11/27/2012 12:35 pm Cost
		Rural Health Clinic (RHC) I		
		County 4.00		
2.00	City, State, Zip Code, County	ORANGE		2.00
		Tuesday		
		from	to	
		5.00	6.00	
		Wednesday		
		from	to	
		7.00	8.00	
11.00	Facility hours of operations (1) Clinic	06:00	15:00	08:00
			12:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 150115 Component CCN: 158507	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 11/27/2012 12:35 pm		
			Rural Health Clinic (RHC) I	Cost		
		Thursday		Friday		
		from	to	from	to	
		9.00	10.00	11.00	12.00	
11.00	Facility hours of operations (1) Clinic	08:00	17:00	06:00	15:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 150115 Component CCN: 158507	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 11/27/2012 12:35 pm Cost
			Rural Health Clinic (RHC) I	
		Saturday		
		from	to	
		13.00	14.00	
11.00	Facility hours of operations (1) Clinic			11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 150115 Component CCN: 158508		Period: From 07/01/2011 To 06/30/2012		Worksheet S-8 Date/Time Prepared: 11/27/2012 12:35 pm	
				Rural Health Clinic (RHC) II		Cost	
1.00 Clinic Address and Identification							
Street				105 COOPER STREET		1.00	
				City		State	
				1.00		2.00	
				Zip Code		3.00	
2.00 City, State, Zip Code, County				LOOGOOTEE		IN47553	
3.00 FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban							
1.00							
0 3.00							
				Grant Award		Date	
				1.00		2.00	
4.00 Source of Federal Funds							
Community Health Center (Section 330(d), PHS Act)				0		4.00	
5.00 Migrant Health Center (Section 329(d), PHS Act)				0		5.00	
6.00 Health Services for the Homeless (Section 340(d), PHS Act)				0		6.00	
7.00 Appalachian Regional Commission				0		7.00	
8.00 Look-Alikes				0		8.00	
9.00 OTHER (SPECIFY)				0		9.00	
10.00 Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)							
				N		0	
				1.00		2.00	
				10.00			
				Sunday		Monday	
				from to		from to	
				1.00 2.00		3.00 4.00	
11.00 Facility hours of operations (1)							
Clinic				08:00		18:00	
1.00							
2.00							
12.00 Have you received an approval for an exception to the productivity standard?							
				N		12.00	
13.00 Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.							
				N		0	
14.00 Provider name, CCN number							
				Provider name		CCN number	
				1.00		2.00	
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable, and the total number of visits in column 5. (see instructions)							
				Y/N		V	
				1.00		2.00	
				XVIII		XIX	
				3.00		4.00	
				Total Visits		5.00	
				0		0	
15.00							

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 150115 Component CCN: 158508	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 11/27/2012 12:35 pm Cost
			Rural Health Clinic (RHC) II	
		County 4.00		
2.00	City, State, Zip Code, County	MARTIN		2.00
		Tuesday		
		from	to	
		5.00	6.00	
		Wednesday		
		from	to	
		7.00	8.00	
11.00	Facility hours of operations (1) Clinic	08:00	18:00	08:00
				18:00
				11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 150115 Component CCN: 158508		Period: From 07/01/2011 To 06/30/2012		Worksheet S-8 Date/Time Prepared: 11/27/2012 12:35 pm Cost	
				Rural Health Clinic (RHC) II			
		Thursday		Friday			
		from	to	from	to		
		9.00	10.00	11.00	12.00		
11.00	Facility hours of operations (1) Clinic	08:00	18:00	08:00	12:00	11.00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 150115 Component CCN: 158508	Period: From 07/01/2011 To 06/30/2012	Worksheet S-8 Date/Time Prepared: 11/27/2012 12:35 pm
			Rural Health Clinic (RHC) II	Cost
		Saturday		
		from	to	
		13.00	14.00	
11.00	Facility hours of operations (1) Clinic			11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet S-10 Date/Time Prepared: 11/27/2012 12:35 pm
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				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)		0.423666		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		8,206,456		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0		5.00
6.00	Medicaid charges		26,634,216		6.00
7.00	Medicaid cost (line 1 times line 6)		11,284,012		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		3,077,556		8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0		9.00
10.00	Stand-alone SCHIP charges		0		10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0		11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		3,077,556		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	5,880,854	0	5,880,854	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	2,491,518	0	2,491,518	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,491,518	0	2,491,518	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		8,182,647		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		143,745		27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		8,038,902		28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		3,405,809		29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		5,897,327		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		8,974,883		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet A

Date/Time Prepared:
11/27/2012 12:35 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		6,470,721	6,470,721	0	6,470,721	1.00
2.00	00200		5,899,603	5,899,603	0	5,899,603	2.00
4.00	00400		15,832,613	17,139,283	-773,267	16,366,016	4.00
5.00	00500	1,306,670	21,943,774	28,448,863	244,530	28,693,393	5.00
6.00	00600	6,505,089	4,977,043	6,476,115	21,907	6,498,022	6.00
8.00	00800	1,499,072	102,242	322,898	4,847	327,745	8.00
9.00	00900	220,656	216,375	1,163,456	17,367	1,180,823	9.00
10.00	01000	947,081	655,453	1,677,785	-1,195,530	482,255	10.00
11.00	01100	1,022,332	0	0	1,178,356	1,178,356	11.00
13.00	01300	0	87,826	816,865	6,870	823,735	13.00
14.00	01400	729,039	273,302	490,096	-203,603	286,493	14.00
15.00	01500	216,794	8,854,738	10,129,949	12,717	10,142,666	15.00
16.00	01600	1,275,211	84,499	890,533	14,284	904,817	16.00
806,034							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	6,007,009	494,765	6,501,774	-391,147	6,110,627	30.00
31.00	03100	2,554,440	99,995	2,654,435	-59,625	2,594,810	31.00
40.00	04000	1,052,941	119,591	1,172,532	11,961	1,184,493	40.00
41.00	04100	629,944	143,455	773,399	5,505	778,904	41.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	1,118,188	51,843	1,170,031	16,182	1,186,213	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,539,406	3,580,131	7,119,537	-2,557,222	4,562,315	50.00
52.00	05200	0	0	0	450,264	450,264	52.00
53.00	05300	3,157,877	406,255	3,564,132	-175,472	3,388,660	53.00
54.00	05400	1,888,572	671,971	2,560,543	23,555	2,584,098	54.00
56.00	05600	202,925	570,203	773,128	1,042	774,170	56.00
60.00	06000	2,246,591	3,574,639	5,821,230	27,611	5,848,841	60.00
65.00	06500	1,025,645	404,848	1,430,493	-89,292	1,341,201	65.00
66.00	06600	1,647,142	194,129	1,841,271	-40,753	1,800,518	66.00
69.00	06900	1,595,515	4,280,472	5,875,987	-2,386,469	3,489,518	69.00
69.01	06901	0	0	0	60,058	60,058	69.01
69.02	06902	103,921	9,520	113,441	623	114,064	69.02
69.03	06903	150,201	32,586	182,787	1,630	184,417	69.03
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	5,154,553	5,154,553	-2,219,193	2,935,360	71.00
72.00	07200	0	0	0	7,950,511	7,950,511	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	193,535	77,937	271,472	926	272,398	88.00
88.01	08801	361,947	81,033	442,980	1,935	444,915	88.01
89.00	08900	0	0	0	0	0	89.00
90.00	09000	228,736	431,992	660,728	-23,668	637,060	90.00
90.01	09001	423,704	149,296	573,000	-40,473	532,527	90.01
90.02	09002	1,056,050	980,701	2,036,751	-38,882	1,997,869	90.02
91.00	09100	5,529,492	561,010	6,090,502	22,360	6,112,862	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	1,516,753	171,310	1,688,063	21,182	1,709,245	95.00
96.00	09600	0	0	0	0	0	96.00
101.00	10100	792,342	156,475	948,817	10,536	959,353	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		51,550,854	87,796,899	139,347,753	-87,837	139,259,916	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	11,206,772	3,693,018	14,899,790	37,063	14,936,853	192.00
192.01	19201	524,084	28,248	552,332	2,266	554,598	192.01
194.00	07950	4,303	25,398	29,701	0	29,701	194.00
194.02	07952	162,910	2,884	165,794	6,207	172,001	194.02
194.03	07953	1,164,266	1,227,442	2,391,708	30,074	2,421,782	194.03
194.04	07954	281,722	122,511	404,233	3,402	407,635	194.04
194.05	07955	110,762	16,177	126,939	4,075	131,014	194.05
194.06	07956	0	0	0	0	0	194.06
194.08	07958	166,968	506,317	673,285	4,750	678,035	194.08
194.09	07959	0	0	0	0	0	194.09
200.00		65,172,641	93,418,894	158,591,535	0	158,591,535	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet A
Date/Time Prepared:
11/27/2012 12:35 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,200,030	5,270,691	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-1,642	5,897,961	2.00
4.00	00400	EMPLOYEE BENEFITS	-1,323,208	15,042,808	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-8,634,912	20,058,481	5.00
6.00	00600	MAINTENANCE & REPAIRS	-694	6,497,328	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	-715	327,030	8.00
9.00	00900	HOUSEKEEPING	-2,254	1,178,569	9.00
10.00	01000	DIETARY	-59,752	422,503	10.00
11.00	01100	CAFETERIA	-474,939	703,417	11.00
13.00	01300	NURSING ADMINISTRATION	-5,352	818,383	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	286,493	14.00
15.00	01500	PHARMACY	-224,617	9,918,049	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-27,788	877,029	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	6,110,627	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,594,810	31.00
40.00	04000	SUBPROVIDER - I PF	-325,037	859,456	40.00
41.00	04100	SUBPROVIDER - I RF	-84,810	694,094	41.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	-4,734	1,181,479	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,090	4,561,225	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	450,264	52.00
53.00	05300	ANESTHESIOLOGY	-3,202,620	186,040	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,584,098	54.00
56.00	05600	RADIOISOTOPE	0	774,170	56.00
60.00	06000	LABORATORY	-163,298	5,685,543	60.00
65.00	06500	RESPIRATORY THERAPY	-14,872	1,326,329	65.00
66.00	06600	PHYSICAL THERAPY	-8,691	1,791,827	66.00
69.00	06900	ELECTROCARDIOLOGY	-843,628	2,645,890	69.00
69.01	06901	PULMONARY	0	60,058	69.01
69.02	06902	CARDIOPULMONARY	0	114,064	69.02
69.03	06903	SLEEP LAB	-1,339	183,078	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,935,360	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,950,511	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-4,362	268,036	88.00
88.01	08801	RURAL HEALTH CLINIC II	-51,352	393,563	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-95,700	541,360	90.00
90.01	09001	IMED	-467,843	64,684	90.01
90.02	09002	ONCOLOGY	-1,340	1,996,529	90.02
91.00	09100	EMERGENCY	-3,485,138	2,627,724	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-7,647	1,701,598	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	959,353	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-20,719,404	118,540,512	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	14,936,853	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	554,598	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	29,701	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0	172,001	194.02
194.03	07953	MKT/PHY SERVICES	0	2,421,782	194.03
194.04	07954	COMMUNITY EDUCATION	0	407,635	194.04
194.05	07955	VOLUNTEER	0	131,014	194.05
194.06	07956	MAB	0	0	194.06
194.08	07958	PUBLIC RELATIONS	0	678,035	194.08
194.09	07959	UNUSED SPACE	0	0	194.09
200.00		TOTAL (SUM OF LINES 118-199)	-20,719,404	137,872,131	200.00

RECLASSIFICATIONS

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-6

Date/Time Prepared:
11/27/2012 12:35 pm

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
A - PULMONARY FUNCTION TESTING						
1.00	PULMONARY		69.01	60,058	0	1.00
	TOTALS			60,058	0	
B - LABOR AND DELIVERY						
1.00	DELIVERY ROOM & LABOR ROOM		52.00	385,260	65,004	1.00
	TOTALS			385,260	65,004	
C - CAFETERIA						
1.00	CAFETERIA		11.00	718,013	460,343	1.00
	TOTALS			718,013	460,343	
D - IMPLANTABLE DEVICES						
1.00	IMPL. DEV. CHARGED TO PATIENTS		72.00	0	7,950,511	1.00
	TOTALS			0	7,950,511	
E - BILLABLE SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00	0	5,731,318	1.00
2.00			0.00	0	0	2.00
3.00			0.00	0	0	3.00
4.00			0.00	0	0	4.00
5.00			0.00	0	0	5.00
6.00			0.00	0	0	6.00
7.00			0.00	0	0	7.00
8.00			0.00	0	0	8.00
9.00			0.00	0	0	9.00
10.00			0.00	0	0	10.00
11.00			0.00	0	0	11.00
12.00			0.00	0	0	12.00
	TOTALS			0	5,731,318	
F - GAINSHARE RECLASS						
1.00	ADMINISTRATIVE & GENERAL		5.00	244,530	0	1.00
2.00	MAINTENANCE & REPAIRS		6.00	21,907	0	2.00
3.00	LAUNDRY & LINEN SERVICE		8.00	4,847	0	3.00
4.00	HOUSEKEEPING		9.00	17,367	0	4.00
5.00	DIETARY		10.00	19,522	0	5.00
6.00	NURSING ADMINISTRATION		13.00	6,870	0	6.00
7.00	CENTRAL SERVICES & SUPPLY		14.00	4,316	0	7.00
8.00	PHARMACY		15.00	12,717	0	8.00
9.00	MEDICAL RECORDS & LIBRARY		16.00	14,284	0	9.00
10.00	ADULTS & PEDIATRICS		30.00	64,644	0	10.00
11.00	INTENSIVE CARE UNIT		31.00	26,305	0	11.00
12.00	SUBPROVIDER - IPF		40.00	11,961	0	12.00
13.00	SUBPROVIDER - IRF		41.00	5,505	0	13.00
14.00	SKILLED NURSING FACILITY		44.00	16,182	0	14.00
15.00	OPERATING ROOM		50.00	34,277	0	15.00
16.00	ANESTHESIOLOGY		53.00	850	0	16.00
17.00	RADIOLOGY-DIAGNOSTIC		54.00	23,555	0	17.00
18.00	RADIOISOTOPE		56.00	1,042	0	18.00
19.00	LABORATORY		60.00	27,611	0	19.00
20.00	RESPIRATORY THERAPY		65.00	11,567	0	20.00
21.00	PHYSICAL THERAPY		66.00	20,141	0	21.00
22.00	ELECTROCARDIOLOGY		69.00	17,565	0	22.00
23.00	CARDIOPULMONARY		69.02	623	0	23.00
24.00	SLEEP LAB		69.03	1,630	0	24.00
25.00	RURAL HEALTH CLINIC		88.00	926	0	25.00
26.00	RURAL HEALTH CLINIC II		88.01	1,935	0	26.00
27.00	CLINIC		90.00	2,431	0	27.00
28.00	IMED		90.01	5,844	0	28.00
29.00	ONCOLOGY		90.02	10,398	0	29.00
30.00	EMERGENCY		91.00	22,360	0	30.00
31.00	AMBULANCE SERVICES		95.00	21,182	0	31.00
32.00	HOME HEALTH AGENCY		101.00	10,536	0	32.00
33.00	VOLUNTEER		194.05	4,075	0	33.00
34.00	PHYSICIANS' PRIVATE OFFICES		192.00	37,063	0	34.00
35.00	PSYCHIATRICAL/PSYCHOLOGICAL SERVICES		192.01	2,266	0	35.00
36.00	MEMORIAL HOSPITAL FOUNDATION		194.02	6,207	0	36.00
37.00	MKT/PHY SERVICES		194.03	30,074	0	37.00
38.00	COMMUNITY EDUCATION		194.04	3,402	0	38.00
39.00	PUBLIC RELATIONS		194.08	4,750	0	39.00
	TOTALS			773,267	0	
500.00	Grand Total: Increases			1,936,598	14,207,176	500.00

RECLASSIFICATIONS

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-6
Date/Time Prepared:
11/27/2012 12:35 pm

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7	Ref.	
6.00	7.00	8.00	9.00	10.00		
A - PULMONARY FUNCTION TESTING						
1.00	RESPIRATORY THERAPY	65.00	60,058	0	0	1.00
	TOTALS		60,058	0		
B - LABOR AND DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	385,260	65,004	0	1.00
	TOTALS		385,260	65,004		
C - CAFETERIA						
1.00	DIETARY	10.00	718,013	460,343	0	1.00
	TOTALS		718,013	460,343		
D - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	7,950,511	0	1.00
	TOTALS		0	7,950,511		
E - BILLABLE SUPPLIES						
1.00	DIETARY	10.00	0	36,696	0	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	207,919	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	5,527	0	3.00
4.00	INTENSIVE CARE UNIT	31.00	0	85,930	0	4.00
5.00	OPERATING ROOM	50.00	0	2,591,499	0	5.00
6.00	ANESTHESIOLOGY	53.00	0	176,322	0	6.00
7.00	RESPIRATORY THERAPY	65.00	0	40,801	0	7.00
8.00	PHYSICAL THERAPY	66.00	0	60,894	0	8.00
9.00	ELECTROCARDIOLOGY	69.00	0	2,404,034	0	9.00
10.00	CLINIC	90.00	0	26,099	0	10.00
11.00	IMED	90.01	0	46,317	0	11.00
12.00	ONCOLOGY	90.02	0	49,280	0	12.00
	TOTALS		0	5,731,318		
F - GAINSHARE RECLASS						
1.00	EMPLOYEE BENEFITS	4.00	773,267	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
18.00		0.00	0	0	0	18.00
19.00		0.00	0	0	0	19.00
20.00		0.00	0	0	0	20.00
21.00		0.00	0	0	0	21.00
22.00		0.00	0	0	0	22.00
23.00		0.00	0	0	0	23.00
24.00		0.00	0	0	0	24.00
25.00		0.00	0	0	0	25.00
26.00		0.00	0	0	0	26.00
27.00		0.00	0	0	0	27.00
28.00		0.00	0	0	0	28.00
29.00		0.00	0	0	0	29.00
30.00		0.00	0	0	0	30.00
31.00		0.00	0	0	0	31.00
32.00		0.00	0	0	0	32.00
33.00		0.00	0	0	0	33.00
34.00		0.00	0	0	0	34.00
35.00		0.00	0	0	0	35.00
36.00		0.00	0	0	0	36.00
37.00		0.00	0	0	0	37.00
38.00		0.00	0	0	0	38.00
39.00		0.00	0	0	0	39.00
	TOTALS		773,267	0		
500.00	Grand Total: Decreases		1,936,598	14,207,176		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/27/2012 12:35 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	5,907,661	182,866	0	182,866	0 1.00
2.00	Land Improvements	0	0	0	0	0 2.00
3.00	Buildings and Fixtures	104,474,625	900,909	0	900,909	0 3.00
4.00	Building Improvements	381,931	4,244,749	0	4,244,749	0 4.00
5.00	Fixed Equipment	0	0	0	0	0 5.00
6.00	Movable Equipment	62,408,771	4,693,787	0	4,693,787	0 6.00
7.00	HIT designated Assets	0	0	0	0	0 7.00
8.00	Subtotal (sum of lines 1-7)	173,172,988	10,022,311	0	10,022,311	0 8.00
9.00	Reconciling Items	0	0	0	0	0 9.00
10.00	Total (line 8 minus line 9)	173,172,988	10,022,311	0	10,022,311	0 10.00
SUMMARY OF CAPITAL						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,945,708	0	2,363,545	161,468	0 1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,899,603	0	0	0	0 2.00
3.00	Total (sum of lines 1-2)	9,845,311	0	2,363,545	161,468	0 3.00
COMPUTATION OF RATIOS						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	116,092,741	0	116,092,741	0.633710	0 1.00
2.00	CAP REL COSTS-MVBLE EQUIP	67,102,558	0	67,102,558	0.366290	0 2.00
3.00	Total (sum of lines 1-2)	183,195,299	0	183,195,299	1.000000	0 3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/27/2012 12:35 pm

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	6,090,527	0		1.00	
2.00	Land Improvements	0	0		2.00	
3.00	Buildings and Fixtures	105,375,534	0		3.00	
4.00	Building Improvements	4,626,680	0		4.00	
5.00	Fixed Equipment	0	0		5.00	
6.00	Movable Equipment	67,102,558	0		6.00	
7.00	HIT designated Assets	0	0		7.00	
8.00	Subtotal (sum of lines 1-7)	183,195,299	0		8.00	
9.00	Reconciling Items	0	0		9.00	
10.00	Total (line 8 minus line 9)	183,195,299	0		10.00	
SUMMARY OF CAPITAL						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	6,470,721		1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,899,603		2.00	
3.00	Total (sum of lines 1-2)	0	12,370,324		3.00	
ALLOCATION OF OTHER CAPITAL						
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,899,536	0
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	5,897,961	0
3.00	Total (sum of lines 1-2)	0	0	0	9,797,497	0

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/27/2012 12:35 pm

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	1,209,687	161,468	0	0	5,270,691	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	5,897,961	2.00
3.00	Total (sum of lines 1-2)	1,209,687	161,468	0	0	11,168,652	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-8

Date/Time Prepared:
11/27/2012 12:35 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center		Line #
			1.00	2.00	3.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			OCAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			OCAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00 Investment income - other (chapter 2)		0		0.00	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-8,437	ADMINISTRATIVE & GENERAL	5.00	7.00
8.00 Television and radio service (chapter 21)		0		0.00	8.00
9.00 Parking lot (chapter 21)		0		0.00	9.00
10.00 Provider-based physician adjustment	A-8-2	-8,470,052			10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	B	-90,567	ADMINISTRATIVE & GENERAL	5.00	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0			12.00
13.00 Laundry and linen service	B	-715	LAUNDRY & LINEN SERVICE	8.00	13.00
14.00 Cafeteria-employees and guests	B	-474,939	CAFETERIA	11.00	14.00
15.00 Rental of quarters to employee and others		0		0.00	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	16.00
17.00 Sale of drugs to other than patients	B	-224,617	PHARMACY	15.00	17.00
18.00 Sale of medical records and abstracts	B	-27,788	MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00 Vending machines	B	-5,990	ADMINISTRATIVE & GENERAL	5.00	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		ORESPIRATORY THERAPY	65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY	66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			OCAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			OCAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00	28.00
29.00 Physicians' assistant		0		0.00	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	67.00	30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	32.00
33.00 TELEPHONE DEPRECIATION	A	-45,806	CAP REL COSTS-BLDG & FIXT	1.00	33.00
33.01 MAINTENANCE	B	-138	MAINTENANCE & REPAIRS	6.00	33.01
33.02 MISCELLANEOUS REVENUE	B	-6,162	ADMINISTRATIVE & GENERAL	5.00	33.02
33.03 ADVERTISING - BENEFITS	A	-30,996	EMPLOYEE BENEFITS	4.00	33.03
33.04 ADVERTISING - ONCOLOGY	A	-1,238	ONCOLOGY	90.02	33.04
33.05 ADVERTISING - FRENCH LICK	A	-1,900	RURAL HEALTH CLINIC	88.00	33.05
33.06 ADVERTISING - LOOGOOTEE	A	-1,074	RURAL HEALTH CLINIC II	88.01	33.06
33.07 ADVERTISING - AMBULANCE	A	-3,907	AMBULANCE SERVICES	95.00	33.07
33.08 ADVERTISING - REHAB	A	-349	SUBPROVIDER - IRF	41.00	33.08
33.09 ADVERTISING - SURGERY	A	-1,058	OPERATING ROOM	50.00	33.09
33.10 CLINICAL ENGINEERING	B	-556	MAINTENANCE & REPAIRS	6.00	33.10
33.11 MISCELLANEOUS - DIETARY	B	-440	DIETARY	10.00	33.11
33.12 MISCELLANEOUS - LAB	B	-13,298	LABORATORY	60.00	33.12
33.13 MISCELLANEOUS - FINANCE	B	-57,424	ADMINISTRATIVE & GENERAL	5.00	33.13
33.14 MISCELLANEOUS - AMBULANCE	B	-3,740	AMBULANCE SERVICES	95.00	33.14
33.15 ACCOUNTS PAYABLE DISCOUNT	B	-41,687	ADMINISTRATIVE & GENERAL	5.00	33.15
33.16 MISCELLANEOUS - SLEEP LAB	B	-1,339	SLEEP LAB	69.03	33.16
33.17 MISCELLANEOUS - PHYSICAL THERAPY	B	-1,363	PHYSICAL THERAPY	66.00	33.17
33.18 MISCELLANEOUS - CLINICAL	B	-5,352	NURSING ADMINISTRATION	13.00	33.18
33.19 MISCELLANEOUS - FRENCH LICK	B	-2,462	RURAL HEALTH CLINIC	88.00	33.19
33.20 MISCELLANEOUS - LOOGOOTEE	B	-50,278	RURAL HEALTH CLINIC II	88.01	33.20
33.21 BAD DEBT EXPENSE ADJUSTMENT	A	-8,182,647	ADMINISTRATIVE & GENERAL	5.00	33.21

ADJUSTMENTS TO EXPENSES

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-8

Date/Time Prepared:
11/27/2012 12:35 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #
			Cost Center		
			1.00	2.00	
33.22 MISCELLANEOUS - ONCOLOGY	B	-102	ONCOLOGY	90.02	33.22
33.23 MISCELLANEOUS - HOUSEKEEPING	B	-2,254	HOUSEKEEPING	9.00	33.23
33.24 CRNA EXPENSE	A	-1,723,911	ANESTHESIOLOGY	53.00	33.24
33.25 MISC. PROC. CENTER	B	-2,080	ADMINISTRATIVE & GENERAL	5.00	33.25
33.26 AHA LIVES - 1993	A	-366	CAP REL COSTS-BLDG & FIXT	1.00	33.26
33.27 AHA & IHA LOBBYING DUES	A	-3,698	ADMINISTRATIVE & GENERAL	5.00	33.27
33.28 INTEREST	B	-1,153,858	CAP REL COSTS-BLDG & FIXT	1.00	33.28
33.29 DIETARY SUPPLEMENTS	B	-59,312	DIETARY	10.00	33.29
33.30 START-UP COST OFFSET	A	-1,642	CAP REL COSTS-MVBLE EQUIP	2.00	33.30
33.31 START-UP COST OFFSET	A	-15,862	SUBPROVIDER - IPF	40.00	33.31
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-20,719,404			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-8

Date/Time Prepared:
11/27/2012 12:35 pm

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	TELEPHONE DEPRECIATION	9	33.00
33.01	MAINTENANCE	0	33.01
33.02	MISCELLANEOUS REVENUE	0	33.02
33.03	ADVERTISING - BENEFITS	0	33.03
33.04	ADVERTISING - ONCOLOGY	0	33.04
33.05	ADVERTISING - FRENCH LICK	0	33.05
33.06	ADVERTISING - LOOGOOTEE	0	33.06
33.07	ADVERTISING - AMBULANCE	0	33.07
33.08	ADVERTISING - REHAB	0	33.08
33.09	ADVERTISING - SURGERY	0	33.09
33.10	CLINICAL ENGINEERING	0	33.10
33.11	MISCELLANEOUS - DIETARY	0	33.11
33.12	MISCELLANEOUS - LAB	0	33.12
33.13	MISCELLANEOUS - FINANCE	0	33.13
33.14	MISCELLANEOUS - AMBULANCE	0	33.14
33.15	ACCOUNTS PAYABLE DISCOUNT	0	33.15
33.16	MISCELLANEOUS - SLEEP LAB	0	33.16
33.17	MISCELLANEOUS - PHYSICAL THERAPY	0	33.17
33.18	MISCELLANEOUS - CLINICAL	0	33.18
33.19	MISCELLANEOUS - FRENCH LICK	0	33.19
33.20	MISCELLANEOUS - LOOGOOTEE	0	33.20
33.21	BAD DEBT EXPENSE ADJUSTMENT	0	33.21
33.22	MISCELLANEOUS - ONCOLOGY	0	33.22
33.23	MISCELLANEOUS - HOUSEKEEPING	0	33.23
33.24	CRNA EXPENSE	0	33.24
33.25	MISC. PROC. CENTER	0	33.25
33.26	AHA LIVES - 1993	9	33.26
33.27	AHA & IHA LOBBYING DUES	0	33.27

ADJUSTMENTS TO EXPENSES

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-8

Date/Time Prepared:
11/27/2012 12:35 pm

Cost Center Description		Wkst.	A-7 Ref.	
		5.00		
33.28	INTEREST		11	33.28
33.29	DIETARY SUPPLEMENTS		0	33.29
33.30	START-UP COST OFFSET		9	33.30
33.31	START-UP COST OFFSET		0	33.31
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-8-2

Date/Time Prepared:
11/27/2012 12:35 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	4.00	EMPLOYEE BENEFITS	1,292,212	1,292,212	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	236,220	236,220	2.00
3.00	40.00	SUBPROVIDER - IPF	309,175	309,175	3.00
4.00	41.00	SUBPROVIDER - IRF	121,525	13,196	4.00
5.00	44.00	SKILLED NURSING FACILITY	7,200	0	5.00
6.00	50.00	OPERATING ROOM	32	32	6.00
7.00	53.00	ANESTHESIOLOGY	1,478,709	1,478,709	7.00
8.00	60.00	LABORATORY	150,000	150,000	8.00
9.00	65.00	RESPIRATORY THERAPY	24,463	0	9.00
10.00	66.00	PHYSICAL THERAPY	7,328	7,328	10.00
11.00	69.00	ELECTROCARDIOLOGY	1,177,201	5,290	11.00
12.00	90.00	CLINIC	95,700	95,700	12.00
13.00	90.01	IMED	467,843	467,843	13.00
14.00	91.00	EMERGENCY	3,485,138	3,485,138	14.00
200.00			8,852,746	7,540,843	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-8-2

Date/Time Prepared:
11/27/2012 12:35 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	108,329	142,500	541	37,064	1,853	4.00
5.00	7,200	142,500	36	2,466	123	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	24,463	142,500	140	9,591	480	9.00
10.00	0	0	0	0	0	10.00
11.00	1,171,911	142,500	4,869	333,573	16,679	11.00
12.00	0	0	0	0	0	12.00
13.00	0	0	0	0	0	13.00
14.00	0	0	0	0	0	14.00
200.00	1,311,903		5,586	382,694	19,135	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-8-2

Date/Time Prepared:
11/27/2012 12:35 pm

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 16.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	37,064	4.00
5.00	0	0	0	0	2,466	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	9,591	9.00
10.00	0	0	0	0	0	10.00
11.00	0	0	0	0	333,573	11.00
12.00	0	0	0	0	0	12.00
13.00	0	0	0	0	0	13.00
14.00	0	0	0	0	0	14.00
200.00	0	0	0	0	382,694	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet A-8-2

Date/Time Prepared:
11/27/2012 12:35 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	1,292,212	1.00
2.00	0	236,220	2.00
3.00	0	309,175	3.00
4.00	71,265	84,461	4.00
5.00	4,734	4,734	5.00
6.00	0	32	6.00
7.00	0	1,478,709	7.00
8.00	0	150,000	8.00
9.00	14,872	14,872	9.00
10.00	0	7,328	10.00
11.00	838,338	843,628	11.00
12.00	0	95,700	12.00
13.00	0	467,843	13.00
14.00	0	3,485,138	14.00
200.00	929,209	8,470,052	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet B
Part I
Date/Time Prepared:
11/27/2012 12:35 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	5,270,691	5,270,691			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	5,897,961		5,897,961		2.00
4.00 00400	EMPLOYEE BENEFITS	15,042,808	25,254	28,260	15,096,322	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	20,058,481	1,014,731	1,135,495	1,576,353	5.00
6.00 00600	MAINTENANCE & REPAIRS	6,497,328	426,914	477,721	355,220	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	327,030	19,403	21,712	52,666	8.00
9.00 00900	HOUSEKEEPING	1,178,569	18,158	20,319	225,244	9.00
10.00 01000	DIETARY	422,503	72,006	80,575	75,632	10.00
11.00 01100	CAFETERIA	703,417	14,811	16,574	167,690	11.00
13.00 01300	NURSING ADMINISTRATION	818,383	10,108	11,311	171,869	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	286,493	11,912	13,329	51,640	14.00
15.00 01500	PHARMACY	9,918,049	40,602	45,434	300,792	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	877,029	44,709	50,030	191,583	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	6,110,627	424,037	474,502	1,328,040	30.00
31.00 03100	INTENSIVE CARE UNIT	2,594,810	155,006	173,454	602,725	31.00
40.00 04000	SUBPROVIDER - I/PF	859,456	43,546	48,729	248,705	40.00
41.00 04100	SUBPROVIDER - I/RF	694,094	63,859	71,458	148,407	41.00
43.00 04300	NURSERY	0	0	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	1,181,479	83,984	93,979	264,929	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	4,561,225	280,040	313,368	834,623	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	450,264	32,321	36,167	89,976	52.00
53.00 05300	ANESTHESIOLOGY	186,040	0	0	737,711	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,584,098	131,802	147,488	446,572	54.00
56.00 05600	RADIO SOTOPE	774,170	13,231	14,806	47,636	56.00
60.00 06000	LABORATORY	5,685,543	63,769	71,358	531,133	60.00
65.00 06500	RESPIRATORY THERAPY	1,326,329	21,609	24,181	228,211	65.00
66.00 06600	PHYSICAL THERAPY	1,791,827	63,106	70,616	389,389	66.00
69.00 06900	ELECTROCARDIOLOGY	2,645,890	167,842	187,817	376,730	69.00
69.01 06901	PULMONARY	60,058	991	1,109	14,026	69.01
69.02 06902	CARDIOPULMONARY	114,064	13,127	14,689	24,416	69.02
69.03 06903	SLEEP LAB	183,078	19,075	21,345	35,460	69.03
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,935,360	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	7,950,511	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	268,036	15,415	17,249	45,416	88.00
88.01 08801	RURAL HEALTH CLINIC II	393,563	49,405	55,285	84,984	88.01
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	541,360	384,903	430,711	53,988	90.00
90.01 09001	IMED	64,684	34,572	38,686	100,320	90.01
90.02 09002	ONCOLOGY	1,996,529	100,935	112,947	249,066	90.02
91.00 09100	EMERGENCY	2,627,724	116,178	130,005	1,296,618	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	1,701,598	28,437	31,821	359,180	95.00
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
101.00 10100	HOME HEALTH AGENCY	959,353	19,224	21,512	187,510	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	118,540,512	4,025,022	4,504,042	11,894,460	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,099	12,420	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	14,936,853	823,050	921,002	2,625,984	192.00
192.01 19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	554,598	15,981	17,883	122,927	192.01
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	29,701	0	0	1,005	194.00
194.02 07952	MEMORIAL HOSPITAL FOUNDATION	172,001	6,701	7,499	39,497	194.02
194.03 07953	MKT/PHY SERVICES	2,421,782	72,065	80,642	278,935	194.03
194.04 07954	COMMUNITY EDUCATION	407,635	48,406	54,167	66,590	194.04
194.05 07955	VOLUNTEER	131,014	7,268	8,133	26,820	194.05
194.06 07956	MAB	0	0	0	0	194.06
194.08 07958	PUBLIC RELATIONS	678,035	6,671	7,465	40,104	194.08
194.09 07959	UNUSED SPACE	0	254,428	284,708	0	194.09
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet B
Part I
Date/Time Prepared:
11/27/2012 12:35 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
202.00 TOTAL (sum lines 118-201)	137,872,131	5,270,691	5,897,961	15,096,322	137,872,131	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet B
Part I
Date/Time Prepared:
11/27/2012 12:35 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,785,060				5.00
6.00	00600	MAINTENANCE & REPAIRS	1,617,233	9,374,416			6.00
8.00	00800	LAUNDRY & LINEN SERVICE	87,732	47,818	556,361		8.00
9.00	00900	HOUSEKEEPING	300,692	44,750	0	1,787,732	9.00
10.00	01000	DIETARY	135,663	177,458	0	34,179	998,016
11.00	01100	CAFETERIA	188,153	36,502	0	7,030	0
13.00	01300	NURSING ADMINISTRATION	210,915	24,910	0	4,798	0
14.00	01400	CENTRAL SERVICES & SUPPLY	75,757	29,356	2,230	5,654	0
15.00	01500	PHARMACY	2,148,381	100,063	0	19,273	0
16.00	01600	MEDICAL RECORDS & LIBRARY	242,538	110,185	0	21,222	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,738,157	1,045,035	168,049	201,279	482,974
31.00	03100	INTENSIVE CARE UNIT	735,106	382,012	56,747	73,577	188,106
40.00	04000	SUBPROVIDER - I/PF	250,269	107,320	9,521	20,670	82,462
41.00	04100	SUBPROVIDER - I/RF	203,857	157,379	13,824	30,312	61,296
43.00	04300	NURSERY	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	338,652	206,979	36,708	39,865	183,178
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,248,652	690,156	105,976	132,928	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	126,909	79,654	3,914	15,342	0
53.00	05300	ANESTHESIOLOGY	192,585	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	690,067	324,825	51,658	62,563	0
56.00	05600	RADIOISOTOPE	177,177	32,607	0	6,280	0
60.00	06000	LABORATORY	1,324,237	157,158	0	30,270	0
65.00	06500	RESPIRATORY THERAPY	333,640	53,256	1,669	10,257	0
66.00	06600	PHYSICAL THERAPY	482,623	155,524	9,625	29,955	0
69.00	06900	ELECTROCARDIOLOGY	704,310	413,646	26,431	79,670	0
69.01	06901	PULMONARY	15,883	2,443	0	471	0
69.02	06902	CARDIOPULMONARY	34,670	32,350	0	6,231	0
69.03	06903	SLEEP LAB	53,988	47,010	0	9,054	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	611,970	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,657,538	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	72,159	37,990	0	7,317	0
88.01	08801	RURAL HEALTH CLINIC II	121,594	121,759	0	23,451	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	294,160	948,591	0	182,703	0
90.01	09001	IMED	49,673	85,202	83	16,410	0
90.02	09002	ONCOLOGY	512,757	248,753	4,415	47,911	0
91.00	09100	EMERGENCY	869,479	286,321	65,511	55,147	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	442,198	70,083	0	13,498	0
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	247,593	47,377	0	9,125	0
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,536,967	6,304,472	556,361	1,196,442	998,016
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,903	27,353	0	5,268	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,025,100	2,028,400	0	390,683	0
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	148,312	39,386	0	7,586	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	6,402	0	0	0	0
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	47,054	16,515	0	3,181	0
194.03	07953	MKT/PHY SERVICES	594,888	177,605	0	34,208	0
194.04	07954	COMMUNITY EDUCATION	120,252	119,297	0	22,977	0
194.05	07955	VOLUNTEER	36,116	17,911	0	3,450	0
194.06	07956	MAB	0	0	0	0	0
194.08	07958	PUBLIC RELATIONS	152,666	16,441	0	3,167	0
194.09	07959	UNUSED SPACE	112,400	627,036	0	120,770	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	23,785,060	9,374,416	556,361	1,787,732	998,016

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150115

Period: From 07/01/2011 To 06/30/2012

Worksheet B Part I Date/Time Prepared: 11/27/2012 12:35 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	1,134,177					11.00
13.00	01300	15,921	1,268,215				13.00
14.00	01400	10,784	0	487,155			14.00
15.00	01500	24,525	0	0	12,597,119		15.00
16.00	01600	29,175	0	0	50	1,566,521	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	145,011	631,284	0	1,372	86,949	30.00
31.00	03100	63,369	275,867	0	176	30,907	31.00
40.00	04000	21,038	91,587	0	83	12,326	40.00
41.00	04100	16,602	72,274	0	0	9,225	41.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	33,993	0	0	13	7,427	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	86,551	0	0	5,800	174,760	50.00
52.00	05200	8,764	38,154	0	0	9,501	52.00
53.00	05300	17,460	0	0	45	17,415	53.00
54.00	05400	49,551	0	0	152,876	203,983	54.00
56.00	05600	3,622	0	0	0	35,840	56.00
60.00	06000	69,341	0	0	80	144,453	60.00
65.00	06500	25,746	0	0	93,001	19,853	65.00
66.00	06600	40,474	0	0	4,174	33,131	66.00
69.00	06900	38,303	0	0	1,391	117,961	69.00
69.01	06901	1,428	0	0	0	3,763	69.01
69.02	06902	2,764	0	0	0	3,186	69.02
69.03	06903	5,065	0	0	0	6,395	69.03
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	487,155	0	56,366	71.00
72.00	07200	0	0	0	0	80,919	72.00
73.00	07300	0	0	0	11,986,522	333,022	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	4,758	0	0	9,422	2,935	88.00
88.01	08801	8,110	0	0	15,187	5,227	88.01
89.00	08900	0	0	0	0	0	89.00
90.00	09000	6,690	0	0	2,417	11,398	90.00
90.01	09001	8,247	35,903	0	69,920	5,127	90.01
90.02	09002	28,288	123,146	0	0	55,743	90.02
91.00	09100	63,521	0	0	8,459	67,620	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	54,167	0	0	14,309	14,969	95.00
96.00	09600	0	0	0	0	0	96.00
101.00	10100	20,158	0	0	466	8,747	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		903,426	1,268,215	487,155	12,365,763	1,559,148	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	164,470	0	0	230,754	0	192.00
192.01	19201	10,760	0	0	0	7,373	192.01
194.00	07950	0	0	0	0	0	194.00
194.02	07952	3,545	0	0	0	0	194.02
194.03	07953	36,363	0	0	1	0	194.03
194.04	07954	9,632	0	0	559	0	194.04
194.05	07955	1,900	0	0	42	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.08	07958	4,081	0	0	0	0	194.08
194.09	07959	0	0	0	0	0	194.09
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,134,177	1,268,215	487,155	12,597,119	1,566,521	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet B
Part I
Date/Time Prepared:
11/27/2012 12:35 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,837,316	0	12,837,316	30.00
31.00	03100	INTENSIVE CARE UNIT	5,331,862	0	5,331,862	31.00
40.00	04000	SUBPROVIDER - IPF	1,795,712	0	1,795,712	40.00
41.00	04100	SUBPROVIDER - IRF	1,542,587	0	1,542,587	41.00
43.00	04300	NURSERY	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,471,186	0	2,471,186	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,434,079	0	8,434,079	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	890,966	0	890,966	52.00
53.00	05300	ANESTHESIOLOGY	1,151,256	0	1,151,256	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,845,483	0	4,845,483	54.00
56.00	05600	RADIOISOTOPE	1,105,369	0	1,105,369	56.00
60.00	06000	LABORATORY	8,077,342	0	8,077,342	60.00
65.00	06500	RESPIRATORY THERAPY	2,137,752	0	2,137,752	65.00
66.00	06600	PHYSICAL THERAPY	3,070,444	0	3,070,444	66.00
69.00	06900	ELECTROCARDIOLOGY	4,759,991	0	4,759,991	69.00
69.01	06901	PULMONARY	100,172	0	100,172	69.01
69.02	06902	CARDIOPULMONARY	245,497	0	245,497	69.02
69.03	06903	SLEEP LAB	380,470	0	380,470	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,090,851	0	4,090,851	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,688,968	0	9,688,968	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,319,544	0	12,319,544	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	480,697	0	480,697	88.00
88.01	08801	RURAL HEALTH CLINIC II	878,565	0	878,565	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	2,856,921	0	2,856,921	90.00
90.01	09001	IMED	508,827	0	508,827	90.01
90.02	09002	ONCOLOGY	3,480,490	0	3,480,490	90.02
91.00	09100	EMERGENCY	5,586,583	0	5,586,583	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,730,260	0	2,730,260	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	1,521,065	0	1,521,065	101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	103,320,255	0	103,320,255	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	61,043	0	61,043	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,146,296	0	26,146,296	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	924,806	0	924,806	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	37,108	0	37,108	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	295,993	0	295,993	194.02
194.03	07953	MKT/PHY SERVICES	3,696,489	0	3,696,489	194.03
194.04	07954	COMMUNITY EDUCATION	849,515	0	849,515	194.04
194.05	07955	VOLUNTEER	232,654	0	232,654	194.05
194.06	07956	MAB	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	908,630	0	908,630	194.08
194.09	07959	UNUSED SPACE	1,399,342	0	1,399,342	194.09
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	137,872,131	0	137,872,131	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet B Part II Date/Time Prepared: 11/27/2012 12:35 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	0	25,254	28,260	53,514	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	1,014,731	1,135,495	2,150,226	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	426,914	477,721	904,635	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	19,403	21,712	41,115	8.00
9.00 00900	HOUSEKEEPING	0	18,158	20,319	38,477	9.00
10.00 01000	DIETARY	0	72,006	80,575	152,581	10.00
11.00 01100	CAFETERIA	0	14,811	16,574	31,385	11.00
13.00 01300	NURSING ADMINISTRATION	0	10,108	11,311	21,419	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	11,912	13,329	25,241	14.00
15.00 01500	PHARMACY	0	40,602	45,434	86,036	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	44,709	50,030	94,739	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	424,037	474,502	898,539	30.00
31.00 03100	INTENSIVE CARE UNIT	0	155,006	173,454	328,460	31.00
40.00 04000	SUBPROVIDER - I/P	0	43,546	48,729	92,275	40.00
41.00 04100	SUBPROVIDER - I/R	0	63,859	71,458	135,317	41.00
43.00 04300	NURSERY	0	0	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	0	83,984	93,979	177,963	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	280,040	313,368	593,408	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	32,321	36,167	68,488	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	131,802	147,488	279,290	54.00
56.00 05600	RADIOISOTOPE	0	13,231	14,806	28,037	56.00
60.00 06000	LABORATORY	0	63,769	71,358	135,127	60.00
65.00 06500	RESPIRATORY THERAPY	0	21,609	24,181	45,790	65.00
66.00 06600	PHYSICAL THERAPY	0	63,106	70,616	133,722	66.00
69.00 06900	ELECTROCARDIOLOGY	0	167,842	187,817	355,659	69.00
69.01 06901	PULMONARY	0	991	1,109	2,100	69.01
69.02 06902	CARDIOPULMONARY	0	13,127	14,689	27,816	69.02
69.03 06903	SLEEP LAB	0	19,075	21,345	40,420	69.03
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	15,415	17,249	32,664	88.00
88.01 08801	RURAL HEALTH CLINIC II	0	49,405	55,285	104,690	88.01
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	0	384,903	430,711	815,614	90.00
90.01 09001	IMED	0	34,572	38,686	73,258	90.01
90.02 09002	ONCOLOGY	0	100,935	112,947	213,882	90.02
91.00 09100	EMERGENCY	0	116,178	130,005	246,183	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	0	28,437	31,821	60,258	95.00
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
101.00 10100	HOME HEALTH AGENCY	0	19,224	21,512	40,736	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	4,025,022	4,504,042	8,529,064	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,099	12,420	23,519	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	823,050	921,002	1,744,052	192.00
192.01 19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	15,981	17,883	33,864	192.01
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.02 07952	MEMORIAL HOSPITAL FOUNDATION	0	6,701	7,499	14,200	194.02
194.03 07953	MKT/PHY SERVICES	0	72,065	80,642	152,707	194.03
194.04 07954	COMMUNITY EDUCATION	0	48,406	54,167	102,573	194.04
194.05 07955	VOLUNTEER	0	7,268	8,133	15,401	194.05
194.06 07956	MAB	0	0	0	0	194.06
194.08 07958	PUBLIC RELATIONS	0	6,671	7,465	14,136	194.08
194.09 07959	UNUSED SPACE	0	254,428	284,708	539,136	194.09
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	5,270,691	5,897,961	11,168,652	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet B Part II Date/Time Prepared: 11/27/2012 12:35 pm				
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	6.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	2,155,815				5.00	
6.00	00600	MAINTENANCE & REPAIRS	146,580	1,052,474			6.00	
8.00	00800	LAUNDRY & LINEN SERVICE	7,952	5,369	54,623		8.00	
9.00	00900	HOUSEKEEPING	27,254	5,024	0	71,554	9.00	
10.00	01000	DIETARY	12,296	19,923	0	1,368	186,436	10.00
11.00	01100	CAFETERIA	17,053	4,098	0	281	0	11.00
13.00	01300	NURSING ADMINISTRATION	19,117	2,797	0	192	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,866	3,296	219	226	0	14.00
15.00	01500	PHARMACY	194,721	11,234	0	771	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,983	12,371	0	849	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	157,540	117,327	16,499	8,056	90,224	30.00
31.00	03100	INTENSIVE CARE UNIT	66,627	42,889	5,571	2,945	35,139	31.00
40.00	04000	SUBPROVIDER - IPF	22,683	12,049	935	827	15,404	40.00
41.00	04100	SUBPROVIDER - IRF	18,477	17,669	1,357	1,213	11,450	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	30,694	23,238	3,604	1,596	34,219	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	113,173	77,484	10,405	5,320	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,503	8,943	384	614	0	52.00
53.00	05300	ANESTHESIOLOGY	17,455	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	62,545	36,468	5,072	2,504	0	54.00
56.00	05600	RADIOISOTOPE	16,059	3,661	0	251	0	56.00
60.00	06000	LABORATORY	120,024	17,644	0	1,212	0	60.00
65.00	06500	RESPIRATORY THERAPY	30,240	5,979	164	411	0	65.00
66.00	06600	PHYSICAL THERAPY	43,743	17,461	945	1,199	0	66.00
69.00	06900	ELECTROCARDIOLOGY	63,836	46,440	2,595	3,189	0	69.00
69.01	06901	PULMONARY	1,440	274	0	19	0	69.01
69.02	06902	CARDIOPULMONARY	3,142	3,632	0	249	0	69.02
69.03	06903	SLEEP LAB	4,893	5,278	0	362	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	55,467	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	150,233	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	6,540	4,265	0	293	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	11,021	13,670	0	939	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	26,662	106,499	0	7,313	0	90.00
90.01	09001	IMED	4,502	9,566	8	657	0	90.01
90.02	09002	ONCOLOGY	46,474	27,928	433	1,918	0	90.02
91.00	09100	EMERGENCY	78,806	32,145	6,432	2,207	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	40,079	7,868	0	540	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	22,441	5,319	0	365	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,680,121	707,808	54,623	47,886	186,436	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	444	3,071	0	211	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	364,848	227,730	0	15,638	0	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	13,442	4,422	0	304	0	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	580	0	0	0	0	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	4,265	1,854	0	127	0	194.02
194.03	07953	MKT/PHY SERVICES	53,918	19,940	0	1,369	0	194.03
194.04	07954	COMMUNITY EDUCATION	10,899	13,394	0	920	0	194.04
194.05	07955	VOLUNTEER	3,273	2,011	0	138	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	13,837	1,846	0	127	0	194.08
194.09	07959	UNUSED SPACE	10,188	70,398	0	4,834	0	194.09
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)	2,155,815	1,052,474	54,623	71,554	186,436	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN: 150115		Period: From 07/01/2011 To 06/30/2012		Worksheet B Part II Date/Time Prepared: 11/27/2012 12:35 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	53,412					11.00
13.00	01300	750	44,884				13.00
14.00	01400	508	0	36,539			14.00
15.00	01500	1,155	0	0	294,983		15.00
16.00	01600	1,374	0	0	1	131,996	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	6,829	22,343	0	32	7,321	30.00
31.00	03100	2,984	9,763	0	4	2,602	31.00
40.00	04000	991	3,241	0	2	1,038	40.00
41.00	04100	782	2,558	0	0	777	41.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	1,601	0	0	0	625	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	4,076	0	0	136	14,715	50.00
52.00	05200	413	1,350	0	0	800	52.00
53.00	05300	822	0	0	1	1,466	53.00
54.00	05400	2,333	0	0	3,580	17,175	54.00
56.00	05600	171	0	0	0	3,018	56.00
60.00	06000	3,265	0	0	2	12,163	60.00
65.00	06500	1,212	0	0	2,178	1,672	65.00
66.00	06600	1,906	0	0	98	2,790	66.00
69.00	06900	1,804	0	0	33	9,932	69.00
69.01	06901	67	0	0	0	317	69.01
69.02	06902	130	0	0	0	268	69.02
69.03	06903	239	0	0	0	538	69.03
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	36,539	0	4,746	71.00
72.00	07200	0	0	0	0	6,813	72.00
73.00	07300	0	0	0	280,684	28,136	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	224	0	0	221	247	88.00
88.01	08801	382	0	0	356	440	88.01
89.00	08900	0	0	0	0	0	89.00
90.00	09000	315	0	0	57	960	90.00
90.01	09001	388	1,271	0	1,637	432	90.01
90.02	09002	1,332	4,358	0	0	4,694	90.02
91.00	09100	2,991	0	0	198	5,694	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	2,551	0	0	335	1,260	95.00
96.00	09600	0	0	0	0	0	96.00
101.00	10100	949	0	0	11	736	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		42,544	44,884	36,539	289,566	131,375	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	7,747	0	0	5,403	0	192.00
192.01	19201	507	0	0	0	621	192.01
194.00	07950	0	0	0	0	0	194.00
194.02	07952	167	0	0	0	0	194.02
194.03	07953	1,712	0	0	0	0	194.03
194.04	07954	454	0	0	13	0	194.04
194.05	07955	89	0	0	1	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.08	07958	192	0	0	0	0	194.08
194.09	07959	0	0	0	0	0	194.09
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		53,412	44,884	36,539	294,983	131,996	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet B Part II Date/Time Prepared: 11/27/2012 12:35 pm
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,329,418	0	1,329,418	30.00
31.00	03100	INTENSIVE CARE UNIT	499,121	0	499,121	31.00
40.00	04000	SUBPROVIDER - IPF	150,327	0	150,327	40.00
41.00	04100	SUBPROVIDER - IRF	190,126	0	190,126	41.00
43.00	04300	NURSERY	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	274,479	0	274,479	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	821,676	0	821,676	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	92,814	0	92,814	52.00
53.00	05300	ANESTHESIOLOGY	22,359	0	22,359	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	410,550	0	410,550	54.00
56.00	05600	RADIOISOTOPE	51,366	0	51,366	56.00
60.00	06000	LABORATORY	291,320	0	291,320	60.00
65.00	06500	RESPIRATORY THERAPY	88,455	0	88,455	65.00
66.00	06600	PHYSICAL THERAPY	203,245	0	203,245	66.00
69.00	06900	ELECTROCARDIOLOGY	484,824	0	484,824	69.00
69.01	06901	PULMONARY	4,267	0	4,267	69.01
69.02	06902	CARDIOPULMONARY	35,324	0	35,324	69.02
69.03	06903	SLEEP LAB	51,856	0	51,856	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	96,752	0	96,752	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	157,046	0	157,046	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	308,820	0	308,820	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	44,615	0	44,615	88.00
88.01	08801	RURAL HEALTH CLINIC II	131,799	0	131,799	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	957,611	0	957,611	90.00
90.01	09001	IMED	92,075	0	92,075	90.01
90.02	09002	ONCOLOGY	301,902	0	301,902	90.02
91.00	09100	EMERGENCY	379,253	0	379,253	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	114,164	0	114,164	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	71,222	0	71,222	101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,656,786	0	7,656,786	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	27,245	0	27,245	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,374,720	0	2,374,720	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	53,596	0	53,596	192.01
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	584	0	584	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	20,753	0	20,753	194.02
194.03	07953	MKT/PHY SERVICES	230,635	0	230,635	194.03
194.04	07954	COMMUNITY EDUCATION	128,489	0	128,489	194.04
194.05	07955	VOLUNTEER	21,008	0	21,008	194.05
194.06	07956	MAB	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	30,280	0	30,280	194.08
194.09	07959	UNUSED SPACE	624,556	0	624,556	194.09
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	11,168,652	0	11,168,652	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet B-1
Date/Time Prepared:
11/27/2012 12:35 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	707,094				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		707,094			2.00
4.00 00400	EMPLOYEE BENEFITS	3,388	3,388	64,639,238		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	136,132	136,132	6,749,619	-23,785,060	5.00
6.00 00600	MAINTENANCE & REPAIRS	57,273	57,273	1,520,979	0	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	2,603	2,603	225,503	0	8.00
9.00 00900	HOUSEKEEPING	2,436	2,436	964,448	0	9.00
10.00 01000	DIETARY	9,660	9,660	323,841	0	10.00
11.00 01100	CAFETERIA	1,987	1,987	718,013	0	11.00
13.00 01300	NURSING ADMINISTRATION	1,356	1,356	735,909	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,598	1,598	221,110	0	14.00
15.00 01500	PHARMACY	5,447	5,447	1,287,928	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	5,998	5,998	820,318	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	56,887	56,887	5,686,393	0	30.00
31.00 03100	INTENSIVE CARE UNIT	20,795	20,795	2,580,745	0	31.00
40.00 04000	SUBPROVIDER - I/PF	5,842	5,842	1,064,902	0	40.00
41.00 04100	SUBPROVIDER - I/RF	8,567	8,567	635,449	0	41.00
43.00 04300	NURSERY	0	0	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	11,267	11,267	1,134,370	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	37,569	37,569	3,573,683	0	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	4,336	4,336	385,260	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	3,158,727	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	17,682	17,682	1,912,127	0	54.00
56.00 05600	RADIO SOTOPE	1,775	1,775	203,967	0	56.00
60.00 06000	LABORATORY	8,555	8,555	2,274,202	0	60.00
65.00 06500	RESPIRATORY THERAPY	2,899	2,899	977,154	0	65.00
66.00 06600	PHYSICAL THERAPY	8,466	8,466	1,667,283	0	66.00
69.00 06900	ELECTROCARDIOLOGY	22,517	22,517	1,613,080	0	69.00
69.01 06901	PULMONARY	133	133	60,058	0	69.01
69.02 06902	CARDIOPULMONARY	1,761	1,761	104,544	0	69.02
69.03 06903	SLEEP LAB	2,559	2,559	151,831	0	69.03
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	2,068	2,068	194,461	0	88.00
88.01 08801	RURAL HEALTH CLINIC II	6,628	6,628	363,882	0	88.01
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	51,637	51,637	231,167	0	90.00
90.01 09001	IMED	4,638	4,638	429,548	0	90.01
90.02 09002	ONCOLOGY	13,541	13,541	1,066,448	0	90.02
91.00 09100	EMERGENCY	15,586	15,586	5,551,852	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	3,815	3,815	1,537,935	0	95.00
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
101.00 10100	HOME HEALTH AGENCY	2,579	2,579	802,878	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	539,980	539,980	50,929,614	-23,785,060	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,489	1,489	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	110,417	110,417	11,243,835	0	192.00
192.01 19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,144	2,144	526,350	0	192.01
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	4,303	0	194.00
194.02 07952	MEMORIAL HOSPITAL FOUNDATION	899	899	169,117	0	194.02
194.03 07953	MKT/PHY SERVICES	9,668	9,668	1,194,340	0	194.03
194.04 07954	COMMUNITY EDUCATION	6,494	6,494	285,124	0	194.04
194.05 07955	VOLUNTEER	975	975	114,837	0	194.05
194.06 07956	MAB	0	0	0	0	194.06
194.08 07958	PUBLIC RELATIONS	895	895	171,718	0	194.08
194.09 07959	UNUSED SPACE	34,133	34,133	0	0	194.09
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet B-1

Date/Time Prepared:
11/27/2012 12:35 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
202.00	Cost to be allocated (per Wkst. B, Part I)	5,270,691	5,897,961	15,096,322	5A	23,785,060	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	7.454017	8.341127	0.233547		0.208482	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			53,514		2,155,815	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000828		0.018896	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet B-1

Date/Time Prepared:
11/27/2012 12:35 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS)	
		6.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	510,301					6.00
8.00	00800	2,603	853,083				8.00
9.00	00900	2,436	0	505,262			9.00
10.00	01000	9,660	0	9,660	26,735		10.00
11.00	01100	1,987	0	1,987	0	1,747,918	11.00
13.00	01300	1,356	0	1,356	0	24,537	13.00
14.00	01400	1,598	3,419	1,598	0	16,620	14.00
15.00	01500	5,447	0	5,447	0	37,797	15.00
16.00	01600	5,998	0	5,998	0	44,963	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	56,887	257,675	56,887	12,938	223,482	30.00
31.00	03100	20,795	87,011	20,795	5,039	97,660	31.00
40.00	04000	5,842	14,599	5,842	2,209	32,423	40.00
41.00	04100	8,567	21,197	8,567	1,642	25,586	41.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	11,267	56,286	11,267	4,907	52,387	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	37,569	162,495	37,569	0	133,387	50.00
52.00	05200	4,336	6,002	4,336	0	13,507	52.00
53.00	05300	0	0	0	0	26,908	53.00
54.00	05400	17,682	79,208	17,682	0	76,364	54.00
56.00	05600	1,775	0	1,775	0	5,582	56.00
60.00	06000	8,555	0	8,555	0	106,864	60.00
65.00	06500	2,899	2,559	2,899	0	39,678	65.00
66.00	06600	8,466	14,758	8,466	0	62,376	66.00
69.00	06900	22,517	40,528	22,517	0	59,030	69.00
69.01	06901	133	0	133	0	2,200	69.01
69.02	06902	1,761	0	1,761	0	4,260	69.02
69.03	06903	2,559	0	2,559	0	7,806	69.03
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	2,068	0	2,068	0	7,332	88.00
88.01	08801	6,628	0	6,628	0	12,498	88.01
89.00	08900	0	0	0	0	0	89.00
90.00	09000	51,637	0	51,637	0	10,310	90.00
90.01	09001	4,638	127	4,638	0	12,710	90.01
90.02	09002	13,541	6,769	13,541	0	43,595	90.02
91.00	09100	15,586	100,450	15,586	0	97,895	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	3,815	0	3,815	0	83,478	95.00
96.00	09600	0	0	0	0	0	96.00
101.00	10100	2,579	0	2,579	0	31,066	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		343,187	853,083	338,148	26,735	1,392,301	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	1,489	0	1,489	0	0	190.00
192.00	19200	110,417	0	110,417	0	253,469	192.00
192.01	19201	2,144	0	2,144	0	16,582	192.01
194.00	07950	0	0	0	0	0	194.00
194.02	07952	899	0	899	0	5,463	194.02
194.03	07953	9,668	0	9,668	0	56,041	194.03
194.04	07954	6,494	0	6,494	0	14,844	194.04
194.05	07955	975	0	975	0	2,928	194.05
194.06	07956	0	0	0	0	0	194.06
194.08	07958	895	0	895	0	6,290	194.08
194.09	07959	34,133	0	34,133	0	0	194.09
200.00							200.00
201.00							201.00
202.00		9,374,416	556,361	1,787,732	998,016	1,134,177	202.00
203.00		18,370,366	0,652,177	3,538,228	37,329,942	0,648,873	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet B-1

Date/Time Prepared:
11/27/2012 12:35 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS)	
		6.00	8.00	9.00	10.00	11.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	1,052,474	54,623	71,554	186,436	53,412	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2.062457	0.064030	0.141618	6.973480	0.030557	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet B-1

Date/Time Prepared:
11/27/2012 12:35 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (REVENUE)	
		13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
6.00	00600					6.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300	448,963				13.00
14.00	01400	0	100			14.00
15.00	01500	0	0	8,646,639		15.00
16.00	01600	0	0	34	247,007,027	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	223,482	0	942	13,710,074	30.00
31.00	03100	97,660	0	121	4,873,400	31.00
40.00	04000	32,423	0	57	1,943,587	40.00
41.00	04100	25,586	0	0	1,454,535	41.00
43.00	04300	0	0	0	0	43.00
44.00	04400	0	0	9	1,171,070	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	0	0	3,981	27,555,931	50.00
52.00	05200	13,507	0	0	1,498,130	52.00
53.00	05300	0	0	31	2,745,981	53.00
54.00	05400	0	0	104,934	32,163,847	54.00
56.00	05600	0	0	0	5,651,205	56.00
60.00	06000	0	0	55	22,777,123	60.00
65.00	06500	0	0	63,836	3,130,399	65.00
66.00	06600	0	0	2,865	5,224,107	66.00
69.00	06900	0	0	955	18,600,043	69.00
69.01	06901	0	0	0	593,392	69.01
69.02	06902	0	0	0	502,381	69.02
69.03	06903	0	0	0	1,008,337	69.03
70.00	07000	0	0	0	0	70.00
71.00	07100	0	100	0	8,887,664	71.00
72.00	07200	0	0	0	12,759,209	72.00
73.00	07300	0	0	8,227,525	52,510,252	73.00
74.00	07400	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	0	0	6,467	462,835	88.00
88.01	08801	0	0	10,424	824,164	88.01
89.00	08900	0	0	0	0	89.00
90.00	09000	0	0	1,659	1,797,195	90.00
90.01	09001	12,710	0	47,993	808,347	90.01
90.02	09002	43,595	0	0	8,789,524	90.02
91.00	09100	0	0	5,806	10,662,254	91.00
92.00	09200	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	0	0	9,822	2,360,277	95.00
96.00	09600	0	0	0	0	96.00
101.00	10100	0	0	320	1,379,196	101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600	0	0	0	0	116.00
118.00		448,963	100	8,487,836	245,844,459	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	190.00
192.00	19200	0	0	158,389	0	192.00
192.01	19201	0	0	0	1,162,568	192.01
194.00	07950	0	0	0	0	194.00
194.02	07952	0	0	0	0	194.02
194.03	07953	0	0	1	0	194.03
194.04	07954	0	0	384	0	194.04
194.05	07955	0	0	29	0	194.05
194.06	07956	0	0	0	0	194.06
194.08	07958	0	0	0	0	194.08
194.09	07959	0	0	0	0	194.09
200.00						200.00
201.00						201.00
202.00		1,268,215	487,155	12,597,119	1,566,521	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet B-1

Date/Time Prepared:
11/27/2012 12:35 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (REVENUE)		
		13.00	14.00	15.00	16.00		
203.00	Unit cost multiplier (Wkst. B, Part I)	2.824765	4,871.550000	1.456880	0.006342		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	44,884	36,539	294,983	131,996		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.099973	365.390000	0.034115	0.000534		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet C
Part I
Date/Time Prepared:
11/27/2012 12:35 pm

		Title XVIII		Hospital		PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		12,837,316	0	12,837,316	30.00
31.00	03100 INTENSIVE CARE UNIT		5,331,862	0	5,331,862	31.00
40.00	04000 SUBPROVIDER - I/PF		1,795,712	0	1,795,712	40.00
41.00	04100 SUBPROVIDER - I/RF		1,542,587	71,265	1,613,852	41.00
43.00	04300 NURSERY		0	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY		2,471,186	4,734	2,475,920	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		8,434,079	0	8,434,079	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		890,966	0	890,966	52.00
53.00	05300 ANESTHESIOLOGY		1,151,256	0	1,151,256	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		4,845,483	0	4,845,483	54.00
56.00	05600 RADIOISOTOPE		1,105,369	0	1,105,369	56.00
60.00	06000 LABORATORY		8,077,342	0	8,077,342	60.00
65.00	06500 RESPIRATORY THERAPY	0	2,137,752	14,872	2,152,624	65.00
66.00	06600 PHYSICAL THERAPY	0	3,070,444	0	3,070,444	66.00
69.00	06900 ELECTROCARDIOLOGY		4,759,991	838,338	5,598,329	69.00
69.01	06901 PULMONARY		100,172	0	100,172	69.01
69.02	06902 CARDIOPULMONARY		245,497	0	245,497	69.02
69.03	06903 SLEEP LAB		380,470	0	380,470	69.03
70.00	07000 ELECTROENCEPHALOGRAPHY		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		4,090,851	0	4,090,851	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		9,688,968	0	9,688,968	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		12,319,544	0	12,319,544	73.00
74.00	07400 RENAL DIALYSIS		0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC		480,697	0	480,697	88.00
88.01	08801 RURAL HEALTH CLINIC II		878,565	0	878,565	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
90.00	09000 CLINIC		2,856,921	0	2,856,921	90.00
90.01	09001 IMED		508,827	0	508,827	90.01
90.02	09002 ONCOLOGY		3,480,490	0	3,480,490	90.02
91.00	09100 EMERGENCY		5,586,583	0	5,586,583	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1,436,643	0	1,436,643	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		2,730,260	0	2,730,260	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED		0	0	0	96.00
101.00	10100 HOME HEALTH AGENCY		1,521,065	0	1,521,065	101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600 HOSPICE		0	0	0	116.00
200.00	Subtotal (see instructions)	0	104,756,898	929,209	105,686,107	200.00
201.00	Less Observation Beds		1,436,643		1,436,643	201.00
202.00	Total (see instructions)	0	103,320,255	929,209	104,249,464	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet C
Part I
Date/Time Prepared:
11/27/2012 12:35 pm

		Title XVIIII			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,710,074		13,710,074		30.00
31.00	03100	INTENSIVE CARE UNIT	4,873,400		4,873,400		31.00
40.00	04000	SUBPROVIDER - I PF	1,943,587		1,943,587		40.00
41.00	04100	SUBPROVIDER - I RF	1,454,535		1,454,535		41.00
43.00	04300	NURSERY	0		0		43.00
44.00	04400	SKILLED NURSING FACILITY	1,171,070		1,171,070		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,705,962	21,849,969	27,555,931	0.306071	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,160,814	337,316	1,498,130	0.594719	52.00
53.00	05300	ANESTHESIOLOGY	813,886	1,932,095	2,745,981	0.419251	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,186,642	27,977,205	32,163,847	0.150650	54.00
56.00	05600	RADIOISOTOPE	440,275	5,210,930	5,651,205	0.195599	56.00
60.00	06000	LABORATORY	5,917,823	16,859,300	22,777,123	0.354625	60.00
65.00	06500	RESPIRATORY THERAPY	1,542,773	1,587,626	3,130,399	0.682901	65.00
66.00	06600	PHYSICAL THERAPY	3,394,807	1,829,300	5,224,107	0.587745	66.00
69.00	06900	ELECTROCARDIOLOGY	6,694,446	11,905,597	18,600,043	0.255913	69.00
69.01	06901	PULMONARY	70,011	523,381	593,392	0.168813	69.01
69.02	06902	CARDIO PULMONARY	184	502,197	502,381	0.488667	69.02
69.03	06903	SLEEP LAB	0	1,008,337	1,008,337	0.377324	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,493,383	4,394,281	8,887,664	0.460284	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,393,089	3,366,120	12,759,209	0.759371	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,251,626	29,258,626	52,510,252	0.234612	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	462,835	462,835		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	824,164	824,164		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	11,253	1,785,942	1,797,195	1.589656	90.00
90.01	09001	IMED	0	808,347	808,347	0.629466	90.01
90.02	09002	ONCOLOGY	201,679	8,587,845	8,789,524	0.395982	90.02
91.00	09100	EMERGENCY	2,156,192	8,506,062	10,662,254	0.523959	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	410,000	1,008,574	1,418,574	1.012737	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	743,563	1,616,714	2,360,277	1.156754	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY	0	1,379,196	1,379,196		101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0		116.00
200.00		Subtotal (see instructions)	93,741,074	153,521,959	247,263,033		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	93,741,074	153,521,959	247,263,033		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet C Part I Date/Time Prepared: 11/27/2012 12:35 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.306071		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.594719		52.00
53.00	05300 ANESTHESIOLOGY	0.419251		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.150650		54.00
56.00	05600 RADIOISOTOPE	0.195599		56.00
60.00	06000 LABORATORY	0.354625		60.00
65.00	06500 RESPIRATORY THERAPY	0.687652		65.00
66.00	06600 PHYSICAL THERAPY	0.587745		66.00
69.00	06900 ELECTROCARDIOLOGY	0.300985		69.00
69.01	06901 PULMONARY	0.168813		69.01
69.02	06902 CARDIOPULMONARY	0.488667		69.02
69.03	06903 SLEEP LAB	0.377324		69.03
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.460284		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.759371		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.234612		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC			88.00
88.01	08801 RURAL HEALTH CLINIC II			88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000 CLINIC	1.589656		90.00
90.01	09001 IMED	0.629466		90.01
90.02	09002 ONCOLOGY	0.395982		90.02
91.00	09100 EMERGENCY	0.523959		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.012737		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	1.156754		95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
101.00	10100 HOME HEALTH AGENCY			101.00
	SPECIAL PURPOSE COST CENTERS			
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet C
Part I
Date/Time Prepared:
11/27/2012 12:35 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	12,837,316		12,837,316	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	5,331,862		5,331,862	0	0	31.00
40.00	04000 SUBPROVIDER - I/PF	1,795,712		1,795,712	0	0	40.00
41.00	04100 SUBPROVIDER - I/RF	1,542,587		1,542,587	0	0	41.00
43.00	04300 NURSERY	0		0	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	2,471,186		2,471,186	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	8,434,079		8,434,079	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	890,966		890,966	0	0	52.00
53.00	05300 ANESTHESIOLOGY	1,151,256		1,151,256	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,845,483		4,845,483	0	0	54.00
56.00	05600 RADIOISOTOPE	1,105,369		1,105,369	0	0	56.00
60.00	06000 LABORATORY	8,077,342		8,077,342	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	2,137,752	0	2,137,752	0	0	65.00
66.00	06600 PHYSICAL THERAPY	3,070,444	0	3,070,444	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	4,759,991		4,759,991	0	0	69.00
69.01	06901 PULMONARY	100,172		100,172	0	0	69.01
69.02	06902 CARDIOPULMONARY	245,497		245,497	0	0	69.02
69.03	06903 SLEEP LAB	380,470		380,470	0	0	69.03
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,090,851		4,090,851	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	9,688,968		9,688,968	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	12,319,544		12,319,544	0	0	73.00
74.00	07400 RENAL DIALYSIS	0		0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	480,697		480,697	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	878,565		878,565	0	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000 CLINIC	2,856,921		2,856,921	0	0	90.00
90.01	09001 IMED	508,827		508,827	0	0	90.01
90.02	09002 ONCOLOGY	3,480,490		3,480,490	0	0	90.02
91.00	09100 EMERGENCY	5,586,583		5,586,583	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,436,643		1,436,643	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	2,730,260		2,730,260	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
101.00	10100 HOME HEALTH AGENCY	1,521,065		1,521,065	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600 HOSPICE	0		0	0	0	116.00
200.00	Subtotal (see instructions)	104,756,898	0	104,756,898	0	0	200.00
201.00	Less Observation Beds	1,436,643		1,436,643	0	0	201.00
202.00	Total (see instructions)	103,320,255	0	103,320,255	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 150115		Period: From 07/01/2011 To 06/30/2012		Worksheet C Part I Date/Time Prepared: 11/27/2012 12:35 pm	
			Title XIX		Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,710,074		13,710,074			30.00
31.00	03100	INTENSIVE CARE UNIT	4,873,400		4,873,400			31.00
40.00	04000	SUBPROVIDER - I PF	1,943,587		1,943,587			40.00
41.00	04100	SUBPROVIDER - I RF	1,454,535		1,454,535			41.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	1,171,070		1,171,070			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,705,962	21,849,969	27,555,931	0.306071	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,160,814	337,316	1,498,130	0.594719	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	813,886	1,932,095	2,745,981	0.419251	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,186,642	27,977,205	32,163,847	0.150650	0.000000	54.00
56.00	05600	RADIOISOTOPE	440,275	5,210,930	5,651,205	0.195599	0.000000	56.00
60.00	06000	LABORATORY	5,917,823	16,859,300	22,777,123	0.354625	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,542,773	1,587,626	3,130,399	0.682901	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,394,807	1,829,300	5,224,107	0.587745	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	6,694,446	11,905,597	18,600,043	0.255913	0.000000	69.00
69.01	06901	PULMONARY	70,011	523,381	593,392	0.168813	0.000000	69.01
69.02	06902	CARDIOPULMONARY	184	502,197	502,381	0.488667	0.000000	69.02
69.03	06903	SLEEP LAB	0	1,008,337	1,008,337	0.377324	0.000000	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,493,383	4,394,281	8,887,664	0.460284	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,393,089	3,366,120	12,759,209	0.759371	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,251,626	29,258,626	52,510,252	0.234612	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	462,835	462,835	1.038593	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	824,164	824,164	1.066007	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	11,253	1,785,942	1,797,195	1.589656	0.000000	90.00
90.01	09001	IMED	0	808,347	808,347	0.629466	0.000000	90.01
90.02	09002	ONCOLOGY	201,679	8,587,845	8,789,524	0.395982	0.000000	90.02
91.00	09100	EMERGENCY	2,156,192	8,506,062	10,662,254	0.523959	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	410,000	1,008,574	1,418,574	1.012737	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	743,563	1,616,714	2,360,277	1.156754	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY	0	1,379,196	1,379,196			101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	93,741,074	153,521,959	247,263,033			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	93,741,074	153,521,959	247,263,033			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet C Part I Date/Time Prepared: 11/27/2012 12:35 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600 RADIOISOTOPE	0.000000		56.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901 PULMONARY	0.000000		69.01
69.02	06902 CARDIOPULMONARY	0.000000		69.02
69.03	06903 SLEEP LAB	0.000000		69.03
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 IMED	0.000000		90.01
90.02	09002 ONCOLOGY	0.000000		90.02
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150115		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part I Date/Time Prepared: 11/27/2012 12:35 pm	
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	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	03000 ADULTS & PEDIATRICS	1,329,418	0	1,329,418	14,154	93.93	30.00
31.00	03100 INTENSIVE CARE UNIT	499,121	0	499,121	5,039	99.05	31.00
40.00	04000 SUBPROVIDER - IPF	150,327	0	150,327	2,227	67.50	40.00
41.00	04100 SUBPROVIDER - IRF	190,126	0	190,126	1,642	115.79	41.00
43.00	04300 NURSERY	0	0	0	1,988	0.00	43.00
44.00	04400 SKILLED NURSING FACILITY	274,479		274,479	4,907	55.94	44.00
200.00	Total (lines 30-199)	2,443,471		2,443,471	29,957		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part I Date/Time Prepared: 11/27/2012 12:35 pm
		Title XVIII	Hospital	PPS

Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	5,927	556,723	30.00
31.00	03100 INTENSIVE CARE UNIT	3,293	326,172	31.00
40.00	04000 SUBPROVIDER - IPF	802	54,135	40.00
41.00	04100 SUBPROVIDER - IRF	1,346	155,853	41.00
43.00	04300 NURSERY	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	3,956	221,299	44.00
200.00	Total (lines 30-199)	15,324	1,314,182	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part II Date/Time Prepared: 11/27/2012 12:35 pm
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Cost Center Description		Title XVIII			Hospital	PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	821,676	27,555,931	0.029818	2,865,253	85,436	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	92,814	1,498,130	0.061953	4,531	281	52.00
53.00	05300 ANESTHESIOLOGY	22,359	2,745,981	0.008142	280,952	2,288	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	410,550	32,163,847	0.012764	2,783,980	35,535	54.00
56.00	05600 RADIOISOTOPE	51,366	5,651,205	0.009089	263,558	2,395	56.00
60.00	06000 LABORATORY	291,320	22,777,123	0.012790	3,433,472	43,914	60.00
65.00	06500 RESPIRATORY THERAPY	88,455	3,130,399	0.028257	760,668	21,494	65.00
66.00	06600 PHYSICAL THERAPY	203,245	5,224,107	0.038905	962,398	37,442	66.00
69.00	06900 ELECTROCARDIOLOGY	484,824	18,600,043	0.026066	3,097,832	80,748	69.00
69.01	06901 PULMONARY	4,267	593,392	0.007191	32,397	233	69.01
69.02	06902 CARDIOPULMONARY	35,324	502,381	0.070313	85	6	69.02
69.03	06903 SLEEP LAB	51,856	1,008,337	0.051427	0	0	69.03
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	96,752	8,887,664	0.010886	2,186,809	23,806	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	157,046	12,759,209	0.012308	5,455,365	67,145	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	308,820	52,510,252	0.005881	11,568,411	68,034	73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	44,615	462,835	0.096395	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	131,799	824,164	0.159918	0	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	957,611	1,797,195	0.532836	291	155	90.00
90.01	09001 IMED	92,075	808,347	0.113905	0	0	90.01
90.02	09002 ONCOLOGY	301,902	8,789,524	0.034348	9,381	322	90.02
91.00	09100 EMERGENCY	379,253	10,662,254	0.035570	1,199,886	42,680	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	148,489	1,418,574	0.104675	387,891	40,602	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00	Total (lines 50-199)	5,176,418	220,370,894		35,293,160	552,516	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150115		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part III Date/Time Prepared: 11/27/2012 12:35 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150115		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part III Date/Time Prepared: 11/27/2012 12:35 pm	
Cost Center Description		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PPS	
		6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	14,154	0.00	5,927	0	30.00	
31.00	03100 INTENSIVE CARE UNIT	5,039	0.00	3,293	0	31.00	
40.00	04000 SUBPROVIDER - IPF	2,227	0.00	802	0	40.00	
41.00	04100 SUBPROVIDER - IRF	1,642	0.00	1,346	0	41.00	
43.00	04300 NURSERY	1,988	0.00	0	0	43.00	
44.00	04400 SKILLED NURSING FACILITY	4,907	0.00	3,956	0	44.00	
200.00	Total (lines 30-199)	29,957		15,324	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet D
Part IV
Date/Time Prepared:
11/27/2012 12:35 pm

Cost Center Description		Title XVIII				Hospital		PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00	
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00	
60.00	06000	LABORATORY	0	0	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00	
69.01	06901	PULMONARY	0	0	0	0	69.01	
69.02	06902	CARDIOPULMONARY	0	0	0	0	69.02	
69.03	06903	SLEEP LAB	0	0	0	0	69.03	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00	
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00	
90.00	09000	CLINIC	0	0	0	0	90.00	
90.01	09001	IMED	0	0	0	0	90.01	
90.02	09002	ONCOLOGY	0	0	0	0	90.02	
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	0	0	0	0	95.00	
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00	
200.00		Total (lines 50-199)	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part IV Date/Time Prepared: 11/27/2012 12:35 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	27,555,931	0.000000	0.000000	2,865,253	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,498,130	0.000000	0.000000	4,531	52.00
53.00	05300 ANESTHESIOLOGY	0	2,745,981	0.000000	0.000000	280,952	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	32,163,847	0.000000	0.000000	2,783,980	54.00
56.00	05600 RADIOISOTOPE	0	5,651,205	0.000000	0.000000	263,558	56.00
60.00	06000 LABORATORY	0	22,777,123	0.000000	0.000000	3,433,472	60.00
65.00	06500 RESPIRATORY THERAPY	0	3,130,399	0.000000	0.000000	760,668	65.00
66.00	06600 PHYSICAL THERAPY	0	5,224,107	0.000000	0.000000	962,398	66.00
69.00	06900 ELECTROCARDIOLOGY	0	18,600,043	0.000000	0.000000	3,097,832	69.00
69.01	06901 PULMONARY	0	593,392	0.000000	0.000000	32,397	69.01
69.02	06902 CARDIOPULMONARY	0	502,381	0.000000	0.000000	85	69.02
69.03	06903 SLEEP LAB	0	1,008,337	0.000000	0.000000	0	69.03
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,887,664	0.000000	0.000000	2,186,809	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	12,759,209	0.000000	0.000000	5,455,365	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	52,510,252	0.000000	0.000000	11,568,411	73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	462,835	0.000000	0.000000	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	824,164	0.000000	0.000000	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000 CLINIC	0	1,797,195	0.000000	0.000000	291	90.00
90.01	09001 IMED	0	808,347	0.000000	0.000000	0	90.01
90.02	09002 ONCOLOGY	0	8,789,524	0.000000	0.000000	9,381	90.02
91.00	09100 EMERGENCY	0	10,662,254	0.000000	0.000000	1,199,886	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,418,574	0.000000	0.000000	387,891	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00	Total (lines 50-199)	0	220,370,894			35,293,160	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part IV Date/Time Prepared: 11/27/2012 12:35 pm
	Title XVIII	Hospital	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	6,116,467	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	500,801	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	13,836,553	0	54.00
56.00	05600 RADIOISOTOPE	0	2,918	0	56.00
60.00	06000 LABORATORY	0	969,592	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	29,720	0	65.00
66.00	06600 PHYSICAL THERAPY	0	34,971	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	3,607,374	0	69.00
69.01	06901 PULMONARY	0	158,583	0	69.01
69.02	06902 CARDIOPULMONARY	0	152,165	0	69.02
69.03	06903 SLEEP LAB	0	305,524	0	69.03
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,344,440	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1,695,567	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	12,804,334	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000 CLINIC	0	162,776	0	90.00
90.01	09001 IMED	0	73,469	0	90.01
90.02	09002 ONCOLOGY	0	788,936	0	90.02
91.00	09100 EMERGENCY	0	1,856,074	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	511,495	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00	Total (lines 50-199)	0	44,951,759	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 11/27/2012 12:35 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges					
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)			
	1.00	2.00	3.00	4.00			
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.306071	6,116,467	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.594719	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.419251	500,801	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150650	13,836,553	0	0	54.00
56.00	05600	RADIOISOTOPE	0.195599	2,918	0	0	56.00
60.00	06000	LABORATORY	0.354625	969,592	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.682901	29,720	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.587745	34,971	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.255913	3,607,374	0	0	69.00
69.01	06901	PULMONARY	0.168813	158,583	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.488667	152,165	0	0	69.02
69.03	06903	SLEEP LAB	0.377324	305,524	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.460284	1,344,440	183	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.759371	1,695,567	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.234612	12,804,334	0	23,461	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00	09000	CLINIC	1.589656	162,776	0	0	90.00
90.01	09001	IMED	0.629466	73,469	0	0	90.01
90.02	09002	ONCOLOGY	0.395982	788,936	0	0	90.02
91.00	09100	EMERGENCY	0.523959	1,856,074	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.012737	511,495	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1.156754		0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	96.00
200.00		Subtotal (see instructions)		44,951,759	183	23,461	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		44,951,759	183	23,461	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 11/27/2012 12:35 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	1,872,073	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00 05300 ANESTHESIOLOGY	209,961	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,084,477	0	0		54.00
56.00 05600 RADIOISOTOPE	571	0	0		56.00
60.00 06000 LABORATORY	343,842	0	0		60.00
65.00 06500 RESPIRATORY THERAPY	20,296	0	0		65.00
66.00 06600 PHYSICAL THERAPY	20,554	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	923,174	0	0		69.00
69.01 06901 PULMONARY	26,771	0	0		69.01
69.02 06902 CARDIOPULMONARY	74,358	0	0		69.02
69.03 06903 SLEEP LAB	115,282	0	0		69.03
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	618,824	84	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1,287,564	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3,004,050	0	5,504		73.00
74.00 07400 RENAL DIALYSIS	0	0	0		74.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0	0	0		88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0	0		88.01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00 09000 CLINIC	258,758	0	0		90.00
90.01 09001 IMED	46,246	0	0		90.01
90.02 09002 ONCOLOGY	312,404	0	0		90.02
91.00 09100 EMERGENCY	972,507	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	518,010	0	0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES		0			95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00 Subtotal (see instructions)	12,709,722	84	5,504		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	12,709,722	84	5,504		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150115		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part II Date/Time Prepared: 11/27/2012 12:35 pm	
		Component CCN: 15S115		Title XVIII		Subprovider - IPF	
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	821,676	27,555,931	0.029818	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	92,814	1,498,130	0.061953	0	52.00
53.00	05300	ANESTHESIOLOGY	22,359	2,745,981	0.008142	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	410,550	32,163,847	0.012764	30,152	54.00
56.00	05600	RADIOISOTOPE	51,366	5,651,205	0.009089	0	56.00
60.00	06000	LABORATORY	291,320	22,777,123	0.012790	89,203	60.00
65.00	06500	RESPIRATORY THERAPY	88,455	3,130,399	0.028257	810	65.00
66.00	06600	PHYSICAL THERAPY	203,245	5,224,107	0.038905	2,966	66.00
69.00	06900	ELECTROCARDIOLOGY	484,824	18,600,043	0.026066	3,645	69.00
69.01	06901	PULMONARY	4,267	593,392	0.007191	0	69.01
69.02	06902	CARDIOPULMONARY	35,324	502,381	0.070313	0	69.02
69.03	06903	SLEEP LAB	51,856	1,008,337	0.051427	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	96,752	8,887,664	0.010886	2,442	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	157,046	12,759,209	0.012308	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	308,820	52,510,252	0.005881	193,207	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	44,615	462,835	0.096395	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	131,799	824,164	0.159918	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	89.00
90.00	09000	CLINIC	957,611	1,797,195	0.532836	0	90.00
90.01	09001	IMED	92,075	808,347	0.113905	0	90.01
90.02	09002	ONCOLOGY	301,902	8,789,524	0.034348	0	90.02
91.00	09100	EMERGENCY	379,253	10,662,254	0.035570	38,142	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	148,489	1,418,574	0.104675	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	96.00
200.00		Total (lines 50-199)	5,176,418	220,370,894		360,567	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150115 Component CCN: 15S115	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part IV Date/Time Prepared: 11/27/2012 12:35 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901 PULMONARY	0	0	0	0	0	69.01
69.02	06902 CARDIOPULMONARY	0	0	0	0	0	69.02
69.03	06903 SLEEP LAB	0	0	0	0	0	69.03
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 IMED	0	0	0	0	0	90.01
90.02	09002 ONCOLOGY	0	0	0	0	0	90.02
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						95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150115 Component CCN: 15S115	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part IV Date/Time Prepared: 11/27/2012 12:35 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient Program Charges	
	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)		
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	27,555,931	0.000000	0.000000	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	1,498,130	0.000000	0.000000	0	52.00
53.00 05300 ANESTHESIOLOGY	0	2,745,981	0.000000	0.000000	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	32,163,847	0.000000	0.000000	30,152	54.00
56.00 05600 RADIOISOTOPE	0	5,651,205	0.000000	0.000000	0	56.00
60.00 06000 LABORATORY	0	22,777,123	0.000000	0.000000	89,203	60.00
65.00 06500 RESPIRATORY THERAPY	0	3,130,399	0.000000	0.000000	810	65.00
66.00 06600 PHYSICAL THERAPY	0	5,224,107	0.000000	0.000000	2,966	66.00
69.00 06900 ELECTROCARDIOLOGY	0	18,600,043	0.000000	0.000000	3,645	69.00
69.01 06901 PULMONARY	0	593,392	0.000000	0.000000	0	69.01
69.02 06902 CARDIOPULMONARY	0	502,381	0.000000	0.000000	0	69.02
69.03 06903 SLEEP LAB	0	1,008,337	0.000000	0.000000	0	69.03
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,887,664	0.000000	0.000000	2,442	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	12,759,209	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	52,510,252	0.000000	0.000000	193,207	73.00
74.00 07400 RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	462,835	0.000000	0.000000	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	824,164	0.000000	0.000000	0	88.01
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00 09000 CLINIC	0	1,797,195	0.000000	0.000000	0	90.00
90.01 09001 IMED	0	808,347	0.000000	0.000000	0	90.01
90.02 09002 ONCOLOGY	0	8,789,524	0.000000	0.000000	0	90.02
91.00 09100 EMERGENCY	0	10,662,254	0.000000	0.000000	38,142	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,418,574	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00 Total (lines 50-199)	0	220,370,894			360,567	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150115 Component CCN: 15S115	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part IV Date/Time Prepared: 11/27/2012 12:35 pm PPS
Title XVIII		Subprovider - IPF	

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	0	56.00
60.00	06000 LABORATORY	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
69.01	06901 PULMONARY	0	0	0	69.01
69.02	06902 CARDIOPULMONARY	0	0	0	69.02
69.03	06903 SLEEP LAB	0	0	0	69.03
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 IMED	0	0	0	90.01
90.02	09002 ONCOLOGY	0	0	0	90.02
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00	Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150115		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part II Date/Time Prepared: 11/27/2012 12:35 pm	
		Component CCN: 15T115		Title XVIII		Subprovider - IRF PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	821,676	27,555,931	0.029818	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	92,814	1,498,130	0.061953	0	52.00
53.00	05300	ANESTHESIOLOGY	22,359	2,745,981	0.008142	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	410,550	32,163,847	0.012764	18,689	239 54.00
56.00	05600	RADIOISOTOPE	51,366	5,651,205	0.009089	0	56.00
60.00	06000	LABORATORY	291,320	22,777,123	0.012790	65,393	836 60.00
65.00	06500	RESPIRATORY THERAPY	88,455	3,130,399	0.028257	23,979	678 65.00
66.00	06600	PHYSICAL THERAPY	203,245	5,224,107	0.038905	727,659	28,310 66.00
69.00	06900	ELECTROCARDIOLOGY	484,824	18,600,043	0.026066	2,593	68 69.00
69.01	06901	PULMONARY	4,267	593,392	0.007191	0	0 69.01
69.02	06902	CARDIOPULMONARY	35,324	502,381	0.070313	0	0 69.02
69.03	06903	SLEEP LAB	51,856	1,008,337	0.051427	0	0 69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	96,752	8,887,664	0.010886	33,231	362 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	157,046	12,759,209	0.012308	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	308,820	52,510,252	0.005881	462,870	2,722 73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0 74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	44,615	462,835	0.096395	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	131,799	824,164	0.159918	0	0 88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0 89.00
90.00	09000	CLINIC	957,611	1,797,195	0.532836	0	0 90.00
90.01	09001	IMED	92,075	808,347	0.113905	0	0 90.01
90.02	09002	ONCOLOGY	301,902	8,789,524	0.034348	0	0 90.02
91.00	09100	EMERGENCY	379,253	10,662,254	0.035570	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	148,489	1,418,574	0.104675	0	0 92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0.000000	0	0 95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0 96.00
200.00		Total (lines 50-199)	5,176,418	220,370,894		1,334,414	33,215 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150115 Component CCN: 15T115	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part IV Date/Time Prepared: 11/27/2012 12:35 pm
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901 PULMONARY	0	0	0	0	0	69.01
69.02	06902 CARDIOPULMONARY	0	0	0	0	0	69.02
69.03	06903 SLEEP LAB	0	0	0	0	0	69.03
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 IMED	0	0	0	0	0	90.01
90.02	09002 ONCOLOGY	0	0	0	0	0	90.02
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						95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150115 Component CCN: 15T115	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part IV Date/Time Prepared: 11/27/2012 12:35 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	27,555,931	0.000000	0.000000	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,498,130	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	2,745,981	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	32,163,847	0.000000	0.000000	18,689	54.00
56.00	05600 RADIOISOTOPE	0	5,651,205	0.000000	0.000000	0	56.00
60.00	06000 LABORATORY	0	22,777,123	0.000000	0.000000	65,393	60.00
65.00	06500 RESPIRATORY THERAPY	0	3,130,399	0.000000	0.000000	23,979	65.00
66.00	06600 PHYSICAL THERAPY	0	5,224,107	0.000000	0.000000	727,659	66.00
69.00	06900 ELECTROCARDIOLOGY	0	18,600,043	0.000000	0.000000	2,593	69.00
69.01	06901 PULMONARY	0	593,392	0.000000	0.000000	0	69.01
69.02	06902 CARDIOPULMONARY	0	502,381	0.000000	0.000000	0	69.02
69.03	06903 SLEEP LAB	0	1,008,337	0.000000	0.000000	0	69.03
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,887,664	0.000000	0.000000	33,231	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	12,759,209	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	52,510,252	0.000000	0.000000	462,870	73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	462,835	0.000000	0.000000	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	824,164	0.000000	0.000000	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000 CLINIC	0	1,797,195	0.000000	0.000000	0	90.00
90.01	09001 IMED	0	808,347	0.000000	0.000000	0	90.01
90.02	09002 ONCOLOGY	0	8,789,524	0.000000	0.000000	0	90.02
91.00	09100 EMERGENCY	0	10,662,254	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,418,574	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00	Total (lines 50-199)	0	220,370,894			1,334,414	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150115 Component CCN: 15T115	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part IV Date/Time Prepared: 11/27/2012 12:35 pm PPS
Title XVIII		Subprovider - IRF	

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	0	56.00
60.00	06000 LABORATORY	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
69.01	06901 PULMONARY	0	0	0	69.01
69.02	06902 CARDIOPULMONARY	0	0	0	69.02
69.03	06903 SLEEP LAB	0	0	0	69.03
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 IMED	0	0	0	90.01
90.02	09002 ONCOLOGY	0	0	0	90.02
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00	Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150115 Component CCN: 155305	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part IV Date/Time Prepared: 11/27/2012 12:35 pm
		Title XVIII	Skilled Nursing Facility PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	PULMONARY	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	IMED	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	0	0	90.02
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
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150115 Component CCN: 155305	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part IV Date/Time Prepared: 11/27/2012 12:35 pm PPS
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	27,555,931	0.000000	0.000000	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,498,130	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	2,745,981	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	32,163,847	0.000000	0.000000	22,066	54.00
56.00	05600 RADIOISOTOPE	0	5,651,205	0.000000	0.000000	0	56.00
60.00	06000 LABORATORY	0	22,777,123	0.000000	0.000000	225,875	60.00
65.00	06500 RESPIRATORY THERAPY	0	3,130,399	0.000000	0.000000	78,232	65.00
66.00	06600 PHYSICAL THERAPY	0	5,224,107	0.000000	0.000000	896,868	66.00
69.00	06900 ELECTROCARDIOLOGY	0	18,600,043	0.000000	0.000000	5,855	69.00
69.01	06901 PULMONARY	0	593,392	0.000000	0.000000	0	69.01
69.02	06902 CARDIOPULMONARY	0	502,381	0.000000	0.000000	0	69.02
69.03	06903 SLEEP LAB	0	1,008,337	0.000000	0.000000	0	69.03
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,887,664	0.000000	0.000000	145,686	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	12,759,209	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	52,510,252	0.000000	0.000000	1,865,550	73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	462,835	0.000000	0.000000	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	824,164	0.000000	0.000000	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000 CLINIC	0	1,797,195	0.000000	0.000000	0	90.00
90.01	09001 IMED	0	808,347	0.000000	0.000000	0	90.01
90.02	09002 ONCOLOGY	0	8,789,524	0.000000	0.000000	0	90.02
91.00	09100 EMERGENCY	0	10,662,254	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,418,574	0.000000	0.000000	17,796	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0.000000	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00	Total (lines 50-199)	0	220,370,894			3,257,928	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150115 Component CCN: 155305	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part IV Date/Time Prepared: 11/27/2012 12:35 pm PPS
		Title XVIII	Skilled Nursing Facility

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	0	56.00
60.00	06000 LABORATORY	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
69.01	06901 PULMONARY	0	0	0	69.01
69.02	06902 CARDIOPULMONARY	0	0	0	69.02
69.03	06903 SLEEP LAB	0	0	0	69.03
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 IMED	0	0	0	90.01
90.02	09002 ONCOLOGY	0	0	0	90.02
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00	Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 11/27/2012 12:35 pm
		Title XIX	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost		
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)			
			1.00	2.00		3.00	4.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.306071	0	2,090,149	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.594719	0	163,377	0	52.00
53.00	05300	ANESTHESIOLOGY	0.419251	0	200,480	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150650	0	2,297,870	0	54.00
56.00	05600	RADIOISOTOPE	0.195599	0	265,554	0	56.00
60.00	06000	LABORATORY	0.354625	0	1,429,177	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.682901	0	64,810	0	65.00
66.00	06600	PHYSICAL THERAPY	0.587745	0	197,857	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.255913	0	748,492	0	69.00
69.01	06901	PULMONARY	0.168813	0	41,072	0	69.01
69.02	06902	CARDIOPULMONARY	0.488667	0	11,046	0	69.02
69.03	06903	SLEEP LAB	0.377324	0	84,755	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.460284	0	34,274	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.759371	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.234612	0	995,430	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1.038593				88.00
88.01	08801	RURAL HEALTH CLINIC II	1.066007				88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00	09000	CLINIC	1.589656	0	130,762	0	90.00
90.01	09001	IMED	0.629466	0	0	0	90.01
90.02	09002	ONCOLOGY	0.395982	0	2,054,774	0	90.02
91.00	09100	EMERGENCY	0.523959	0	1,394,929	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.012737	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1.156754	0	190,118		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	96.00
200.00		Subtotal (see instructions)		0	12,394,926	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	12,394,926	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 11/27/2012 12:35 pm
	Title XIX	Hospital	Cost

Cost Center Description	Costs			Hospital	Cost	
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)			
	5.00	6.00	7.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	639,734	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	97,163	0	52.00
53.00	05300	ANESTHESIOLOGY	0	84,051	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	346,174	0	54.00
56.00	05600	RADIOISOTOPE	0	51,942	0	56.00
60.00	06000	LABORATORY	0	506,822	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	44,259	0	65.00
66.00	06600	PHYSICAL THERAPY	0	116,289	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	191,549	0	69.00
69.01	06901	PULMONARY	0	6,933	0	69.01
69.02	06902	CARDIOPULMONARY	0	5,398	0	69.02
69.03	06903	SLEEP LAB	0	31,980	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	15,776	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	233,540	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	207,867	0	90.00
90.01	09001	IMED	0	0	0	90.01
90.02	09002	ONCOLOGY	0	813,654	0	90.02
91.00	09100	EMERGENCY	0	730,886	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	219,920	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00		Subtotal (see instructions)	0	4,343,937	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	4,343,937	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1 Date/Time Prepared: 11/27/2012 12:35 pm
		Title XVIII	Hospital	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)			14,154 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			14,154 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)			12,586 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)			5,927 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)			12,837,316 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)			12,837,316 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			16,005,897 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			16,005,897 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.802037 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			1,271.72 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)			12,837,316 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)			906.97 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			5,375,611 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			5,375,611 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150115		Period: From 07/01/2011 To 06/30/2012		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 11/27/2012 12:35 pm	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	5,331,862	5,039	1,058.12	3,293	3,484,389		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)					13,601,629		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					22,461,629		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)					882,895		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					552,516		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,435,411		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					21,026,218		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)					1,568		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					906.97		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,422,129		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150115		Period: From 07/01/2011 To 06/30/2012		Worksheet D-1 Date/Time Prepared: 11/27/2012 12:35 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,329,418	12,837,316	0.103559	1,422,129	147,274	90.00
91.00	Nursing School cost	0	12,837,316	0.000000	1,422,129	0	91.00
92.00	Allied health cost	0	12,837,316	0.000000	1,422,129	0	92.00
93.00	All other Medical Education	0	12,837,316	0.000000	1,422,129	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1
		Component CCN: 15S115		Date/Time Prepared: 11/27/2012 12:35 pm
		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)		2,227	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,227	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)		2,209	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)		802	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,795,712	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,795,712	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,962,537	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		1,962,537	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.914995	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)		888.43	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,795,712	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)		806.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		646,685	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)		646,685	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150115		Period: From 07/01/2011 To 06/30/2012		Worksheet D-1	
		Component CCN: 15S115				Date/Time Prepared: 11/27/2012 12:35 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					106,011		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					752,696		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)					54,135		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					4,279		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					58,414		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					694,282		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)					18		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					806.34		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					14,514		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150115 Component CCN: 15S115		Period: From 07/01/2011 To 06/30/2012		Worksheet D-1 Date/Time Prepared: 11/27/2012 12:35 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	150,327	1,795,712	0.083714	14,514	1,215	90.00
91.00	Nursing School cost	0	1,795,712	0.000000	14,514	0	91.00
92.00	Allied health cost	0	1,795,712	0.000000	14,514	0	92.00
93.00	All other Medical Education	0	1,795,712	0.000000	14,514	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1
		Component CCN: 15T115		Date/Time Prepared: 11/27/2012 12:35 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,642	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,642	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,642	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)		1,346	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,613,852	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,613,852	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,454,535	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		1,454,535	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.109531	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)		885.83	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,613,852	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)		982.86	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,322,930	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,322,930	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150115		Period: From 07/01/2011 To 06/30/2012		Worksheet D-1	
		Component CCN: 15T115				Date/Time Prepared: 11/27/2012 12:35 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					594,843		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,917,773		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)					155,853		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					33,215		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					189,068		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,728,705		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: 150115 Component CCN: 15T115		Period: From 07/01/2011 To 06/30/2012		Worksheet D-1 Date/Time Prepared: 11/27/2012 12:35 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	190,126	1,613,852	0.117809	0	0	90.00
91.00	Nursing School cost	0	1,613,852	0.000000	0	0	91.00
92.00	Allied health cost	0	1,613,852	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,613,852	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150115 Component CCN: 155305	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1 Date/Time Prepared: 11/27/2012 12:35 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,907	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,907	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)		4,907	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)		3,956	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)		2,475,920	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,475,920	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,204,362	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		1,204,362	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		2.055794	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)		245.44	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,475,920	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1	
		Component CCN: 155305		Date/Time Prepared: 11/27/2012 12:35 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
	Intensive Care Type Inpatient Hospital Units				
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
	Cost Center Description				
					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				49.00
	PASS THROUGH COST ADJUSTMENTS				
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				53.00
	TARGET AMOUNT AND LIMIT COMPUTATION				
54.00	Program discharges				54.00
55.00	Target amount per discharge				55.00
56.00	Target amount (line 54 x line 55)				56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				57.00
58.00	Bonus payment (see instructions)				58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				61.00
62.00	Relief payment (see instructions)				62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST				
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY				
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)				2,475,920 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				504.57 71.00
72.00	Program routine service cost (line 9 x line 71)				1,996,079 72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				0 73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				1,996,079 74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				0 75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				0.00 76.00
77.00	Program capital-related costs (line 9 x line 76)				0 77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				0 78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				0 79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				0 80.00
81.00	Inpatient routine service cost per diem limitation				0.00 81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				0 82.00
83.00	Reasonable inpatient routine service costs (see instructions)				1,996,079 83.00
84.00	Program inpatient ancillary services (see instructions)				1,188,238 84.00
85.00	Utilization review - physician compensation (see instructions)				0 85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				3,184,317 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: 150115 Component CCN: 155305		Period: From 07/01/2011 To 06/30/2012		Worksheet D-1 Date/Time Prepared: 11/27/2012 12:35 pm	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital -related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1 Date/Time Prepared: 11/27/2012 12:35 pm
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		14,154	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,154	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)		12,586	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)		611	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)		1,988	15.00
16.00	Nursery days (title V or XIX only)		94	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)		12,837,316	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)		12,837,316	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		18,583,474	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		18,583,474	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.690792	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,476.52	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)		12,837,316	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)		906.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		554,159	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)		554,159	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150115		Period: From 07/01/2011 To 06/30/2012		Worksheet D-1	
Date/Time Prepared: 11/27/2012 12:35 pm		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)	0	1,988	0.00	94	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	5,331,862	5,039	1,058.12	238	251,833		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)					1,165,625		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,971,617		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					1,568		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					906.97		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,422,129		89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet D-1
Date/Time Prepared:
11/27/2012 12:35 pm

Cost Center Description	Cost	Title XIX		Hospital	
		Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
	1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
90.00 Capital-related cost	0	0	0.000000	0	0 90.00
91.00 Nursing School cost	0	0	0.000000	0	0 91.00
92.00 Allied health cost	0	0	0.000000	0	0 92.00
93.00 All other Medical Education	0	0	0.000000	0	0 93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1
		Component CCN: 15S115		Date/Time Prepared: 11/27/2012 12:35 pm
		Title XIX	Subprovider - IPF	Cost
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)		2,227	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,227	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)		2,209	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)		553	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)		1,988	15.00
16.00	Nursery days (title V or XIX only)		94	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,795,712	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,795,712	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,943,587	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		1,943,587	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.923916	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)		879.85	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,795,712	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)		806.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		445,906	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)		445,906	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150115		Period: From 07/01/2011 To 06/30/2012		Worksheet D-1	
		Component CCN: 15S115				Date/Time Prepared: 11/27/2012 12:35 pm	
		Title XIX		Subprovider - IPF		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)	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)						112,350	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						558,256	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						18	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						806.34	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						14,514	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150115 Component CCN: 15S115		Period: From 07/01/2011 To 06/30/2012		Worksheet D-1 Date/Time Prepared: 11/27/2012 12:35 pm	
		Title XIX		Subprovider - IPF		Cost	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1
		Component CCN: 15T115		Date/Time Prepared: 11/27/2012 12:35 pm
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,642	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,642	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,642	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)		39	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)		1,988	15.00
16.00	Nursery days (title V or XIX only)		94	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,542,587	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,542,587	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,454,535	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		1,454,535	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.060536	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)		885.83	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,542,587	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)		939.46	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		36,639	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)		36,639	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150115		Period: From 07/01/2011 To 06/30/2012		Worksheet D-1	
		Component CCN: 15T115		Date/Time Prepared: 11/27/2012 12:35 pm			
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					12,709	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					49,348	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150115 Component CCN: 15T115		Period: From 07/01/2011 To 06/30/2012		Worksheet D-1 Date/Time Prepared: 11/27/2012 12:35 pm	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150115 Component CCN: 155305	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1 Date/Time Prepared: 11/27/2012 12:35 pm
		Title XIX	Skilled Nursing Facility	Cost
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)		4,907	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,907	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)		4,907	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)		143	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)		1,988	15.00
16.00	Nursery days (title V or XIX only)		94	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)		2,471,186	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)		2,471,186	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,171,070	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		1,171,070	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		2.110195	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)		238.65	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,471,186	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150115		Period: From 07/01/2011 To 06/30/2012		Worksheet D-1	
		Component CCN: 155305				Date/Time Prepared: 11/27/2012 12:35 pm	
		Title XIX		Skilled Nursing Facility		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						
					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					2,471,186	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					503.60	71.00
72.00	Program routine service cost (line 9 x line 71)					72,015	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					72,015	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					274,479	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					55.94	76.00
77.00	Program capital-related costs (line 9 x line 76)					7,999	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					64,016	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					64,016	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					7,999	83.00
84.00	Program inpatient ancillary services (see instructions)					0	84.00
85.00	Utilization review - physician compensation (see instructions)					0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					7,999	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: 150115 Component CCN: 155305		Period: From 07/01/2011 To 06/30/2012		Worksheet D-1 Date/Time Prepared: 11/27/2012 12:35 pm	
		Title XIX		Skilled Nursing Facility		Cost	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital -related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet D-3 Date/Time Prepared: 11/27/2012 12:35 pm	
Cost Center Description		Title XVIII	Hospital	PPS	
		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		4,855,341	30.00
31.00	03100	INTENSIVE CARE UNIT		2,988,487	31.00
40.00	04000	SUBPROVIDER - IPF		2,640	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.306071	2,865,253	876,971 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.594719	4,531	2,695 52.00
53.00	05300	ANESTHESIOLOGY	0.419251	280,952	117,789 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150650	2,783,980	419,407 54.00
56.00	05600	RADIOISOTOPE	0.195599	263,558	51,552 56.00
60.00	06000	LABORATORY	0.354625	3,433,472	1,217,595 60.00
65.00	06500	RESPIRATORY THERAPY	0.687652	760,668	523,075 65.00
66.00	06600	PHYSICAL THERAPY	0.587745	962,398	565,645 66.00
69.00	06900	ELECTROCARDIOLOGY	0.300985	3,097,832	932,401 69.00
69.01	06901	PULMONARY	0.168813	32,397	5,469 69.01
69.02	06902	CARDIOPULMONARY	0.488667	85	42 69.02
69.03	06903	SLEEP LAB	0.377324	0	0 69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.460284	2,186,809	1,006,553 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.759371	5,455,365	4,142,646 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.234612	11,568,411	2,714,088 73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0 74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0 88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0 89.00
90.00	09000	CLINIC	1.589656	291	463 90.00
90.01	09001	IMED	0.629466	0	0 90.01
90.02	09002	ONCOLOGY	0.395982	9,381	3,715 90.02
91.00	09100	EMERGENCY	0.523959	1,199,886	628,691 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.012737	387,891	392,832 92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0 96.00
200.00		Total (sum of lines 50-94 and 96-98)		35,293,160	13,601,629 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		35,293,160	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet D-3	
		Component CCN: 15S115		Date/Time Prepared: 11/27/2012 12:35 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
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		705,677	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.306071	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.594719	0	52.00
53.00	05300	ANESTHESIOLOGY	0.419251	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150650	30,152	54.00
56.00	05600	RADIOISOTOPE	0.195599	0	56.00
60.00	06000	LABORATORY	0.354625	89,203	60.00
65.00	06500	RESPIRATORY THERAPY	0.687652	810	65.00
66.00	06600	PHYSICAL THERAPY	0.587745	2,966	66.00
69.00	06900	ELECTROCARDIOLOGY	0.300985	3,645	69.00
69.01	06901	PULMONARY	0.168813	0	69.01
69.02	06902	CARDIOPULMONARY	0.488667	0	69.02
69.03	06903	SLEEP LAB	0.377324	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.460284	2,442	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.759371	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.234612	193,207	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	1.589656	0	90.00
90.01	09001	IMED	0.629466	0	90.01
90.02	09002	ONCOLOGY	0.395982	0	90.02
91.00	09100	EMERGENCY	0.523959	38,142	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.012737	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES		0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		360,567	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)		360,567	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet D-3	
		Component CCN: 15T115		Date/Time Prepared: 11/27/2012 12:35 pm	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		1,177,125	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.306071	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.594719	0	52.00
53.00	05300	ANESTHESIOLOGY	0.419251	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150650	18,689	54.00
56.00	05600	RADIOISOTOPE	0.195599	0	56.00
60.00	06000	LABORATORY	0.354625	65,393	60.00
65.00	06500	RESPIRATORY THERAPY	0.687652	23,979	65.00
66.00	06600	PHYSICAL THERAPY	0.587745	727,659	66.00
69.00	06900	ELECTROCARDIOLOGY	0.300985	2,593	69.00
69.01	06901	PULMONARY	0.168813	0	69.01
69.02	06902	CARDIOPULMONARY	0.488667	0	69.02
69.03	06903	SLEEP LAB	0.377324	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.460284	33,231	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.759371	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.234612	462,870	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	1.589656	0	90.00
90.01	09001	IMED	0.629466	0	90.01
90.02	09002	ONCOLOGY	0.395982	0	90.02
91.00	09100	EMERGENCY	0.523959	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.012737	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		1,334,414	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)		1,334,414	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet D-3	
		Component CCN: 155305		Date/Time Prepared: 11/27/2012 12:35 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.306071	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.594719	0	52.00
53.00	05300	ANESTHESIOLOGY	0.419251	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150650	22,066	54.00
56.00	05600	RADIOISOTOPE	0.195599	0	56.00
60.00	06000	LABORATORY	0.354625	225,875	60.00
65.00	06500	RESPIRATORY THERAPY	0.682901	78,232	65.00
66.00	06600	PHYSICAL THERAPY	0.587745	896,868	66.00
69.00	06900	ELECTROCARDIOLOGY	0.255913	5,855	69.00
69.01	06901	PULMONARY	0.168813	0	69.01
69.02	06902	CARDIOPULMONARY	0.488667	0	69.02
69.03	06903	SLEEP LAB	0.377324	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.460284	145,686	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.759371	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.234612	1,865,550	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	1.589656	0	90.00
90.01	09001	IMED	0.629466	0	90.01
90.02	09002	ONCOLOGY	0.395982	0	90.02
91.00	09100	EMERGENCY	0.523959	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.012737	17,796	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES		0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		3,257,928	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		3,257,928	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet D-3 Date/Time Prepared: 11/27/2012 12:35 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		2,278,092		30.00
31.00	03100 INTENSIVE CARE UNIT		261,436		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.306071	343,616	105,171	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.594719	44,485	26,456	52.00
53.00	05300 ANESTHESIOLOGY	0.419251	91,079	38,185	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.150650	250,709	37,769	54.00
56.00	05600 RADIOISOTOPE	0.195599	13,906	2,720	56.00
60.00	06000 LABORATORY	0.354625	506,468	179,606	60.00
65.00	06500 RESPIRATORY THERAPY	0.682901	148,872	101,665	65.00
66.00	06600 PHYSICAL THERAPY	0.587745	30,018	17,643	66.00
69.00	06900 ELECTROCARDIOLOGY	0.255913	496,545	127,072	69.00
69.01	06901 PULMONARY	0.168813	4,440	750	69.01
69.02	06902 CARDIOPULMONARY	0.488667	0	0	69.02
69.03	06903 SLEEP LAB	0.377324	0	0	69.03
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.460284	22,155	10,198	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.759371	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.234612	1,720,704	403,698	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.038593	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	1.066007	0	0	88.01
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000 CLINIC	1.589656	208	331	90.00
90.01	09001 IMED	0.629466	0	0	90.01
90.02	09002 ONCOLOGY	0.395982	56,468	22,360	90.02
91.00	09100 EMERGENCY	0.523959	175,589	92,001	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.012737	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		3,905,262	1,165,625	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		3,905,262		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet D-3	
		Component CCN: 15S115		Date/Time Prepared: 11/27/2012 12:35 pm	
		Title XIX	Subprovider - IPF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
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		567,502	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.306071	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.594719	0	52.00
53.00	05300	ANESTHESIOLOGY	0.419251	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150650	18,692	54.00
56.00	05600	RADIOISOTOPE	0.195599	0	56.00
60.00	06000	LABORATORY	0.354625	81,784	60.00
65.00	06500	RESPIRATORY THERAPY	0.682901	3,104	65.00
66.00	06600	PHYSICAL THERAPY	0.587745	3,424	66.00
69.00	06900	ELECTROCARDIOLOGY	0.255913	4,386	69.00
69.01	06901	PULMONARY	0.168813	0	69.01
69.02	06902	CARDIOPULMONARY	0.488667	0	69.02
69.03	06903	SLEEP LAB	0.377324	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.460284	883	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.759371	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.234612	157,381	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1.038593	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.066007	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	1.589656	0	90.00
90.01	09001	IMED	0.629466	0	90.01
90.02	09002	ONCOLOGY	0.395982	0	90.02
91.00	09100	EMERGENCY	0.523959	72,426	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.012737	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES		0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		342,080	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)		342,080	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet D-3	
		Component CCN: 15T115		Date/Time Prepared: 11/27/2012 12:35 pm	
		Title XIX	Subprovider - IRF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		29,584	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.306071	2,924	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.594719	0	52.00
53.00	05300	ANESTHESIOLOGY	0.419251	1,048	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150650	0	54.00
56.00	05600	RADIOISOTOPE	0.195599	0	56.00
60.00	06000	LABORATORY	0.354625	1,029	60.00
65.00	06500	RESPIRATORY THERAPY	0.682901	74	65.00
66.00	06600	PHYSICAL THERAPY	0.587745	15,978	66.00
69.00	06900	ELECTROCARDIOLOGY	0.255913	0	69.00
69.01	06901	PULMONARY	0.168813	0	69.01
69.02	06902	CARDIOPULMONARY	0.488667	0	69.02
69.03	06903	SLEEP LAB	0.377324	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.460284	156	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.759371	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.234612	6,376	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1.038593	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.066007	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	1.589656	0	90.00
90.01	09001	IMED	0.629466	0	90.01
90.02	09002	ONCOLOGY	0.395982	0	90.02
91.00	09100	EMERGENCY	0.523959	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.012737	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		27,585	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)		27,585	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet D-3	
		Component CCN: 155305		Date/Time Prepared: 11/27/2012 12:35 pm	
		Title XIX	Skilled Nursing Facility	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.306071	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.594719	0	52.00
53.00	05300	ANESTHESIOLOGY	0.419251	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150650	0	54.00
56.00	05600	RADIOISOTOPE	0.195599	0	56.00
60.00	06000	LABORATORY	0.354625	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.682901	0	65.00
66.00	06600	PHYSICAL THERAPY	0.587745	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.255913	0	69.00
69.01	06901	PULMONARY	0.168813	0	69.01
69.02	06902	CARDIOPULMONARY	0.488667	0	69.02
69.03	06903	SLEEP LAB	0.377324	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.460284	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.759371	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.234612	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1.038593	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.066007	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	1.589656	0	90.00
90.01	09001	IMED	0.629466	0	90.01
90.02	09002	ONCOLOGY	0.395982	0	90.02
91.00	09100	EMERGENCY	0.523959	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.012737	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		0	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)		0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part A Date/Time Prepared: 11/27/2012 12:35 pm
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		18,964,017	1.00
2.00	Outlier payments for discharges. (see instructions)		116,629	2.00
2.01	For inpatient PPS services rendered during the cost reporting period enter the operating outlier reconciliation amount for operating expenses from line 92.		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)		106.72	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)		3.17	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		14.60	31.00
32.00	Sum of lines 30 and 31		17.77	32.00
33.00	Allowable disproportionate share percentage (see instructions)		4.30	33.00
34.00	Disproportionate share adjustment (see instructions)		815,453	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)		19,896,099	47.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part A Date/Time Prepared: 11/27/2012 12:35 pm
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
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)		19,896,099	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		1,524,463	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
57.00	Routine service other pass through costs		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)		21,420,562	59.00
60.00	Primary payer payments		19,301	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		21,401,261	61.00
62.00	Deductibles billed to program beneficiaries		2,256,380	62.00
63.00	Coinurance billed to program beneficiaries		15,366	63.00
64.00	Allowable bad debts (see instructions)		61,731	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		43,212	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		32,203	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		19,172,727	67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0	68.00
69.00	Enter the time value of money for operating expenses, the capital outlier reconciliation amount and time value of money for capital related expenses by entering the sum of lines 93, 95 and 96. For SCH, if the hospital specific payment amount on line 48, is greater than the federal specific payment amount on line 47, do not complete this line.		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.95	Recovery of Accelerated Depreciation		0	70.95
70.96	Low Volume Payment-1		0	70.96
70.97	Low Volume Payment-2		0	70.97
70.98	Low Volume Payment-3		0	70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		19,172,727	71.00
72.00	Interim payments		19,289,301	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)		-116,574	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		142,230	75.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Operating outlier amount from Worksheet E, Part A line 2		0	90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the Time Value of Money		0.00	94.00
95.00	Time Value of Money for operating expenses(see instructions)		0	95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0	96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 11/27/2012 12:35 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			5,588 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			12,709,722 2.00
3.00	PPS payments			14,291,179 3.00
4.00	Outlier payment (see instructions)			9,133 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.855 5.00
6.00	Line 2 times line 5			10,866,812 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)			5,588 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			23,644 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)			23,644 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)			23,644 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			18,056 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)			5,588 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)			14,300,312 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			37 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			3,334,449 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)			10,971,414 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)			10,971,414 30.00
31.00	Primary payer payments			1,998 31.00
32.00	Subtotal (line 30 minus line 31)			10,969,416 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)			82,805 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			57,964 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			40,865 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			11,027,380 37.00
38.00	MSP-LCC reconciliation amount from PS&R			-130 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			3,342 39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			11,030,852 40.00
41.00	Interim payments			11,115,767 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)			-84,915 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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 11/27/2012 12:35 pm
		Component CCN: 15S115	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)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
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)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		0	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
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)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		0	40.00
41.00	Interim payments		0	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 11/27/2012 12:35 pm
		Component CCN: 15T115	Title XVIII	Subprovider - IRF
		PPS		
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
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)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		0	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
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)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		0	40.00
41.00	Interim payments		0	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150115 Component CCN: 155305	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 11/27/2012 12:35 pm
		Title XVIII	Skilled Nursing Facility	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)		0	2.00
3.00	PPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		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)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		0	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
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)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R			38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		0	40.00
41.00	Interim payments		0	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet E-1
Part I
Date/Time Prepared:
11/27/2012 12:35 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		19,405,469		11,136,646	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	02/23/2012	116,168	02/23/2012	20,879	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)		-116,168		-20,879	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)		19,289,301		11,115,767	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		116,574		84,915	6.02	
7.00	Total Medicare program liability (see instructions)		19,172,727		11,030,852	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: 150115
Component CCN: 15S115

Period:
From 07/01/2011
To 06/30/2012

Worksheet E-1
Part I
Date/Time Prepared:
11/27/2012 12:35 pm
PPS

Title XVIII

Subprovider -
IPF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		556,450		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		556,450		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		42,569		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		599,019		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150115
Component CCN: 15T115

Period:
From 07/01/2011
To 06/30/2012

Worksheet E-1
Part I
Date/Time Prepared:
11/27/2012 12:35 pm
PPS

Title XVIII

Subprovider -
IRF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					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		1,755,605		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,755,605		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		17,392		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,772,997		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150115
Component CCN: 155305

Period:
From 07/01/2011
To 06/30/2012

Worksheet E-1
Part I
Date/Time Prepared:
11/27/2012 12:35 pm
PPS

Title XVIII

Skilled Nursing
Facility

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					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		1,342,213		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,342,213		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,342,213		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150115 Component CCN: 15S115	Period: From 07/01/2011 To 06/30/2012	Worksheet E-3 Part II Date/Time Prepared: 11/27/2012 12:35 pm
		Title XVIIII	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)			642,813 1.00
2.00	Net IPF PPS Outlier Payments			605 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
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)			6.035519 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)			643,418 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)			643,418 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			643,418 18.00
19.00	Deductibles			86,968 19.00
20.00	Subtotal (line 18 minus line 19)			556,450 20.00
21.00	Coinsurance			0 21.00
22.00	Subtotal (line 20 minus line 21)			556,450 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			60,813 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			42,569 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			58,549 25.00
26.00	Subtotal (sum of lines 22 and 24)			599,019 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)			599,019 31.00
32.00	Interim payments			556,450 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)			42,569 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			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet E-3 Part III Date/Time Prepared: 11/27/2012 12:35 pm
		Component CCN: 15T115	Title XVIII	Subprovider - IRF
				PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			1,767,533 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0294 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			42,734 3.00
4.00	Outlier Payments			0 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			4.486339 10.00
11.00	Medical Education Adjustment Factor $\{((1 + (\text{line } 9/\text{line } 10)) \text{ raised to the power of } .6876 - 1)\}$.			0.000000 11.00
12.00	Medical Education Adjustment (line 1 multiplied by line 11).			0 12.00
13.00	Total PPS Payment (sum of lines 1, 3, 4 and 12)			1,810,267 13.00
14.00	Nursing and Allied Health Managed Care payment (see instruction)			0 14.00
15.00	Organ acquisition			0 15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 16.00
17.00	Subtotal (see instructions)			1,810,267 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			1,810,267 19.00
20.00	Deductibles			36,704 20.00
21.00	Subtotal (line 19 minus line 20)			1,773,563 21.00
22.00	Coinurance			566 22.00
23.00	Subtotal (line 21 minus line 22)			1,772,997 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			0 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			1,772,997 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			1,772,997 32.00
33.00	Interim payments			1,755,605 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus the sum lines 33 and 34)			17,392 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150115 Component CCN: 155305	Period: From 07/01/2011 To 06/30/2012	Worksheet E-3 Part VI Date/Time Prepared: 11/27/2012 12:35 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		1,442,039	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,442,039	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		99,826	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Allowable reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)		1,342,213	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14)		1,342,213	15.00
16.00	Interim payments		1,342,213	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus the sum of lines 16 and 17)		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2		0	19.00

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

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet G

Date/Time Prepared:
11/27/2012 12:35 pm

		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	44,383,199	0	0	0	1.00
2.00	Temporary investments	1,111,750	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	23,278,412	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	5,552,925	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)	74,326,286	0	0	0	11.00
FIXED ASSETS						
12.00	Land	6,090,527	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	105,375,534	0	0	0	15.00
16.00	Accumulated depreciation	-46,705,001	0	0	0	16.00
17.00	Leasehold improvements	4,626,680	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	67,102,558	0	0	0	19.00
20.00	Accumulated depreciation	-46,190,950	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)	90,299,348	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	47,366,381	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,041,268	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	49,407,649	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	214,033,283	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,014,248	0	0	0	37.00
38.00	Salaries, wages, and fees payable	17,641,459	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,595,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	4,453,007	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	26,703,714	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	49,198,353	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	49,198,353	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	75,902,067	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	138,131,216				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	138,131,216	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	214,033,283	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet G-1

Date/Time Prepared:
11/27/2012 12:35 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
1.00	Fund balances at beginning of period		135,009,660		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		5,085,953			2.00
3.00	Total (sum of line 1 and line 2)		140,095,613		0	3.00
4.00	STET	49,806		0		4.00
5.00	OTHER	307,050		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		356,856		0	10.00
11.00	Subtotal (line 3 plus line 10)		140,452,469		0	11.00
12.00	STET	1,325,479		0		12.00
13.00	PENSION	995,774		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		2,321,253		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		138,131,216		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet G-1

Date/Time Prepared:
11/27/2012 12:35 pm

	Endowment Fund		Plant Fund			
	5.00	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 STET	0		0			4.00
5.00 OTHER	0		0			5.00
6.00	0		0			6.00
7.00	0		0			7.00
8.00	0		0			8.00
9.00	0		0			9.00
10.00 Total additions (sum of line 4-9)		0		0		10.00
11.00 Subtotal (line 3 plus line 10)		0		0		11.00
12.00 STET	0		0			12.00
13.00 PENSION	0		0			13.00
14.00	0		0			14.00
15.00	0		0			15.00
16.00	0		0			16.00
17.00	0		0			17.00
18.00 Total deductions (sum of lines 12-17)		0		0		18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/27/2012 12:35 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	16,005,897		16,005,897	1.00
2.00	SUBPROVIDER - IPF	1,962,537		1,962,537	2.00
3.00	SUBPROVIDER - IRF	1,454,535		1,454,535	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	1,204,362		1,204,362	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)	20,627,331		20,627,331	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,188,840		5,188,840	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)	5,188,840		5,188,840	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	25,816,171		25,816,171	17.00
18.00	Ancillary services	74,905,851	162,143,574	237,049,425	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	462,835	462,835	20.00
20.01	RURAL HEALTH CLINIC II	0	824,164	824,164	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,379,196	1,379,196	22.00
23.00	AMBULANCE SERVICES	743,563	1,616,714	2,360,277	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (PHYSICIANS)	0	23,250,822	23,250,822	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	101,465,585	189,677,305	291,142,890	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		158,591,535		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)		158,591,535		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150115

Period:
From 07/01/2011
To 06/30/2012

Worksheet G-3

Date/Time Prepared:
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	291,142,890	1.00
2.00	Less contractual allowances and discounts on patients' accounts	131,344,434	2.00
3.00	Net patient revenues (line 1 minus line 2)	159,798,456	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	158,591,535	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,206,921	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-162,207	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	715	13.00
14.00	Revenue from meals sold to employees and guests	534,691	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	224,617	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	5,990	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS	3,275,226	24.00
25.00	Total other income (sum of lines 6-24)	3,879,032	25.00
26.00	Total (line 5 plus line 25)	5,085,953	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,085,953	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 150115

Period:

Worksheet H

HHA CCN: 157222

From 07/01/2011
To 06/30/2012

Date/Time Prepared:
11/27/2012 12:35 pm

Home Health
Agency I

PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	1.00
2.00	Capital Related - Movable Equipment			0		0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	283,119	0	0	21,270	55,237	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	333,470	0	39,718	0	0	6.00
7.00	Physical Therapy	84,270	0	14,014	0	0	7.00
8.00	Occupational Therapy	22,342	0	3,416	0	0	8.00
9.00	Speech Pathology	2,799	0	308	0	0	9.00
10.00	Medical Social Services	823	0	50	0	0	10.00
11.00	Home Health Aide	65,519	0	22,462	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	792,342	0	79,968	21,270	55,237	24.00

Column, 6 line 24 should agree with the Worksheet A, column 7, line 101, or subscript as applicable.

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 150115

Period: From 07/01/2011

Worksheet H

HHA CCN: 157222

To 06/30/2012

Date/Time Prepared: 11/27/2012 12:35 pm

Home Health Agency I

PPS

		Total (sum of col s. 1 thru 5)	Recl assi fi cati on	Recl assi fi ed Tri al Bal ance (col . 6 + col . 7)	Adj ustments	Net Expenses for Al locati on (col . 8 + col . 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	359,626	0	359,626	3,765	363,391	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	373,188	0	373,188	4,434	377,622	6.00
7.00	Physical Therapy	98,284	0	98,284	1,121	99,405	7.00
8.00	Occupational Therapy	25,758	0	25,758	297	26,055	8.00
9.00	Speech Pathology	3,107	0	3,107	37	3,144	9.00
10.00	Medical Social Services	873	0	873	11	884	10.00
11.00	Home Health Aide	87,981	0	87,981	871	88,852	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	948,817	0	948,817	10,536	959,353	24.00

Column, 6 line 24 should agree with the Worksheet A, column 7, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST	Provider CCN: 150115	Period:	Worksheet H-1
	HHA CCN: 157222	From 07/01/2011 To 06/30/2012	Part I Date/Time Prepared: 11/27/2012 12:35 pm
		Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	
		Bldgs & Fixtures	Movable Equipment			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	363,391	0	0	0	5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	377,622	0	0	0	6.00
7.00	Physical Therapy	99,405	0	0	0	7.00
8.00	Occupational Therapy	26,055	0	0	0	8.00
9.00	Speech Pathology	3,144	0	0	0	9.00
10.00	Medical Social Services	884	0	0	0	10.00
11.00	Home Health Aide	88,852	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	959,353	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 150115	Period: From 07/01/2011	Worksheet H-1
		HHA CCN: 157222	To 06/30/2012	Part I
			Home Health Agency I	Date/Time Prepared: 11/27/2012 12:35 pm
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		Subtotal (col s. 0-4)	Administrative & General	Total (col s. 4A + 5)	
		4A.00	5.00	6.00	
GENERAL SERVICE COST CENTERS					
1.00	Capital Related - Bldg. & Fixtures	0			1.00
2.00	Capital Related - Movable Equipment	0			2.00
3.00	Plant Operation & Maintenance	0			3.00
4.00	Transportation				4.00
5.00	Administrative and General	363,391	363,391		5.00
HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	377,622	230,257	607,879	6.00
7.00	Physical Therapy	99,405	60,613	160,018	7.00
8.00	Occupational Therapy	26,055	15,887	41,942	8.00
9.00	Speech Pathology	3,144	1,917	5,061	9.00
10.00	Medical Social Services	884	539	1,423	10.00
11.00	Home Health Aide	88,852	54,178	143,030	11.00
12.00	Supplies (see instructions)	0	0	0	12.00
13.00	Drugs	0	0	0	13.00
14.00	DME	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	17.00
18.00	Clinic	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	19.00
20.00	Day Care Program	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	21.00
22.00	Homemaker Service	0	0	0	22.00
23.00	All Others (specify)	0	0	0	23.00
24.00	Total (sum of lines 1-23)	595,962		959,353	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 150115
HHA CCN: 157222

Period:
From 07/01/2011
To 06/30/2012

Worksheet H-1
Part II
Date/Time Prepared:
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		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)				
		1.00	2.00	3.00	4.00	5A.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation (see instructions)	0	0	0	0	0	4.00
5.00	Administrative and General	0	0	0	0	-363,391	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-363,391	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	0	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		26.00

COST ALLOCATION - HHA STATISTICAL BASIS		Provider CCN: 150115 HHA CCN: 157222	Period: From 07/01/2011 To 06/30/2012	Worksheet H-1 Part II Date/Time Prepared: 11/27/2012 12:35 pm PPS
			Home Health Agency I	

		Administrative & General (ACCUM. COST)	
		5.00	
GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures		1.00
2.00	Capital Related - Movable Equipment		2.00
3.00	Plant Operation & Maintenance		3.00
4.00	Transportation (see instructions)		4.00
5.00	Administrative and General	595,962	5.00
HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	377,622	6.00
7.00	Physical Therapy	99,405	7.00
8.00	Occupational Therapy	26,055	8.00
9.00	Speech Pathology	3,144	9.00
10.00	Medical Social Services	884	10.00
11.00	Home Health Aide	88,852	11.00
12.00	Supplies (see instructions)	0	12.00
13.00	Drugs	0	13.00
14.00	DME	0	14.00
HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	15.00
16.00	Respiratory Therapy	0	16.00
17.00	Private Duty Nursing	0	17.00
18.00	Clinic	0	18.00
19.00	Health Promoting Activities	0	19.00
20.00	Day Care Program	0	20.00
21.00	Home Delivered Meals Program	0	21.00
22.00	Homemaker Service	0	22.00
23.00	All Others (specify)	0	23.00
24.00	Total (sum of lines 1-23)	595,962	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	363,391	25.00
26.00	Unit Cost Multiplier	0.609755	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150115

Period:

Worksheet H-2

HHA CCN: 157222

From 07/01/2011

Part I

To 06/30/2012

Date/Time Prepared:

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
	0	1.00	2.00	4.00	4A	
1.00 Administrative and General	0	19,224	21,512	67,001	107,737	1.00
2.00 Skilled Nursing Care	607,879	0	0	78,917	686,796	2.00
3.00 Physical Therapy	160,018	0	0	19,943	179,961	3.00
4.00 Occupational Therapy	41,942	0	0	5,287	47,229	4.00
5.00 Speech Pathology	5,061	0	0	662	5,723	5.00
6.00 Medical Social Services	1,423	0	0	195	1,618	6.00
7.00 Home Health Aide	143,030	0	0	15,505	158,535	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	959,353	19,224	21,512	187,510	1,187,599	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000	21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150115

Period:

Worksheet H-2

HHA CCN: 157222

From 07/01/2011
To 06/30/2012

Part I
Date/Time Prepared:

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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
1.00	Administrative and General	22,461	47,377	0	9,125	0	1.00
2.00	Skilled Nursing Care	143,185	0	0	0	0	2.00
3.00	Physical Therapy	37,519	0	0	0	0	3.00
4.00	Occupational Therapy	9,846	0	0	0	0	4.00
5.00	Speech Pathology	1,193	0	0	0	0	5.00
6.00	Medical Social Services	337	0	0	0	0	6.00
7.00	Home Health Aide	33,052	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	247,593	47,377	0	9,125	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150115

Period:

Worksheet H-2

HHA CCN: 157222

From 07/01/2011
To 06/30/2012

Part I
Date/Time Prepared:
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Home Health
Agency I

PPS

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	6,703	0	0	466	0	1.00
2.00	Skilled Nursing Care	7,730	0	0	0	4,344	2.00
3.00	Physical Therapy	1,970	0	0	0	1,533	3.00
4.00	Occupational Therapy	505	0	0	0	374	4.00
5.00	Speech Pathology	57	0	0	0	34	5.00
6.00	Medical Social Services	29	0	0	0	5	6.00
7.00	Home Health Aide	3,164	0	0	0	2,457	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	20,158	0	0	466	8,747	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 150115	Period: From 07/01/2011	Worksheet H-2
		HHA CCN: 157222	To 06/30/2012	Part I
				Date/Time Prepared: 11/27/2012 12:35 pm
			Home Health Agency I	PPS

Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
	24.00	25.00	26.00	27.00	28.00	
1.00 Administrative and General	193,869	0	193,869			1.00
2.00 Skilled Nursing Care	842,055	0	842,055	123,001	965,056	2.00
3.00 Physical Therapy	220,983	0	220,983	32,280	253,263	3.00
4.00 Occupational Therapy	57,954	0	57,954	8,466	66,420	4.00
5.00 Speech Pathology	7,007	0	7,007	1,024	8,031	5.00
6.00 Medical Social Services	1,989	0	1,989	291	2,280	6.00
7.00 Home Health Aide	197,208	0	197,208	28,807	226,015	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	1,521,065	0	1,521,065	193,869	1,521,065	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.146074		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150115
HHA CCN: 157222

Period: From 07/01/2011 To 06/30/2012

Worksheet H-2
Part II
Date/Time Prepared: 11/27/2012 12:35 pm
PPS

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
1.00 Administrative and General	2,579	2,579	286,884	5A	107,737	1.00	
2.00 Skilled Nursing Care	0	0	337,904	0	686,796	2.00	
3.00 Physical Therapy	0	0	85,391	0	179,961	3.00	
4.00 Occupational Therapy	0	0	22,639	0	47,229	4.00	
5.00 Speech Pathology	0	0	2,836	0	5,723	5.00	
6.00 Medical Social Services	0	0	834	0	1,618	6.00	
7.00 Home Health Aide	0	0	66,390	0	158,535	7.00	
8.00 Supplies (see instructions)	0	0	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19)	2,579	2,579	802,878		1,187,599	20.00	
21.00 Total cost to be allocated	19,224	21,512	187,510		247,593	21.00	
22.00 Unit cost multiplier	7.454052	8.341218	0.233547		0.208482	22.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150115
HHA CCN: 157222

Period: From 07/01/2011 To 06/30/2012

Worksheet H-2
Part II
Date/Time Prepared: 11/27/2012 12:35 pm
PPS

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS)	
		6.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	2,579	0	2,579	0	10,330	1.00
2.00	Skilled Nursing Care	0	0	0	0	11,913	2.00
3.00	Physical Therapy	0	0	0	0	3,036	3.00
4.00	Occupational Therapy	0	0	0	0	778	4.00
5.00	Speech Pathology	0	0	0	0	88	5.00
6.00	Medical Social Services	0	0	0	0	45	6.00
7.00	Home Health Aide	0	0	0	0	4,876	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	2,579	0	2,579	0	31,066	20.00
21.00	Total cost to be allocated	47,377	0	9,125	0	20,158	21.00
22.00	Unit cost multiplier	18.370299	0.000000	3.538193	0.000000	0.648877	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150115
HHA CCN: 157222

Period:
From 07/01/2011
To 06/30/2012

Worksheet H-2
Part II
Date/Time Prepared:
11/27/2012 12:35 pm
PPS

Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (REVENUE)		
	13.00	14.00	15.00	16.00		
1.00 Administrative and General	0	0	320	0		1.00
2.00 Skilled Nursing Care	0	0	0	685,000		2.00
3.00 Physical Therapy	0	0	0	241,697		3.00
4.00 Occupational Therapy	0	0	0	58,915		4.00
5.00 Speech Pathology	0	0	0	5,317		5.00
6.00 Medical Social Services	0	0	0	862		6.00
7.00 Home Health Aide	0	0	0	387,405		7.00
8.00 Supplies (see instructions)	0	0	0	0		8.00
9.00 Drugs	0	0	0	0		9.00
10.00 DME	0	0	0	0		10.00
11.00 Home Dialysis Aide Services	0	0	0	0		11.00
12.00 Respiratory Therapy	0	0	0	0		12.00
13.00 Private Duty Nursing	0	0	0	0		13.00
14.00 Clinic	0	0	0	0		14.00
15.00 Health Promotion Activities	0	0	0	0		15.00
16.00 Day Care Program	0	0	0	0		16.00
17.00 Home Delivered Meals Program	0	0	0	0		17.00
18.00 Homemaker Service	0	0	0	0		18.00
19.00 All Others (specify)	0	0	0	0		19.00
20.00 Total (sum of lines 1-19)	0	0	320	1,379,196		20.00
21.00 Total cost to be allocated	0	0	466	8,747		21.00
22.00 Unit cost multiplier	0.000000	0.000000	1.456250	0.006342		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 150115 HHA CCN: 157222		Period: From 07/01/2011 To 06/30/2012		Worksheet H-3 Parts I-III Date/Time Prepared: 11/27/2012 12:35 pm	
		Title XVIII		Home Health Agency I		PPS	
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	
		0	1.00	2.00	3.00	4.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	965,056		965,056	4,767	1.00
2.00	Physical Therapy	3.00	253,263	0	253,263	1,682	2.00
3.00	Occupational Therapy	4.00	66,420	0	66,420	410	3.00
4.00	Speech Pathology	5.00	8,031	0	8,031	37	4.00
5.00	Medical Social Services	6.00	2,280		2,280	6	5.00
6.00	Home Health Aide	7.00	226,015		226,015	2,696	6.00
7.00	Total (sum of lines 1-6)		1,521,065	0	1,521,065	9,598	7.00
				Program Visits			
				Part B			
				Not Subject to Deductibles & Coinsurance		Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	
Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	1,082	994		8.00
9.00	Physical Therapy		99915	794	430		9.00
10.00	Occupational Therapy		99915	143	121		10.00
11.00	Speech Pathology		99915	23	8		11.00
12.00	Medical Social Services		99915	2	0		12.00
13.00	Home Health Aide		99915	576	673		13.00
14.00	Total (sum of lines 8-13)			2,620	2,226		14.00
				Total Charges (from HHA Record)			
		0	1.00	2.00	3.00	4.00	
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	30,933	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	16.00
				HHA Shared Ancillary Costs (col. 1 x col. 2)			
		0	1.00	2.00	3.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy		66.00	0.587745	0	0	1.00
2.00	Occupational Therapy						2.00
3.00	Speech Pathology						3.00
4.00	Cost of Medical Supplies		71.00	0.460284	0	0	4.00
5.00	Cost of Drugs		73.00	0.234612	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150115

Period: From 07/01/2011

Worksheet H-3

HHA CCN: 157222

To 06/30/2012

Parts I-III
Date/Time Prepared: 11/27/2012 12:35 pm

Title XVIII

Home Health Agency I

PPS

Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Part A	Program Visits			
			Not Subject to Deductibles & Coi nsurance	Subject to Deductibles & Coi nsurance		
	5.00	6.00	7.00	8.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
Cost Per Visit Computation						
1.00	Skilled Nursing Care	202.45	1,082	994		1.00
2.00	Physical Therapy	150.57	794	430		2.00
3.00	Occupational Therapy	162.00	143	121		3.00
4.00	Speech Pathology	217.05	23	8		4.00
5.00	Medical Social Services	380.00	2	0		5.00
6.00	Home Health Aide	83.83	576	673		6.00
7.00	Total (sum of lines 1-6)		2,620	2,226		7.00
Cost Center Description						
		5.00	6.00	7.00	8.00	9.00
Limitation Cost Computation						
8.00	Skilled Nursing Care					8.00
9.00	Physical Therapy					9.00
10.00	Occupational Therapy					10.00
11.00	Speech Pathology					11.00
12.00	Medical Social Services					12.00
13.00	Home Health Aide					13.00
14.00	Total (sum of lines 8-13)					14.00
Program Covered Charges						
Cost Center Description	Ratio (col. 3 ÷ col. 4)	Part A	Part B			
			Not Subject to Deductibles & Coi nsurance	Subject to Deductibles & Coi nsurance		
	5.00	6.00	7.00	8.00		
Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	0.000000				15.00
16.00	Cost of Drugs	0.000000		0	0	16.00
Cost Center Description						
			Transfer to Part I as Indicated			
			4.00			
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	col. 2, line 2.00				1.00
2.00	Occupational Therapy					2.00
3.00	Speech Pathology					3.00
4.00	Cost of Medical Supplies	col. 2, line 15.00				4.00
5.00	Cost of Drugs	col. 2, line 16.00				5.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 150115 HHA CCN: 157222		Period: From 07/01/2011 To 06/30/2012		Worksheet H-3 Parts I-III Date/Time Prepared: 11/27/2012 12:35 pm PPS	
		Title XVII I		Home Health Agency I			
Cost Center Description	Cost of Services			Total Program Cost (sum of col.s. 9-10)			
	Part A	Part B					
		Not Subject to Deductibles & Coi nsurance	Subject to Deductibles & Coi nsurance				
9.00	10.00	11.00	12.00				
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	219,051	201,235	420,286	1.00		
2.00	Physical Therapy	119,553	64,745	184,298	2.00		
3.00	Occupational Therapy	23,166	19,602	42,768	3.00		
4.00	Speech Pathology	4,992	1,736	6,728	4.00		
5.00	Medical Social Services	760	0	760	5.00		
6.00	Home Health Aide	48,286	56,418	104,704	6.00		
7.00	Total (sum of lines 1-6)	415,808	343,736	759,544	7.00		
Cost Center Description							
		10.00	11.00	12.00			
Limitation Cost Computation							
8.00	Skilled Nursing Care				8.00		
9.00	Physical Therapy				9.00		
10.00	Occupational Therapy				10.00		
11.00	Speech Pathology				11.00		
12.00	Medical Social Services				12.00		
13.00	Home Health Aide				13.00		
14.00	Total (sum of lines 8-13)				14.00		
Cost of Services							
Cost Center Description	Part A	Part B					
		Not Subject to Deductibles & Coi nsurance	Subject to Deductibles & Coi nsurance				
	9.00	10.00	11.00				
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies				15.00		
16.00	Cost of Drugs		0	0	16.00		

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 150115 HHA CCN: 157222	Period: From 07/01/2011 To 06/30/2012	Worksheet H-4 Part I-II Date/Time Prepared: 11/27/2012 12:35 pm
		Title XVII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount 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(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		383,574	267,213
12.00	Total PPS Reimbursement - Full Episodes with Outliers		2,518	3,507
13.00	Total PPS Reimbursement - LUPA Episodes		8,146	5,869
14.00	Total PPS Reimbursement - PEP Episodes		230	2,100
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		241	1,924
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)			0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		394,709	280,613
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		394,709	280,613
25.00	Coinsurance billed to program patients (from your records)			0
26.00	Net cost (line 24 minus line 25)		394,709	280,613
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		394,709	280,613
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		394,709	280,613
32.00	Interim payments (see instructions)		394,709	280,613
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 32 and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	0

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 150115
HHA CCN: 157222

Period:
From 07/01/2011
To 06/30/2012

Worksheet H-5
Date/Time Prepared:
11/27/2012 12:35 pm
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		394,709		280,613	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			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			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. H-4, Part II, column as appropriate, line 32)		394,709		280,613	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			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)		394,709		280,613	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet L Parts I-III Date/Time Prepared: 11/27/2012 12:35 pm
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,515,180	1.00
2.00	Capital DRG outlier payments		9,283	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		48.16	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)		1,524,463	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

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS		Provider CCN: 150115 Component CCN: 158507		Period: From 07/01/2011 To 06/30/2012		Worksheet M-1 Date/Time Prepared: 11/27/2012 12:35 pm	
		Title XVIII		Rural Health Clinic (RHC) I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	Reclassified	
		1.00	2.00	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	17,209	7,500	24,709	0	24,709	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	108,826	0	108,826	0	108,826	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	39,933	0	39,933	0	39,933	9.00
10.00	Subtotal (sum of lines 1-9)	165,968	7,500	173,468	0	173,468	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	18,272	18,272	0	18,272	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	27,567	52,165	79,732	0	79,732	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	27,567	70,437	98,004	0	98,004	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	193,535	77,937	271,472	0	271,472	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	193,535	77,937	271,472	0	271,472	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 150115 Component CCN: 158507	Period: From 07/01/2011 To 06/30/2012	Worksheet M-1 Date/Time Prepared: 11/27/2012 12:35 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	82	24,791
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	521	109,347
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	0
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	191	40,124
10.00	Subtotal (sum of lines 1-9)	794	174,262
11.00	Physician Services Under Agreement	0	0
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11-13)	0	0
15.00	Medical Supplies	0	18,272
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	-4,230	75,502
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15-20)	-4,230	93,774
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-3,436	268,036
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	0
30.00	Administrative Costs	0	0
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0
32.00	Total facility costs (sum of lines 22, 28 and 31)	-3,436	268,036

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS		Provider CCN: 150115 Component CCN: 158508		Period: From 07/01/2011 To 06/30/2012		Worksheet M-1 Date/Time Prepared: 11/27/2012 12:35 pm	
		Title XVIII		Rural Health Clinic (RHC) II		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	Reclassified	
		1.00	2.00	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	155,654	0	155,654	0	155,654	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	106,296	0	106,296	0	106,296	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	54,379	0	54,379	0	54,379	9.00
10.00	Subtotal (sum of lines 1-9)	316,329	0	316,329	0	316,329	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	22,345	22,345	0	22,345	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	45,618	58,688	104,306	0	104,306	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	45,618	81,033	126,651	0	126,651	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	361,947	81,033	442,980	0	442,980	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	361,947	81,033	442,980	0	442,980	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 150115 Component CCN: 158508	Period: From 07/01/2011 To 06/30/2012	Worksheet M-1 Date/Time Prepared: 11/27/2012 12:35 pm
	Title XVIII	Rural Health Clinic (RHC) II	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	832	156,486
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	568	106,864
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	0
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	291	54,670
10.00	Subtotal (sum of lines 1-9)	1,691	318,020
11.00	Physician Services Under Agreement	0	0
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11-13)	0	0
15.00	Medical Supplies	0	22,345
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	-51,108	53,198
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15-20)	-51,108	75,543
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-49,417	393,563
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	0
30.00	Administrative Costs	0	0
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0
32.00	Total facility costs (sum of lines 22, 28 and 31)	-49,417	393,563

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 150115	Period: From 07/01/2011	Worksheet M-2		
		Component CCN: 158507	To 06/30/2012	Date/Time Prepared: 11/27/2012 12:35 pm		
		Title XVIII	Rural Health Clinic (RHC) I	Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.09	341	4,200	378	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.90	3,317	2,100	1,890	3.00
4.00	Subtotal (sum of lines 1-3)	0.99	3,658		2,268	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	0.99	3,658			8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)				268,036	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				268,036	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)				0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				212,661	15.00
16.00	Total overhead (sum of lines 14 and 15)				212,661	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				212,661	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				212,661	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				480,697	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 150115	Period: From 07/01/2011	Worksheet M-2		
		Component CCN: 158508	To 06/30/2012	Date/Time Prepared: 11/27/2012 12:35 pm		
		Title XVIII	Rural Health Clinic (RHC) II	Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.93	4,167	4,200	3,906	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	1.08	2,579	2,100	2,268	3.00
4.00	Subtotal (sum of lines 1-3)	2.01	6,746		6,174	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	2.01	6,746			8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)				393,563	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				393,563	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)				0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				485,002	15.00
16.00	Total overhead (sum of lines 14 and 15)				485,002	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				485,002	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				485,002	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				878,565	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet M-3
		Component CCN: 158507		Date/Time Prepared: 11/27/2012 12:35 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		480,697	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		118	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		480,579	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		3,658	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		3,658	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		131.38	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27, Sec. 505 or your contractor)	78.07	78.54	8.00
9.00	Rate for Program covered visits (see instructions)	78.07	78.54	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	538	395	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	42,002	31,023	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)	0	0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	42,002	31,023	16.00
16.01	Total program charges (see instructions)(from contractor's records)		114,017	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		47,826	16.04
16.05	Total program cost (see instructions)		47,826	16.05
17.00	Primary payer amounts		303	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		13,243	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		47,523	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		47,523	22.00
23.00	Reimbursable bad debts (see instructions)		0	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		47,523	26.00
27.00	Interim payments		46,160	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		1,363	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 150115	Period: From 07/01/2011 To 06/30/2012	Worksheet M-3	
		Component CCN: 158508		Date/Time Prepared: 11/27/2012 12:35 pm	
		Title XVIIII	Rural Health Clinic (RHC) II	Cost	
				1.00	
DETERMINATION OF RATE FOR RHC/FQHC SERVICES					
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		878,565		1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		147		2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		878,418		3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		6,746		4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0		5.00
6.00	Total adjusted visits (line 4 plus line 5)		6,746		6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		130.21		7.00
			Cal culation of Li mit t (1)		
			Prior to January 1	On on After January 1	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27, Sec. 505 or your contractor)		78.07	78.54	8.00
9.00	Rate for Program covered visits (see instructions)		78.07	78.54	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		1,147	1,198	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		89,546	94,091	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		89,546	94,091	16.00
16.01	Total program charges (see instructions)(from contractor's records)			269,333	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			120,262	16.04
16.05	Total program cost (see instructions)			120,262	16.05
17.00	Primary payer amounts			25	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			33,309	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			120,237	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			120,237	22.00
23.00	Reimbursable bad debts (see instructions)			0	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)			120,237	26.00
27.00	Interim payments			117,396	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)			2,841	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2			0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 150115 Component CCN: 158507	Period: From 07/01/2011 To 06/30/2012	Worksheet M-4 Date/Time Prepared: 11/27/2012 12:35 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	174,262	174,262	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	57	9	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	57	9	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	268,036	268,036	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	212,661	212,661	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000213	0.000034	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	45	7	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	102	16	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	3	39	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	34.00	0.41	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	0	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		118	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		0	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 150115 Component CCN: 158508	Period: From 07/01/2011 To 06/30/2012	Worksheet M-4 Date/Time Prepared: 11/27/2012 12:35 pm
		Title XVIII	Rural Health Clinic (RHC) II	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	318,020	318,020	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	57	9	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	57	9	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	393,563	393,563	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	485,002	485,002	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000145	0.000023	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	70	11	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	127	20	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	13	173	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	9.77	0.12	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	0	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		147	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		0	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 150115 Component CCN: 158507	Period: From 07/01/2011 To 06/30/2012	Worksheet M-5 Date/Time Prepared: 11/27/2012 12:35 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		47,056	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	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			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50		06/29/2012	896	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-896	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		46,160	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			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		1,363	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		47,523	7.00
		Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 150115 Component CCN: 158508	Period: From 07/01/2011 To 06/30/2012	Worksheet M-5 Date/Time Prepared: 11/27/2012 12:35 pm
	Title XVIII	Rural Health Clinic (RHC) II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		119,029	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	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			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50		06/29/2012	1,633	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-1,633	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		117,396	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			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		2,841	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		120,237	7.00
		Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00