

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: 150059	Period: From 01/01/2012 To 12/31/2012 Worksheet S Parts I-III Date/Time Prepared: 5/29/2013 12:26 pm

<b>PART I - COST REPORT STATUS</b>		
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/29/2013 Time: 12:26 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RIVERVIEW HOSPITAL ( 150059 ) for the cost reporting period beginning 01/01/2012 and ending 12/31/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-115,065	-96,504	0	-1,846,318	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	-6,239	0		-176,747	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0	0	0		0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0		0	11.00
12.00 CMHC I	0	0	0		0	12.00
200.00 Total	0	-121,304	-96,504	0	-2,023,065	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: 150059		Period: From 01/01/2012 To 12/31/2012		Worksheet S-2 Part I Date/Time Prepared: 5/29/2013 12:24 pm					
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IN		4.00 Zip Code: 46060- County: HAMILTON					
1.00 Street: 395 WESTFIELD ROAD		2.00 City: NOBLESVILLE		3.00 State: IN		4.00 Zip Code: 46060-		5.00 County: HAMILTON			
		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	RIVERVIEW HOSPITAL	150059	26900	1	07/07/1966	N	P	O	3.00		
4.00 Subprovider - IPF	RIVERVIEW HOSPITAL	15T059	26900	5	01/01/1994	N	P	O	4.00		
5.00 Subprovider - IRF	REHAB								5.00		
6.00 Subprovider - (Other)	RIVERVIEW HOSPITAL SNF	155669	26900		10/26/1999	N	P	N	6.00		
7.00 Swing Beds - SNF									7.00		
8.00 Swing Beds - NF									8.00		
9.00 Hospital-Based SNF									9.00		
10.00 Hospital-Based NF									10.00		
11.00 Hospital-Based OLTC									11.00		
12.00 Hospital-Based HHA									12.00		
13.00 Separately Certified ASC									13.00		
14.00 Hospital-Based Hospice									14.00		
15.00 Hospital-Based Health Clinic - RHC									15.00		
16.00 Hospital-Based Health Clinic - FQHC									16.00		
17.00 Hospital-Based (CMHC) I									17.00		
18.00 Renal Dialysis									18.00		
19.00 Other									19.00		
							From:		To:		
							1.00		2.00		
20.00 Cost Reporting Period (mm/dd/yyyy)							01/01/2012	12/31/2012			
21.00 Type of Control (see instructions)							9				
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			
23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							3	N			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,009	88	0	0	0	1,789	0				
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	124	0	0	0	0	63	0				
							Urban/Rural S	Date of Geogr			
							1.00	2.00			
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.							1				
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.							1				
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				

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

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	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	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00

			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
			1.00	2.00	3.00	

Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
			1.00	2.00	3.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.		0.00	0.00	0.000000	67.00

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		1.00	2.00	3.00		
<b>Inpatient Psychiatric Facility PPS</b>						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N				70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0		71.00
<b>Inpatient Rehabilitation Facility PPS</b>						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y				75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N		0		76.00
				1.00		
<b>Long Term Care Hospital PPS</b>						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
<b>TEFRA Providers</b>						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
				V	XIX	
				1.00	2.00	
<b>Title V and XIX Services</b>						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	97.00
<b>Rural Providers</b>						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	
				1.00	2.00	3.00
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2			118.00

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	558,554	374,002		0
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
<b>Transplant Center Information</b>					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
<b>All Providers</b>					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y		140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:		Contractor's Number:	
142.00	Street:	PO Box:			
143.00	City:	State:		Zip Code:	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.			Y	145.00
			1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150059	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/29/2013 12:24 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
Description		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	03/19/2013	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150059	Period: From 01/01/2012 To 12/31/2012	Worksheet S-2 Part II Date/Time Prepared: 5/29/2013 12:24 pm
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	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	1.00 N	2.00	3.00 N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				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
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				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
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MI CHAEL	ALESSANDRI NI		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.713.7959	MALESSANDRI NI@BLUEANDCO.COM		43.00

		Part B	
		Date	
		4.00	
<b>PS&amp;R Data</b>			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	03/19/2013	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
<b>Cost Report Preparer Contact Information</b>			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150059

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/29/2013 12:24 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Visi ts / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	90	32,940	0.00	0	1.00
2.00 HMO						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		90	32,940	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	15	5,490	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		105	38,430	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	24	8,784		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	25	9,150		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPI CE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		154				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00
Component	I/P Days / O/P Visi ts / Tri ps			Full Time Equival ents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payrol l	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	6,365	1,009	14,918			1.00
2.00 HMO	0	1,874				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	63				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	6,365	1,009	14,918			7.00
8.00 INTENSIVE CARE UNIT	1,498	0	2,974			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	0			13.00
14.00 Total (see instructions)	7,863	1,009	17,892	0.00	950.55	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	3,952	124	5,759	0.00	24.17	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	3,414	0	5,106	0.00	0.00	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPI CE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150059

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/29/2013 12:24 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents							
	Title VIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll						
	6.00	7.00	8.00	9.00	10.00						
27.00	Total (sum of lines 14-26)					0.00	974.72	27.00			
28.00	Observation Bed Days							28.00			
29.00	Ambulance Trips							29.00			
30.00	Employee discount days (see instruction)							30.00			
31.00	Employee discount days - IRF							31.00			
32.00	Labor & delivery days (see instructions)							32.00			
33.00	LTCH non-covered days							33.00			
Component	Full Time Equivalents	Discharges									
	Nonpaid Workers	Title V	Title VIII	Title XIX	Total All Patients						
	11.00	12.00	13.00	14.00	15.00						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)							1.00			
2.00	HMO							2.00			
3.00	HMO IPF Subprovider							3.00			
4.00	HMO IRF Subprovider							4.00			
5.00	Hospital Adults & Peds. Swing Bed SNF							5.00			
6.00	Hospital Adults & Peds. Swing Bed NF							6.00			
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)							7.00			
8.00	INTENSIVE CARE UNIT							8.00			
9.00	CORONARY CARE UNIT							9.00			
10.00	BURN INTENSIVE CARE UNIT							10.00			
11.00	SURGICAL INTENSIVE CARE UNIT							11.00			
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00			
13.00	NURSERY							13.00			
14.00	Total (see instructions)					0.00	0	1,751	176	4,214	14.00
15.00	CAH visits										15.00
16.00	SUBPROVIDER - IPF										16.00
17.00	SUBPROVIDER - IRF					0.00	0	339	9	466	17.00
18.00	SUBPROVIDER										18.00
19.00	SKILLED NURSING FACILITY					0.00					19.00
20.00	NURSING FACILITY										20.00
21.00	OTHER LONG TERM CARE										21.00
22.00	HOME HEALTH AGENCY										22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)										23.00
24.00	HOSPICE										24.00
25.00	CMHC - CMHC										25.00
26.00	RURAL HEALTH CLINIC										26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER										26.25
27.00	Total (sum of lines 14-26)					0.00					27.00
28.00	Observation Bed Days										28.00
29.00	Ambulance Trips										29.00
30.00	Employee discount days (see instruction)										30.00
31.00	Employee discount days - IRF										31.00
32.00	Labor & delivery days (see instructions)										32.00
33.00	LTCH non-covered days										33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150059

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/29/2013 12:24 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	64,420,706	2,406,195	66,826,901	2,025,940.00	32.99
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		24,559,766	67,186	24,626,952	634,191.00	38.83
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract labor (see instructions)		17,494	0	17,494	160.00	109.34
12.00	Contract management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		255,559	0	255,559	2,295.00	111.35
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		9,239,796	0	9,239,796		
18.00	Wage-related costs (other) Wkst S-3, Part IV line 25		0	0	0		
19.00	Excluded areas		3,900,117	0	3,900,117		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FOHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits	4.00	339,663	0	339,663	17,946.00	18.93
27.00	Administrative & General	5.00	7,163,222	0	7,163,222	284,324.00	25.19
28.00	Administrative & General under contract (see inst.)		687,978	0	687,978	8,553.00	80.44
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	1,373,481	0	1,373,481	58,474.00	23.49
31.00	Laundry & Linen Service	8.00	79,430	0	79,430	6,243.00	12.72
32.00	Housekeeping	9.00	899,397	0	899,397	68,276.00	13.17
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	935,430	-678,339	257,091	19,277.00	13.34
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	611,153	611,153	45,826.00	13.34
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	630,809	0	630,809	13,632.00	46.27
39.00	Central Services and Supply	14.00	438,551	214,232	652,783	29,062.00	22.46
40.00	Pharmacy	15.00	1,964,469	0	1,964,469	49,111.00	40.00
41.00	Medical Records & Medical Records Library	16.00	614,823	0	614,823	31,354.00	19.61

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 150059		Period: From 01/01/2012 To 12/31/2012		Worksheet S-3 Part II Date/Time Prepared: 5/29/2013 12:24 pm		
	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
42.00	Soci al Servi ce	17.00	304,517	0	304,517	10,198.00	29.86	42.00
43.00	Other General Servi ce	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150059

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/29/2013 12:24 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	65,108,684	2,406,195	67,514,879	2,034,493.00	33.19	1.00
2.00	Excluded area salaries (see instructions)	24,559,766	67,186	24,626,952	634,191.00	38.83	2.00
3.00	Subtotal salaries (line 1 minus line 2)	40,548,918	2,339,009	42,887,927	1,400,302.00	30.63	3.00
4.00	Subtotal other wages & related costs (see inst.)	273,053	0	273,053	2,455.00	111.22	4.00
5.00	Subtotal wage-related costs (see inst.)	9,239,796	0	9,239,796	0.00	21.54	5.00
6.00	Total (sum of lines 3 thru 5)	50,061,767	2,339,009	52,400,776	1,402,757.00	37.36	6.00
7.00	Total overhead cost (see instructions)	15,431,770	147,046	15,578,816	642,276.00	24.26	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150059	Period: From 01/01/2012 To 12/31/2012	Worksheet S-3 Part IV Date/Time Prepared: 5/29/2013 12:24 pm
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions			879,051 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration Fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)			4,522,244 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			101,498 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			21,633 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)			137,300 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			99,258 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			0 16.00
<b>TAXES</b>				
17.00	FICA-Employers Portion Only			3,359,703 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			67,949 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			52,366 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			9,241,002 24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			3,898,912 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150059

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

Worksheet S-3  
Part V  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 150059

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

Worksheet S-7

Date/Time Prepared:  
5/29/2013 12:24 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.				2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	28	0	28 3.00
4.00		RUL	80	0	80 4.00
5.00		RVX	0	0	0 5.00
6.00		RVL	0	0	0 6.00
7.00		RHX	12	0	12 7.00
8.00		RHL	26	0	26 8.00
9.00		RMX	0	0	0 9.00
10.00		RML	8	0	8 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	246	0	246 12.00
13.00		RUB	1,041	0	1,041 13.00
14.00		RUA	653	0	653 14.00
15.00		RVC	224	0	224 15.00
16.00		RVB	471	0	471 16.00
17.00		RVA	322	0	322 17.00
18.00		RHC	13	0	13 18.00
19.00		RHB	50	0	50 19.00
20.00		RHA	27	0	27 20.00
21.00		RMC	12	0	12 21.00
22.00		RMB	56	0	56 22.00
23.00		RMA	66	0	66 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	2	0	2 28.00
29.00		HE2	0	0	0 29.00
30.00		HE1	3	0	3 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	0	0	0 32.00
33.00		HC2	0	0	0 33.00
34.00		HC1	2	0	2 34.00
35.00		HB2	5	0	5 35.00
36.00		HB1	7	0	7 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	0	0	0 40.00
41.00		LC2	0	0	0 41.00
42.00		LC1	0	0	0 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	5	0	5 44.00
45.00		CE2	4	0	4 45.00
46.00		CE1	0	0	0 46.00
47.00		CD2	2	0	2 47.00
48.00		CD1	1	0	1 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	8	0	8 50.00
51.00		CB2	1	0	1 51.00
52.00		CB1	4	0	4 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	3	0	3 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	1	0	1 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: 150059

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

Worksheet S-7

Date/Time Prepared:  
5/29/2013 12:24 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	2	0	2	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	3	0	3	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	5	0	5	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	21	0	21	199.00
200.00	TOTAL		3,414	0	3,414	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
SNF SERVICES						
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).			26900		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)			2,479,572		207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150059	Period: From 01/01/2012 To 12/31/2012	Worksheet S-10 Date/Time Prepared: 5/29/2013 12:24 pm
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			1.00		
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.323675	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		4,891,458	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		Y	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		14,126,205	6.00	
7.00	Medicaid cost (line 1 times line 6)		4,572,299	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00	
			1.00		
			2.00		
			3.00		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	7,728,639	0	7,728,639	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	2,501,567	0	2,501,567	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)	2,501,567	0	2,501,567	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)		13,765,047	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		164,966	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		13,600,081	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		4,402,006	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		6,903,573	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		6,903,573	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 150059	Period: From 01/01/2012 To 12/31/2012	Worksheet A Date/Time Prepared: 5/29/2013 12:24 pm	
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		11,934,581		11,877,396	1.00
4.00	00400	EMPLOYEE BENEFITS	339,663	5,523,066	5,862,729	6,262,734	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,163,222	19,202,796	26,366,018	25,593,601	5.00
7.00	00700	OPERATION OF PLANT	1,373,481	4,317,797	5,691,278	5,691,278	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	79,430	338,238	417,668	417,668	8.00
9.00	00900	HOUSEKEEPING	899,397	343,708	1,243,105	1,243,105	9.00
10.00	01000	DIETARY	935,430	1,638,883	2,574,313	707,518	10.00
11.00	01100	CAFETERIA	0	0	0	1,681,899	11.00
13.00	01300	NURSING ADMINISTRATION	630,809	82,157	712,966	712,966	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	438,551	11,030,636	11,469,187	12,039,307	14.00
15.00	01500	PHARMACY	1,964,469	5,024,836	6,989,305	6,989,305	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	614,823	774,162	1,388,985	1,388,985	16.00
17.00	01700	SOCIAL SERVICE	304,517	25,719	330,236	330,236	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	6,682,839	882,673	7,565,512	8,061,512	30.00
31.00	03100	INTENSIVE CARE UNIT	1,767,652	217,302	1,984,954	1,984,954	31.00
41.00	04100	SUBPROVIDER - IIRF	1,209,811	928,459	2,138,270	2,138,270	41.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,945,951	1,945,951	1,916,348	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	1,999,530	5,377,115	7,376,645	6,793,283	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,664,259	812,221	2,476,480	2,490,580	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	416,937	398,745	815,682	814,727	55.00
57.00	05700	CT SCAN	258,174	46,730	304,904	304,904	57.00
57.01	03630	ULTRA SOUND	159,512	32,744	192,256	192,256	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	199,917	31,142	231,059	231,059	58.00
59.00	05900	CARDIAC CATHETERIZATION	793,438	247,959	1,041,397	1,130,565	59.00
60.00	06000	LABORATORY	2,157,950	2,894,041	5,051,991	5,108,658	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	695,259	695,259	695,259	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	990,852	155,907	1,146,759	1,146,759	65.00
66.00	06600	PHYSICAL THERAPY	3,822,441	1,415,854	5,238,295	5,238,295	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	650,287	84,896	735,183	841,111	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,338,135	1,338,135	1,338,135	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	281,628	281,628	281,628	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	76.00
76.01	03021	CARDIAC REHAB	457,649	107,061	564,710	564,710	76.01
76.02	03022	WOMEN'S CENTER	338,966	57,198	396,164	396,164	76.02
76.03	03330	ENDOSCOPY	575,287	119,862	695,149	695,149	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	OUTPATIENT	263,223	36,482	299,705	313,455	90.01
91.00	09100	EMERGENCY	1,918,235	790,574	2,708,809	2,725,976	91.00
91.01	09101	SHORT STAY	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	45,253	52,882	98,135	90,621	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	41,116,004	79,187,399	120,303,403	120,430,376	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	88,688	116,033	204,721	204,721	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	20,905,944	12,560,222	33,466,166	33,200,457	192.00
192.01	19201	FOUNDATION	170,768	12,158	182,926	182,926	192.01
192.02	19202	CLINICS	1,265,404	737,913	2,003,317	1,957,157	192.02
192.05	19203	PRACTICE MANAGEMENT	467,153	286,588	753,741	753,741	192.05
192.06	19204	MOB - NOBLEVILLE SQUARE	0	335,883	335,883	335,883	192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	0	148,161	148,161	148,161	192.08
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	WORKMED	406,745	140,063	546,808	546,808	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	184,896	194.01
200.00		TOTAL (SUM OF LINES 118-199)	64,420,706	93,524,420	157,945,126	157,945,126	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150059

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

Worksheet A  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-486	11,876,910	1.00
4.00	00400 EMPLOYEE BENEFITS	-126,872	6,135,862	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-12,097,569	13,496,032	5.00
7.00	00700 OPERATION OF PLANT	0	5,691,278	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	417,668	8.00
9.00	00900 HOUSEKEEPING	0	1,243,105	9.00
10.00	01000 DIETARY	0	707,518	10.00
11.00	01100 CAFETERIA	-636,261	1,045,638	11.00
13.00	01300 NURSING ADMINISTRATION	0	712,966	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	12,039,307	14.00
15.00	01500 PHARMACY	-6,075	6,983,230	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-8,898	1,380,087	16.00
17.00	01700 SOCIAL SERVICE	0	330,236	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS	-496,000	7,565,512	30.00
31.00	03100 INTENSIVE CARE UNIT	0	1,984,954	31.00
41.00	04100 SUBPROVIDER - IRF	0	2,138,270	41.00
43.00	04300 NURSERY	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	-331,992	1,584,356	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	-2,507,385	4,285,898	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-473	2,490,107	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	814,727	55.00
57.00	05700 CT SCAN	0	304,904	57.00
57.01	03630 ULTRA SOUND	0	192,256	57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	231,059	58.00
59.00	05900 CARDIAC CATHETERIZATION	-170,511	960,054	59.00
60.00	06000 LABORATORY	-25,999	5,082,659	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	695,259	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	1,146,759	65.00
66.00	06600 PHYSICAL THERAPY	0	5,238,295	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	-84,639	756,472	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	1,338,135	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	281,628	74.00
76.00	03020 OTHER ANCILLARY	0	0	76.00
76.01	03021 CARDIAC REHAB	0	564,710	76.01
76.02	03022 WOMEN'S CENTER	0	396,164	76.02
76.03	03330 ENDOSCOPY	0	695,149	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0	0	90.00
90.01	09001 OUTPATIENT	-1,442	312,013	90.01
91.00	09100 EMERGENCY	0	2,725,976	91.00
91.01	09101 SHORT STAY	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	-4,950	85,671	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00	SUBTOTALS (SUM OF LINES 1-117)	-16,499,552	103,930,824	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	204,721	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	33,200,457	192.00
192.01	19201 FOUNDATION	0	182,926	192.01
192.02	19202 CLINICS	0	1,957,157	192.02
192.05	19203 PRACTICE MANAGEMENT	0	753,741	192.05
192.06	19204 MOB - NOBLESVILLE SQUARE	0	335,883	192.06
192.08	19205 RIVERVIEW MEDICAL ARTS	0	148,161	192.08
193.00	19300 NONPAID WORKERS	0	0	193.00
194.00	07950 WORKMED	0	546,808	194.00
194.01	07951 MEALS ON WHEELS	0	184,896	194.01
200.00	TOTAL (SUM OF LINES 118-199)	-16,499,552	141,445,574	200.00

RECLASSIFICATIONS

Provider CCN: 150059

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

Worksheet A-6

Date/Time Prepared:  
5/29/2013 12:24 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - CAFETERIA RECLASS</b>					
1.00	CAFETERIA	11.00	611,153	1,070,746	1.00
	TOTALS		611,153	1,070,746	
<b>B - MEALS ON WHEELS RECLASS</b>					
1.00	MEALS ON WHEELS	194.01	67,186	117,710	1.00
	TOTALS		67,186	117,710	
<b>C - INSURANCE RECLASS</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	57,185	1.00
	TOTALS		0	57,185	
<b>D - MED SUPPLY RECLASS</b>					
1.00	CENTRAL SERVICES & SUPPLY	14.00		355,888	1.00
2.00		0.00		0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	TOTALS		0	355,888	
<b>E - RSMA RECLASS</b>					
1.00	EMPLOYEE BENEFITS	4.00	0	400,005	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	214,232	0	2.00
3.00	OPERATING ROOM	50.00	2,191,963	0	3.00
	TOTALS		2,406,195	400,005	
<b>F - PHYSICIAN PROFESSIONAL FEES</b>					
1.00	ADULTS & PEDIATRICS	30.00	0	496,000	1.00
2.00	OPERATING ROOM	50.00	0	30,875	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	14,100	3.00
4.00	CARDIAC CATHETERIZATION	59.00	0	89,168	4.00
5.00	LABORATORY	60.00	0	56,667	5.00
6.00	ELECTROCARDIOLOGY	69.00	0	111,875	6.00
7.00	OUTPATIENT	90.01	0	13,750	7.00
8.00	EMERGENCY	91.00	0	17,167	8.00
	TOTALS		0	829,602	
500.00	Grand Total: Increases		3,084,534	2,831,136	500.00

RECLASSIFICATIONS

Provider CCN: 150059

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

Worksheet A-6

Date/Time Prepared:  
5/29/2013 12:24 pm

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
<b>A - CAFETERIA RECLASS</b>						
1.00	DIETARY	10.00	611,153	1,070,746	0	1.00
	TOTALS		611,153	1,070,746		
<b>B - MEALS ON WHEELS RECLASS</b>						
1.00	DIETARY	10.00	67,186	117,710	0	1.00
	TOTALS		67,186	117,710		
<b>C - INSURANCE RECLASS</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	57,185	12	1.00
	TOTALS		0	57,185		
<b>D - MED SUPPLY RECLASS</b>						
1.00	SKILLED NURSING FACILITY	44.00		29,603	0	1.00
2.00	RADIOLOGY-THERAPEUTIC	55.00		955	0	2.00
3.00	ELECTROCARDIOLOGY	69.00		5,947	0	3.00
4.00	AMBULANCE SERVICES	95.00		7,514	0	4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00		265,709	0	5.00
6.00	CLINICS	192.02		46,160	0	6.00
	TOTALS		0	355,888		
<b>E - RSMA RECLASS</b>						
1.00	OPERATING ROOM	50.00	0	400,005	0	1.00
2.00	OPERATING ROOM	50.00	0	214,232	0	2.00
3.00	OPERATING ROOM	50.00	0	2,191,963	0	3.00
	TOTALS		0	2,806,200		
<b>F - PHYSICIAN PROFESSIONAL FEES</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	829,602	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
	TOTALS		0	829,602		
500.00	Grand Total: Decreases		678,339	5,237,331		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150059

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/29/2013 12:24 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	10,915,010	0	0	0	1,100,400	1.00
2.00	Land Improvements	2,261,019	157,375	0	157,375	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	91,438,373	5,244,566	0	5,244,566	125,476	4.00
5.00	Fixed Equipment	32,913,644	709,376	0	709,376	118,709	5.00
6.00	Movable Equipment	64,083,946	6,694,727	0	6,694,727	3,847,734	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	201,611,992	12,806,044	0	12,806,044	5,192,319	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	201,611,992	12,806,044	0	12,806,044	5,192,319	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	9,814,610	0				1.00
2.00	Land Improvements	2,418,394	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	96,557,463	0				4.00
5.00	Fixed Equipment	33,504,311	0				5.00
6.00	Movable Equipment	66,930,939	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	209,225,717	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	209,225,717	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150059

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	9,643,418	0	2,088,201	202,962	0	1.00
3.00	Total (sum of lines 1-2)	9,643,418	0	2,088,201	202,962	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	11,934,581			1.00	
3.00	Total (sum of lines 1-2)	0	11,934,581			3.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150059

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	9,643,418	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	9,643,418	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,087,715	145,777	0	0	11,876,910	1.00
3.00	Total (sum of lines 1-2)	2,087,715	145,777	0	0	11,876,910	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150059

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

Worksheet A-8

Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	*** Cost Center Deleted ***	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0			0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0			0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0			0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0			0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0			0	7.00
8.00 Television and radio service (chapter 21)			0			0	8.00
9.00 Parking lot (chapter 21)			0			0	9.00
10.00 Provider-based physician adjustment	A-8-2	-2,583,947				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0			0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-195,331				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-636,261	0	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts			0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0	*** Cost Center Deleted ***	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 OTHER REVENUES ->HOSPITAL OUTPATIENT	B	-2,185	0	ADMINISTRATIVE & GENERAL	5.00	0	33.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
33.01 OTHER REV MEDICAL REPORT	B	-8,898	MEDICAL RECORDS & LIBRARY		16.00	0 33.01
33.02 OTHER REV RADIOLOGY FILM	B	-209	RADIOLOGY-DIAGNOSTIC		54.00	0 33.02
33.03 OTHER REVENUES-OTHER REV-FITNESS	B	-6,081	ADMINISTRATIVE & GENERAL		5.00	0 33.03
33.04 OTHER REVENUES ->PURCHASE DISCOUNTS	B	-22,210	ADMINISTRATIVE & GENERAL		5.00	0 33.04
33.05 OTHER REV ->VHA DIVIDENDS: OTHER	B	-67,973	ADMINISTRATIVE & GENERAL		5.00	0 33.05
34.00		0			0.00	0 34.00
35.00 NON-OPERATING REV --> MISC. INCOME	B	-15	ADMINISTRATIVE & GENERAL		5.00	0 35.00
36.00 NON-OP EXPENSE INVESTMENT FEES	B	140,131	ADMINISTRATIVE & GENERAL		5.00	0 36.00
37.00 PHARMACY -> OTHER REVENUE	B	-6,075	PHARMACY		15.00	0 37.00
38.00 RADIOLOGY-OTHER REVENUE-CDS FOR LEGAL	B	-154	RADIOLOGY-DIAGNOSTIC		54.00	0 38.00
39.00 AMBULANCE ->OTHER REVENUE	B	-4,950	AMBULANCE SERVICES		95.00	0 39.00
40.00 LABORATORY -> OTHER REVENUE	B	-25,999	LABORATORY		60.00	0 40.00
41.00 EMPLOYEE WELLNESS- OTHER REVENUE	B	-6,967	EMPLOYEE BENEFITS		4.00	0 41.00
42.00 PR/MARKETING- OTHER REVENUE	B	-1,159	ADMINISTRATIVE & GENERAL		5.00	0 42.00
43.00 PHYSICIAN BILLING -> OTHER REVENUE	B	-2,819	ADMINISTRATIVE & GENERAL		5.00	0 43.00
44.00 PHYSICIANS' BILLING -> BILLING FEES	B	-1,833,075	ADMINISTRATIVE & GENERAL		5.00	0 44.00
45.00 ORG IMPROVEMENT ->OTHER REVENUE	B	-4,393	ADMINISTRATIVE & GENERAL		5.00	0 45.00
45.01 205 CONNER STREET- > RENTAL INCOME	B	-21,072	ADMINISTRATIVE & GENERAL		5.00	0 45.01
45.02 MISCELLANEOUS INTEREST INCOME	B	-23,304	ADMINISTRATIVE & GENERAL		5.00	0 45.02
45.03 INTEREST INCOME - BOND FUNDS	B	-486	NEW CAP REL COSTS-BLDG & FIXT		1.00	11 45.03
45.04		0			0.00	0 45.04
45.05 RENTAL INCOME - INFECTIOUS DISEASES	B	-300	OUTPATIENT		90.01	0 45.05
45.06 RENTAL INCOME - TCU	B	-110,403	SKILLED NURSING FACILITY		44.00	0 45.06
45.07 COMMUNITY RELATIONS	B	-1,461,552	ADMINISTRATIVE & GENERAL		5.00	0 45.07
45.08 COMMUNITY RELATIONS BENEFITS	B	-26,050	EMPLOYEE BENEFITS		4.00	0 45.08
45.09 CRNA	B	-703,271	OPERATING ROOM		50.00	0 45.09
45.10 CRNA BENEFITS	B	-93,855	EMPLOYEE BENEFITS		4.00	0 45.10
45.11 PHYSICIAN RECRUITMENT	B	-5,334	ADMINISTRATIVE & GENERAL		5.00	0 45.11
45.12 IHA LOBBYING EXPENSE	A	-3,109	ADMINISTRATIVE & GENERAL		5.00	0 45.12
45.13 HAF EXPENSE	A	-8,782,246	ADMINISTRATIVE & GENERAL		5.00	0 45.13
45.14		0			0.00	0 45.14
45.15		0			0.00	0 45.15
45.16		0			0.00	0 45.16
45.18		0			0.00	0 45.18
45.19		0			0.00	0 45.19
45.20		0			0.00	0 45.20
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-16,499,552				50.00

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

Provider CCN: 150059

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

Worksheet A-8-1

Date/Time Prepared:  
5/29/2013 12:24 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	50.00	OPERATING ROOM	2,827,445	3,022,776	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	0	2,827,445	3,022,776	5.00

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

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
1.00	2.00	3.00	Name	Percentage of Ownership
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

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

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

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

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

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

Provider CCN: 150059

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

Worksheet A-8-1

Date/Time Prepared:  
5/29/2013 12:24 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	-195,331	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-195,331			5.00

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150059

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

Worksheet A-8-2

Date/Time Prepared:  
5/29/2013 12:24 pm

Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours
1.00	2.00	3.00	4.00	5.00	6.00	7.00
1.00	5.00 ADMINISTRATIVE & GENERAL	1,173	1,173	0	0	0
2.00	50.00 OPERATING ROOM	2,160	2,160	0	0	0
3.00	54.00 RADIOLOGY-DIAGNOSTIC	110	110	0	0	0
4.00	30.00 ADULTS & PEDIATRICS	496,000	496,000	0	0	0
5.00	59.00 CARDIAC CATHETERIZATION	47,168	47,168	0	0	0
6.00	50.00 OPERATING ROOM	30,875	30,875	0	0	0
7.00	54.00 RADIOLOGY-DIAGNOSTIC	14,100	0	14,100	225,300	176
8.00	59.00 CARDIAC CATHETERIZATION	42,000	0	42,000	177,200	219
9.00	60.00 LABORATORY	56,667	0	56,667	215,700	839
10.00	69.00 ELECTROCARDIOLOGY	105,000	0	105,000	177,200	239
11.00	69.00 ELECTROCARDIOLOGY	6,875	0	6,875	177,200	116
12.00	90.01 OUTPATIENT	13,750	0	13,750	177,200	148
13.00	91.00 EMERGENCY	17,167	0	17,167	177,200	558
14.00	50.00 OPERATING ROOM	1,575,748	1,575,748	0	0	0
15.00	59.00 CARDIAC CATHETERIZATION	100,000	100,000	0	0	0
16.00	44.00 SKILLED NURSING FACILITY	273,727	0	273,727	177,200	612
200.00		2,782,520	2,253,234	529,286		2,907

Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance
1.00	2.00	8.00	9.00	12.00	13.00	14.00
1.00	5.00 ADMINISTRATIVE & GENERAL	0	0	0	0	0
2.00	50.00 OPERATING ROOM	0	0	0	0	0
3.00	54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
4.00	30.00 ADULTS & PEDIATRICS	0	0	0	0	0
5.00	59.00 CARDIAC CATHETERIZATION	0	0	0	0	0
6.00	50.00 OPERATING ROOM	0	0	0	0	0
7.00	54.00 RADIOLOGY-DIAGNOSTIC	19,064	953	0	0	0
8.00	59.00 CARDIAC CATHETERIZATION	18,657	933	0	0	0
9.00	60.00 LABORATORY	87,006	4,350	0	0	0
10.00	69.00 ELECTROCARDIOLOGY	20,361	1,018	0	0	0
11.00	69.00 ELECTROCARDIOLOGY	9,882	494	0	0	0
12.00	90.01 OUTPATIENT	12,608	630	0	0	0
13.00	91.00 EMERGENCY	47,537	2,377	0	0	0
14.00	50.00 OPERATING ROOM	0	0	0	0	0
15.00	59.00 CARDIAC CATHETERIZATION	0	0	0	0	0
16.00	44.00 SKILLED NURSING FACILITY	52,138	2,607	0	0	0
200.00		267,253	13,362	0	0	0

Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment
1.00	2.00	15.00	16.00	17.00	18.00
1.00	5.00 ADMINISTRATIVE & GENERAL	0	0	0	1,173
2.00	50.00 OPERATING ROOM	0	0	0	2,160
3.00	54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	110
4.00	30.00 ADULTS & PEDIATRICS	0	0	0	496,000
5.00	59.00 CARDIAC CATHETERIZATION	0	0	0	47,168
6.00	50.00 OPERATING ROOM	0	0	0	30,875
7.00	54.00 RADIOLOGY-DIAGNOSTIC	0	19,064	0	0
8.00	59.00 CARDIAC CATHETERIZATION	0	18,657	23,343	23,343
9.00	60.00 LABORATORY	0	87,006	0	0
10.00	69.00 ELECTROCARDIOLOGY	0	20,361	84,639	84,639
11.00	69.00 ELECTROCARDIOLOGY	0	9,882	0	0
12.00	90.01 OUTPATIENT	0	12,608	1,142	1,142
13.00	91.00 EMERGENCY	0	47,537	0	0
14.00	50.00 OPERATING ROOM	0	0	0	1,575,748
15.00	59.00 CARDIAC CATHETERIZATION	0	0	0	100,000
16.00	44.00 SKILLED NURSING FACILITY	0	52,138	221,589	221,589
200.00		0	267,253	330,713	2,583,947

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150059

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL		
		NEW BLDG & FIXT					
	0	1.00	4.00	4A	5.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	11,876,910	11,876,910				1.00	
4.00 00400 EMPLOYEE BENEFITS	6,135,862	60,367	6,196,229			4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	13,496,032	894,619	667,569	15,058,220	15,058,220	5.00	
7.00 00700 OPERATION OF PLANT	5,691,278	4,682,140	128,000	10,501,418	1,251,170	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	417,668	48,722	7,402	473,792	56,449	8.00	
9.00 00900 HOUSEKEEPING	1,243,105	27,918	83,818	1,354,841	161,420	9.00	
10.00 01000 DIETARY	707,518	79,053	23,959	810,530	96,569	10.00	
11.00 01100 CAFETERIA	1,045,638	146,805	56,956	1,249,399	148,857	11.00	
13.00 01300 NURSING ADMINISTRATION	712,966	0	58,788	771,754	91,949	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	12,039,307	91,707	60,835	12,191,849	1,452,573	14.00	
15.00 01500 PHARMACY	6,983,230	80,308	183,077	7,246,615	863,383	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	1,380,087	81,835	57,298	1,519,220	181,004	16.00	
17.00 01700 SOCIAL SERVICE	330,236	0	28,379	358,615	42,726	17.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	7,565,512	1,953,007	622,800	10,141,319	1,208,267	30.00	
31.00 03100 INTENSIVE CARE UNIT	1,984,954	136,515	164,735	2,286,204	272,385	31.00	
41.00 04100 SUBPROVIDER - IIRF	2,138,270	330,220	112,747	2,581,237	307,536	41.00	
43.00 04300 NURSERY	0	0	0	0	0	43.00	
44.00 04400 SKILLED NURSING FACILITY	1,584,356	227,852	0	1,812,208	215,912	44.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	4,285,898	766,795	390,622	5,443,315	648,533	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,490,107	345,681	155,099	2,990,887	356,343	54.00	
55.00 05500 RADIOLOGY-THERAPEUTIC	814,727	174,822	38,856	1,028,405	122,527	55.00	
57.00 05700 CT SCAN	304,904	0	24,060	328,964	39,194	57.00	
57.01 03630 ULTRA SOUND	192,256	0	14,866	207,122	24,677	57.01	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	231,059	0	18,631	249,690	29,749	58.00	
59.00 05900 CARDIAC CATHETERIZATION	960,054	70,879	73,944	1,104,877	131,638	59.00	
60.00 06000 LABORATORY	5,082,659	189,619	201,108	5,473,386	652,116	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	695,259	90,205	0	785,464	93,583	63.00	
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00 06500 RESPIRATORY THERAPY	1,146,759	36,043	92,341	1,275,143	151,924	65.00	
66.00 06600 PHYSICAL THERAPY	5,238,295	0	356,229	5,594,524	666,548	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	756,472	451,520	60,603	1,268,595	151,144	69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1,338,135	0	0	1,338,135	159,429	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
74.00 07400 RENAL DIALYSIS	281,628	13,073	0	294,701	35,112	74.00	
76.00 03020 OTHER ANCILLARY	0	0	0	0	0	76.00	
76.01 03021 CARDIAC REHAB	564,710	0	42,650	607,360	72,363	76.01	
76.02 03022 WOMEN'S CENTER	396,164	200,328	31,590	628,082	74,832	76.02	
76.03 03330 ENDOSCOPY	695,149	174,158	53,613	922,920	109,959	76.03	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	0	0	0	0	0	90.00	
90.01 09001 OUTPATIENT	312,013	26,884	24,531	363,428	43,300	90.01	
91.00 09100 EMERGENCY	2,725,976	393,861	178,768	3,298,605	393,006	91.00	
91.01 09101 SHORT STAY	0	0	0	0	0	91.01	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00 09500 AMBULANCE SERVICES	85,671	0	4,217	89,888	10,710	95.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	103,930,824	11,774,936	4,018,091	101,650,712	10,316,887	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	204,721	101,974	8,265	314,960	37,525	190.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	33,200,457	0	1,948,327	35,148,784	4,187,785	192.00	
192.01 19201 FOUNDATION	182,926	0	15,915	198,841	23,691	192.01	
192.02 19202 CLINICS	1,957,157	0	117,928	2,075,085	247,232	192.02	
192.05 19203 PRACTICE MANAGEMENT	753,741	0	43,536	797,277	94,990	192.05	
192.06 19204 MOB - NOBLESVILLE SQUARE	335,883	0	0	335,883	40,018	192.06	
192.08 19205 RIVERVIEW MEDICAL ARTS	148,161	0	0	148,161	17,652	192.08	
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00	
194.00 07950 WORKMED	546,808	0	37,906	584,714	69,665	194.00	
194.01 07951 MEALS ON WHEELS	184,896	0	6,261	191,157	22,775	194.01	
200.00	Cross Foot Adjustments				0	200.00	
201.00	Negative Cost Centers				0	201.00	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150059

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

Worksheet B Part I Date/Time Prepared: 5/29/2013 12:24 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
202.00	TOTAL (sum lines 118-201)	141,445,574	11,876,910	6,196,229	141,445,574	15,058,220	202.00
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	11,752,588					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	91,767	622,008				8.00
9.00	00900 HOUSEKEEPING	52,584	0	1,568,845			9.00
10.00	01000 DIETARY	148,895	0	4,399	1,060,393		10.00
11.00	01100 CAFETERIA	276,507	0	30,790	0	1,705,553	11.00
13.00	01300 NURSING ADMINISTRATION	0	0	0	0	23,883	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	172,730	4,675	43,986	0	50,915	14.00
15.00	01500 PHARMACY	151,260	0	14,662	0	86,040	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	154,135	0	7,331	0	54,931	16.00
17.00	01700 SOCIAL SERVICE	0	0	0	0	17,866	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	3,678,478	194,964	510,241	530,926	229,080	30.00
31.00	03100 INTENSIVE CARE UNIT	257,124	45,452	67,446	79,493	93,828	31.00
41.00	04100 SUBPROVIDER - I/R	621,967	48,597	98,236	244,545	88,062	41.00
43.00	04300 NURSERY	0	0	0	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	429,158	45,112	86,506	205,429	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	1,444,254	32,625	221,398	0	150,378	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	651,087	36,424	64,513	0	105,414	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	329,276	5,032	14,662	0	22,057	55.00
57.00	05700 CT SCAN	0	0	0	0	15,119	57.00
57.01	03630 ULTRA SOUND	0	0	0	0	5,806	57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	5,865	0	10,193	58.00
59.00	05900 CARDIAC CATHETERIZATION	133,500	16,049	0	0	36,807	59.00
60.00	06000 LABORATORY	357,145	0	27,858	0	153,698	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	169,901	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	67,886	0	10,263	0	53,218	65.00
66.00	06600 PHYSICAL THERAPY	0	5,245	0	0	219,808	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	850,434	5,338	46,919	0	34,181	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	24,623	0	0	0	0	74.00
76.00	03020 OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03021 CARDIAC REHAB	0	459	52,784	0	27,026	76.01
76.02	03022 WOMEN'S CENTER	377,316	3,103	14,662	0	24,357	76.02
76.03	03330 ENDOSCOPY	328,024	27,745	29,324	0	29,584	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 OUTPATIENT	50,637	16,899	11,730	0	14,366	90.01
91.00	09100 EMERGENCY	741,834	83,958	131,959	0	103,129	91.00
91.01	09101 SHORT STAY	0	0	0	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	3,264	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	11,560,522	571,677	1,495,534	1,060,393	1,653,010	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	192,066	0	5,865	0	7,402	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	49,064	0	0	0	192.00
192.01	19201 FOUNDATION	0	0	0	0	11,463	192.01
192.02	19202 CLINICS	0	544	67,446	0	0	192.02
192.05	19203 PRACTICE MANAGEMENT	0	204	0	0	0	192.05
192.06	19204 MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.08	19205 RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150059

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
194.00	07950	WORKMED	0	519	0	0	24,852	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	8,826	194.01
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)	11,752,588	622,008	1,568,845	1,060,393	1,705,553	202.00
Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	887,586					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	13,916,728				14.00
15.00	01500	PHARMACY	0	0	8,361,960			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,916,621		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	419,207	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	395,505	0	0	538,706	322,391	30.00
31.00	03100	INTENSIVE CARE UNIT	161,992	0	0	102,611	31,026	31.00
41.00	04100	SUBPROVIDER - IIRF	152,038	0	0	0	32,860	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	10,994	32,930	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	487,401	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	18,323	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	36,647	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	54,970	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	238,203	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	62,299	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,916,728	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	8,361,960	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03021	CARDIAC REHAB	0	0	0	0	0	76.01
76.02	03022	WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	178,051	0	0	362,802	0	91.00
91.01	09101	SHORT STAY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	887,586	13,916,728	8,361,960	1,912,956	419,207	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	0	192.01
192.02	19202	CLINICS	0	0	0	3,665	0	192.02
192.05	19203	PRACTICE MANAGEMENT	0	0	0	0	0	192.05
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150059

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE
			13.00	14.00	15.00	16.00	17.00
194.00	07950	WORKMED	0	0	0	0	0
194.01	07951	MEALS ON WHEELS	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	887,586	13,916,728	8,361,960	1,916,621	419,207
Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	17,749,877	0	17,749,877		30.00
31.00	03100	INTENSIVE CARE UNIT	3,397,561	0	3,397,561		31.00
41.00	04100	SUBPROVIDER - IRF	4,175,078	0	4,175,078		41.00
43.00	04300	NURSERY	0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	2,838,249	0	2,838,249		44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	8,427,904	0	8,427,904		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,222,991	0	4,222,991		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,558,606	0	1,558,606		55.00
57.00	05700	CT SCAN	383,277	0	383,277		57.00
57.01	03630	ULTRA SOUND	237,605	0	237,605		57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	295,497	0	295,497		58.00
59.00	05900	CARDIAC CATHETERIZATION	1,422,871	0	1,422,871		59.00
60.00	06000	LABORATORY	6,719,173	0	6,719,173		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,048,948	0	1,048,948		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	1,558,434	0	1,558,434		65.00
66.00	06600	PHYSICAL THERAPY	6,724,328	0	6,724,328		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	2,418,910	0	2,418,910		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,916,728	0	13,916,728		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,497,564	0	1,497,564		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,361,960	0	8,361,960		73.00
74.00	07400	RENAL DIALYSIS	354,436	0	354,436		74.00
76.00	03020	OTHER ANCILLARY	0	0	0		76.00
76.01	03021	CARDIAC REHAB	759,992	0	759,992		76.01
76.02	03022	WOMEN'S CENTER	1,122,352	0	1,122,352		76.02
76.03	03330	ENDOSCOPY	1,447,556	0	1,447,556		76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	OUTPATIENT	500,360	0	500,360		90.01
91.00	09100	EMERGENCY	5,293,344	0	5,293,344		91.00
91.01	09101	SHORT STAY	0	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	103,862	0	103,862		95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	96,537,463	0	96,537,463		118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	557,818	0	557,818		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	39,385,633	0	39,385,633		192.00
192.01	19201	FOUNDATION	233,995	0	233,995		192.01
192.02	19202	CLINICS	2,393,972	0	2,393,972		192.02
192.05	19203	PRACTICE MANAGEMENT	892,471	0	892,471		192.05

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150059

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
192.06	19204	MOB - NOBLESVILLE SQUARE	375,901	0	375,901	192.06
192.08	19205	RIVERVIEW MEDICAL ARTS	165,813	0	165,813	192.08
193.00	19300	NONPAID WORKERS	0	0	0	193.00
194.00	07950	WORKMED	679,750	0	679,750	194.00
194.01	07951	MEALS ON WHEELS	222,758	0	222,758	194.01
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)	141,445,574	0	141,445,574	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150059

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

Worksheet B Part II Date/Time Prepared: 5/29/2013 12:24 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS	0	60,367	60,367	60,367		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	894,619	894,619	6,504	901,123	5.00
7.00 00700	OPERATION OF PLANT	0	4,682,140	4,682,140	1,247	74,875	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	48,722	48,722	72	3,378	8.00
9.00 00900	HOUSEKEEPING	0	27,918	27,918	817	9,660	9.00
10.00 01000	DIETARY	0	79,053	79,053	233	5,779	10.00
11.00 01100	CAFETERIA	0	146,805	146,805	555	8,908	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	573	5,503	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	91,707	91,707	593	86,928	14.00
15.00 01500	PHARMACY	0	80,308	80,308	1,784	51,668	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	81,835	81,835	558	10,832	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	277	2,557	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	0	1,953,007	1,953,007	6,068	72,308	30.00
31.00 03100	INTENSIVE CARE UNIT	0	136,515	136,515	1,605	16,301	31.00
41.00 04100	SUBPROVIDER - I RF	0	330,220	330,220	1,099	18,404	41.00
43.00 04300	NURSERY	0	0	0	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	0	227,852	227,852	0	12,921	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	0	766,795	766,795	3,806	38,811	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	345,681	345,681	1,511	21,325	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	174,822	174,822	379	7,333	55.00
57.00 05700	CT SCAN	0	0	0	234	2,346	57.00
57.01 03630	ULTRA SOUND	0	0	0	145	1,477	57.01
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	182	1,780	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	70,879	70,879	720	7,878	59.00
60.00 06000	LABORATORY	0	189,619	189,619	1,959	39,025	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	90,205	90,205	0	5,600	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	36,043	36,043	900	9,092	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	3,471	39,889	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	451,520	451,520	590	9,045	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	9,541	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	13,073	13,073	0	2,101	74.00
76.00 03020	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01 03021	CARDIAC REHAB	0	0	0	416	4,330	76.01
76.02 03022	WOMEN'S CENTER	0	200,328	200,328	308	4,478	76.02
76.03 03330	ENDOSCOPY	0	174,158	174,158	522	6,580	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000	CLINIC	0	0	0	0	0	90.00
90.01 09001	OUTPATIENT	0	26,884	26,884	239	2,591	90.01
91.00 09100	EMERGENCY	0	393,861	393,861	1,742	23,519	91.00
91.01 09101	SHORT STAY	0	0	0	0	0	91.01
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00 09500	AMBULANCE SERVICES	0	0	0	41	641	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	11,774,936	11,774,936	39,150	617,404	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	101,974	101,974	81	2,246	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	18,978	250,592	192.00
192.01 19201	FOUNDATION	0	0	0	155	1,418	192.01
192.02 19202	CLINICS	0	0	0	1,149	14,795	192.02
192.05 19203	PRACTICE MANAGEMENT	0	0	0	424	5,685	192.05
192.06 19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	2,395	192.06
192.08 19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	1,056	192.08
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	WORKMED	0	0	0	369	4,169	194.00
194.01 07951	MEALS ON WHEELS	0	0	0	61	1,363	194.01
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	11,876,910	11,876,910	60,367	901,123	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150059

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	4,758,262				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	37,154	89,326			8.00
9.00	00900	HOUSEKEEPING	21,290	0	59,685		9.00
10.00	01000	DIETARY	60,283	0	167	145,515	10.00
11.00	01100	CAFETERIA	111,949	0	1,171	0	269,388
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	3,772
14.00	01400	CENTRAL SERVICES & SUPPLY	69,933	671	1,673	0	8,042
15.00	01500	PHARMACY	61,241	0	558	0	13,590
16.00	01600	MEDICAL RECORDS & LIBRARY	62,405	0	279	0	8,676
17.00	01700	SOCIAL SERVICE	0	0	0	0	2,822
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	1,489,300	28,000	19,413	72,858	36,181
31.00	03100	INTENSIVE CARE UNIT	104,102	6,527	2,566	10,909	14,820
41.00	04100	SUBPROVIDER - IRF	251,815	6,979	3,737	33,558	13,909
43.00	04300	NURSERY	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	173,753	6,478	3,291	28,190	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	584,734	4,685	8,423	0	23,752
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	263,605	5,231	2,454	0	16,650
55.00	05500	RADIOLOGY-THERAPEUTIC	133,314	723	558	0	3,484
57.00	05700	CT SCAN	0	0	0	0	2,388
57.01	03630	ULTRA SOUND	0	0	0	0	917
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	223	0	1,610
59.00	05900	CARDIAC CATHETERIZATION	54,050	2,305	0	0	5,814
60.00	06000	LABORATORY	144,597	0	1,060	0	24,276
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	68,788	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	27,485	0	390	0	8,406
66.00	06600	PHYSICAL THERAPY	0	753	0	0	34,718
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	344,315	767	1,785	0	5,399
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	9,969	0	0	0	0
76.00	03020	OTHER ANCILLARY	0	0	0	0	0
76.01	03021	CARDIAC REHAB	0	66	2,008	0	4,269
76.02	03022	WOMEN'S CENTER	152,764	446	558	0	3,847
76.03	03330	ENDOSCOPY	132,807	3,984	1,116	0	4,673
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	OUTPATIENT	20,501	2,427	446	0	2,269
91.00	09100	EMERGENCY	300,346	12,057	5,020	0	16,289
91.01	09101	SHORT STAY	0	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	516
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,680,500	82,099	56,896	145,515	261,089
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	77,762	0	223	0	1,169
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,046	0	0	0
192.01	19201	FOUNDATION	0	0	0	0	1,811
192.02	19202	CLINICS	0	78	2,566	0	0
192.05	19203	PRACTICE MANAGEMENT	0	29	0	0	0
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	WORKMED	0	74	0	0	3,925
194.01	07951	MEALS ON WHEELS	0	0	0	0	1,394
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	4,758,262	89,326	59,685	145,515	269,388

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150059		Period: From 01/01/2012 To 12/31/2012		Worksheet B Part II Date/Time Prepared: 5/29/2013 12:24 pm	
Cost Center Description		NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	9,848				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	259,547			14.00
15.00	01500	PHARMACY	0	0	209,149		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	164,585	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	5,656
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	4,388	0	0	46,261	4,350
31.00	03100	INTENSIVE CARE UNIT	1,797	0	0	8,811	419
41.00	04100	SUBPROVIDER - IRF	1,687	0	0	0	443
43.00	04300	NURSERY	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	944	444
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	41,854	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,573	0
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	3,147	0
57.00	05700	CT SCAN	0	0	0	0	0
57.01	03630	ULTRA SOUND	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	0	0	0	4,720	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0	0	0	20,455	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,350	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	259,547	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	209,149	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03020	OTHER ANCILLARY	0	0	0	0	0
76.01	03021	CARDIAC REHAB	0	0	0	0	0
76.02	03022	WOMEN'S CENTER	0	0	0	0	0
76.03	03330	ENDOSCOPY	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	OUTPATIENT	0	0	0	0	0
91.00	09100	EMERGENCY	1,976	0	0	31,155	0
91.01	09101	SHORT STAY	0	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,848	259,547	209,149	164,270	5,656
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	FOUNDATION	0	0	0	0	0
192.02	19202	CLINICS	0	0	0	315	0
192.05	19203	PRACTICE MANAGEMENT	0	0	0	0	0
192.06	19204	MOB - NOBLESVILLE SQUARE	0	0	0	0	0
192.08	19205	RIVERVIEW MEDICAL ARTS	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	WORKMED	0	0	0	0	0
194.01	07951	MEALS ON WHEELS	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	9,848	259,547	209,149	164,585	5,656

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150059

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	3,732,134	0	3,732,134	30.00
31.00	03100	304,372	0	304,372	31.00
41.00	04100	661,851	0	661,851	41.00
43.00	04300	0	0	0	43.00
44.00	04400	453,873	0	453,873	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	1,472,860	0	1,472,860	50.00
52.00	05200	0	0	0	52.00
54.00	05400	658,030	0	658,030	54.00
55.00	05500	323,760	0	323,760	55.00
57.00	05700	4,968	0	4,968	57.00
57.01	03630	2,539	0	2,539	57.01
58.00	05800	3,795	0	3,795	58.00
59.00	05900	141,646	0	141,646	59.00
60.00	06000	405,256	0	405,256	60.00
60.01	06001	0	0	0	60.01
63.00	06300	164,593	0	164,593	63.00
64.00	06400	0	0	0	64.00
65.00	06500	82,316	0	82,316	65.00
66.00	06600	99,286	0	99,286	66.00
67.00	06700	0	0	0	67.00
68.00	06800	0	0	0	68.00
69.00	06900	818,771	0	818,771	69.00
71.00	07100	259,547	0	259,547	71.00
72.00	07200	9,541	0	9,541	72.00
73.00	07300	209,149	0	209,149	73.00
74.00	07400	25,143	0	25,143	74.00
76.00	03020	0	0	0	76.00
76.01	03021	11,089	0	11,089	76.01
76.02	03022	362,729	0	362,729	76.02
76.03	03330	323,840	0	323,840	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	0	0	0	90.00
90.01	09001	55,357	0	55,357	90.01
91.00	09100	785,965	0	785,965	91.00
91.01	09101	0	0	0	91.01
92.00	09200	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	1,198	0	1,198	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		11,373,608	0	11,373,608	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	183,455	0	183,455	190.00
192.00	19200	276,616	0	276,616	192.00
192.01	19201	3,384	0	3,384	192.01
192.02	19202	18,903	0	18,903	192.02
192.05	19203	6,138	0	6,138	192.05
192.06	19204	2,395	0	2,395	192.06
192.08	19205	1,056	0	1,056	192.08
193.00	19300	0	0	0	193.00
194.00	07950	8,537	0	8,537	194.00
194.01	07951	2,818	0	2,818	194.01
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		11,876,910	0	11,876,910	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150059

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

Worksheet B-1  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCU. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)						
	1.00	4.00					
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	482,421						1.00
4.00 00400 EMPLOYEE BENEFITS	2,452	66,487,238					4.00
5.00 00500 ADMINISTRATIVE & GENERAL	36,338	7,163,222	-15,058,220		126,387,354		5.00
7.00 00700 OPERATION OF PLANT	190,181	1,373,481		0	10,501,418	253,450	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	1,979	79,430		0	473,792	1,979	8.00
9.00 00900 HOUSEKEEPING	1,134	899,397		0	1,354,841	1,134	9.00
10.00 01000 DIETARY	3,211	257,091		0	810,530	3,211	10.00
11.00 01100 CAFETERIA	5,963	611,153		0	1,249,399	5,963	11.00
13.00 01300 NURSING ADMINISTRATION	0	630,809		0	771,754	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	3,725	652,783		0	12,191,849	3,725	14.00
15.00 01500 PHARMACY	3,262	1,964,469		0	7,246,615	3,262	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	3,324	614,823		0	1,519,220	3,324	16.00
17.00 01700 SOCIAL SERVICE	0	304,517		0	358,615	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	79,328	6,682,839		0	10,141,319	79,328	30.00
31.00 03100 INTENSIVE CARE UNIT	5,545	1,767,652		0	2,286,204	5,545	31.00
41.00 04100 SUBPROVIDER - I/R	13,413	1,209,811		0	2,581,237	13,413	41.00
43.00 04300 NURSERY	0	0		0	0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	9,255	0		0	1,812,208	9,255	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	31,146	4,191,493		0	5,443,315	31,146	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	14,041	1,664,259		0	2,990,887	14,041	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	7,101	416,937		0	1,028,405	7,101	55.00
57.00 05700 CT SCAN	0	258,174		0	328,964	0	57.00
57.01 03630 ULTRA SOUND	0	159,512		0	207,122	0	57.01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	199,917		0	249,690	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	2,879	793,438		0	1,104,877	2,879	59.00
60.00 06000 LABORATORY	7,702	2,157,950		0	5,473,386	7,702	60.00
60.01 06001 BLOOD LABORATORY	0	0		0	0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	3,664	0		0	785,464	3,664	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	1,464	990,852		0	1,275,143	1,464	65.00
66.00 06600 PHYSICAL THERAPY	0	3,822,441		0	5,594,524	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	18,340	650,287		0	1,268,595	18,340	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	1,338,135	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73.00
74.00 07400 RENAL DIALYSIS	531	0		0	294,701	531	74.00
76.00 03020 OTHER ANCILLARY	0	0		0	0	0	76.00
76.01 03021 CARDIAC REHAB	0	457,649		0	607,360	0	76.01
76.02 03022 WOMEN'S CENTER	8,137	338,966		0	628,082	8,137	76.02
76.03 03330 ENDOSCOPY	7,074	575,287		0	922,920	7,074	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	0	0		0	0	0	90.00
90.01 09001 OUTPATIENT	1,092	263,223		0	363,428	1,092	90.01
91.00 09100 EMERGENCY	15,998	1,918,235		0	3,298,605	15,998	91.00
91.01 09101 SHORT STAY	0	0		0	0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00 09500 AMBULANCE SERVICES	0	45,253		0	89,888	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	478,279	43,115,350	-15,058,220	86,592,492	249,308	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,142	88,688		0	314,960	4,142	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	20,905,944		0	35,148,784	0	192.00
192.01 19201 FOUNDATION	0	170,768		0	198,841	0	192.01
192.02 19202 CLINICS	0	1,265,404		0	2,075,085	0	192.02
192.05 19203 PRACTICE MANAGEMENT	0	467,153		0	797,277	0	192.05
192.06 19204 MOB - NOBLESVILLE SQUARE	0	0		0	335,883	0	192.06
192.08 19205 RIVERVIEW MEDICAL ARTS	0	0		0	148,161	0	192.08
193.00 19300 NONPAID WORKERS	0	0		0	0	0	193.00
194.00 07950 WORKMED	0	406,745		0	584,714	0	194.00
194.01 07951 MEALS ON WHEELS	0	67,186		0	191,157	0	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150059

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

Worksheet B-1

Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)						
	1.00	4.00					
202.00	Cost to be allocated (per Wkst. B, Part I)	11,876,910	6,196,229	5A	15,058,220	11,752,588	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	24.619388	0.093194		0.119143	46.370440	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		60,367		901,123	4,758,262	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.000908		0.007130	18.773967	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150059

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

Worksheet B-1

Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
		8.00	9.00	10.00	11.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800	73,174					8.00
9.00	00900	0	1,070				9.00
10.00	01000	0	3	85,826			10.00
11.00	01100	0	21	0	973,512		11.00
13.00	01300	0	0	0	13,632	293,443	13.00
14.00	01400	550	30	0	29,062	0	14.00
15.00	01500	0	10	0	49,111	0	15.00
16.00	01600	0	5	0	31,354	0	16.00
17.00	01700	0	0	0	10,198	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	22,936	348	42,972	130,757	130,757	30.00
31.00	03100	5,347	46	6,434	53,556	53,556	31.00
41.00	04100	5,717	67	19,793	50,265	50,265	41.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	5,307	59	16,627	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	3,838	151	0	85,834	0	50.00
52.00	05200	0	0	0	0	0	52.00
54.00	05400	4,285	44	0	60,169	0	54.00
55.00	05500	592	10	0	12,590	0	55.00
57.00	05700	0	0	0	8,630	0	57.00
57.01	03630	0	0	0	3,314	0	57.01
58.00	05800	0	4	0	5,818	0	58.00
59.00	05900	1,888	0	0	21,009	0	59.00
60.00	06000	0	19	0	87,729	0	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	7	0	30,376	0	65.00
66.00	06600	617	0	0	125,464	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	628	32	0	19,510	0	69.00
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
76.00	03020	0	0	0	0	0	76.00
76.01	03021	54	36	0	15,426	0	76.01
76.02	03022	365	10	0	13,903	0	76.02
76.03	03330	3,264	20	0	16,886	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	1,988	8	0	8,200	0	90.01
91.00	09100	9,877	90	0	58,865	58,865	91.00
91.01	09101	0	0	0	0	0	91.01
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	1,863	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		67,253	1,020	85,826	943,521	293,443	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	4	0	4,225	0	190.00
192.00	19200	5,772	0	0	0	0	192.00
192.01	19201	0	0	0	6,543	0	192.01
192.02	19202	64	46	0	0	0	192.02
192.05	19203	24	0	0	0	0	192.05
192.06	19204	0	0	0	0	0	192.06
192.08	19205	0	0	0	0	0	192.08
193.00	19300	0	0	0	0	0	193.00
194.00	07950	61	0	0	14,185	0	194.00
194.01	07951	0	0	0	5,038	0	194.01
200.00							200.00
201.00							201.00
202.00		622,008	1,568,845	1,060,393	1,705,553	887,586	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150059

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

Worksheet B-1

Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
		8.00	9.00	10.00	11.00	13.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	8.500396	1,466.210280	12.355149	1.751959	3.024731	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	89,326	59,685	145,515	269,388	9,848	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.220734	55.780374	1.695465	0.276718	0.033560	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150059

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

Worksheet B-1

Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100					1.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300					13.00
14.00	01400	1,000				14.00
15.00	01500	0	1,000			15.00
16.00	01600	0	0	523		16.00
17.00	01700	0	0	0	5,945	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	0	0	147	4,572	30.00
31.00	03100	0	0	28	440	31.00
41.00	04100	0	0	0	466	41.00
43.00	04300	0	0	0	0	43.00
44.00	04400	0	0	3	467	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	0	0	133	0	50.00
52.00	05200	0	0	0	0	52.00
54.00	05400	0	0	5	0	54.00
55.00	05500	0	0	10	0	55.00
57.00	05700	0	0	0	0	57.00
57.01	03630	0	0	0	0	57.01
58.00	05800	0	0	0	0	58.00
59.00	05900	0	0	0	0	59.00
60.00	06000	0	0	15	0	60.00
60.01	06001	0	0	0	0	60.01
63.00	06300	0	0	0	0	63.00
64.00	06400	0	0	0	0	64.00
65.00	06500	0	0	0	0	65.00
66.00	06600	0	0	65	0	66.00
67.00	06700	0	0	0	0	67.00
68.00	06800	0	0	0	0	68.00
69.00	06900	0	0	17	0	69.00
71.00	07100	1,000	0	0	0	71.00
72.00	07200	0	0	0	0	72.00
73.00	07300	0	1,000	0	0	73.00
74.00	07400	0	0	0	0	74.00
76.00	03020	0	0	0	0	76.00
76.01	03021	0	0	0	0	76.01
76.02	03022	0	0	0	0	76.02
76.03	03330	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	0	0	0	0	90.00
90.01	09001	0	0	0	0	90.01
91.00	09100	0	0	99	0	91.00
91.01	09101	0	0	0	0	91.01
92.00	09200	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	0	0	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		1,000	1,000	522	5,945	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	0	0	0	0	190.00
192.00	19200	0	0	0	0	192.00
192.01	19201	0	0	0	0	192.01
192.02	19202	0	0	1	0	192.02
192.05	19203	0	0	0	0	192.05
192.06	19204	0	0	0	0	192.06
192.08	19205	0	0	0	0	192.08
193.00	19300	0	0	0	0	193.00
194.00	07950	0	0	0	0	194.00
194.01	07951	0	0	0	0	194.01
200.00						200.00
201.00						201.00
202.00		13,916,728	8,361,960	1,916,621	419,207	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150059

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

Worksheet B-1

Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)		
		14.00	15.00	16.00	17.00		
203.00	Unit cost multiplier (Wkst. B, Part I)	13,916.728000	8,361.960000	3,664.667304	70.514214		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	259,547	209,149	164,585	5,656		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	259.547000	209.149000	314.694073	0.951388		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150059

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/29/2013 12:24 pm

			Title XVIII		Hospital		PPS		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			
			Total Costs	RCE Dissallowance	Total Costs	Inpatient			
			1.00	2.00	3.00	4.00	5.00	6.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00	03000	ADULTS & PEDIATRICS	17,749,877		17,749,877	0	17,749,877	22,920,013	30.00
31.00	03100	INTENSIVE CARE UNIT	3,397,561		3,397,561	0	3,397,561	6,026,578	31.00
41.00	04100	SUBPROVIDER - I RF	4,175,078		4,175,078	0	4,175,078	5,675,264	41.00
43.00	04300	NURSERY	0		0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,838,249		2,838,249	221,589	3,059,838	2,479,572	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	8,427,904		8,427,904	0	8,427,904	18,554,848	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,222,991		4,222,991	0	4,222,991	1,834,659	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,558,606		1,558,606	0	1,558,606	104,752	55.00
57.00	05700	CT SCAN	383,277		383,277	0	383,277	1,746,667	57.00
57.01	03630	ULTRA SOUND	237,605		237,605	0	237,605	311,219	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	295,497		295,497	0	295,497	407,369	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,422,871		1,422,871	23,343	1,446,214	4,699,745	59.00
60.00	06000	LABORATORY	6,719,173		6,719,173	0	6,719,173	10,766,722	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,048,948		1,048,948	0	1,048,948	1,401,996	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,558,434	0	1,558,434	0	1,558,434	3,426,349	65.00
66.00	06600	PHYSICAL THERAPY	6,724,328	0	6,724,328	0	6,724,328	7,104,207	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,418,910		2,418,910	84,639	2,503,549	2,085,662	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,916,728		13,916,728	0	13,916,728	25,379,210	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,497,564		1,497,564	0	1,497,564	2,168,806	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,361,960		8,361,960	0	8,361,960	12,040,386	73.00
74.00	07400	RENAL DIALYSIS	354,436		354,436	0	354,436	421,343	74.00
76.00	03020	OTHER ANCILLARY	0		0	0	0	0	76.00
76.01	03021	CARDIAC REHAB	759,992		759,992	0	759,992	285,567	76.01
76.02	03022	WOMEN'S CENTER	1,122,352		1,122,352	0	1,122,352	5,305	76.02
76.03	03330	ENDOSCOPY	1,447,556		1,447,556	0	1,447,556	930,723	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>									
90.00	09000	CLINIC	0		0	0	0	0	90.00
90.01	09001	OUTPATIENT	500,360		500,360	1,142	501,502	189,884	90.01
91.00	09100	EMERGENCY	5,293,344		5,293,344	0	5,293,344	3,172,446	91.00
91.01	09101	SHORT STAY	0		0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,817,702		1,817,702		1,817,702	637,622	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>									
95.00	09500	AMBULANCE SERVICES	103,862		103,862	0	103,862	0	95.00
200.00		Subtotal (see instructions)	98,355,165	0	98,355,165	330,713	98,685,878	134,776,914	200.00
201.00		Less Observation Beds	1,817,702		1,817,702		1,817,702		201.00
202.00		Total (see instructions)	96,537,463	0	96,537,463	330,713	96,868,176	134,776,914	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150059

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
		Outpatient	Total (col. 6 + col. 7)					
		7.00	8.00					
		9.00	10.00	11.00				
Title XVIII Hospital PPS								
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS		22,920,013				30.00
31.00	03100	INTENSIVE CARE UNIT		6,026,578				31.00
41.00	04100	SUBPROVIDER - IRF		5,675,264				41.00
43.00	04300	NURSERY		0				43.00
44.00	04400	SKILLED NURSING FACILITY		2,479,572				44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	22,797,000	41,351,848	0.203810	0.000000	0.203810	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,581,550	13,416,209	0.314768	0.000000	0.314768	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,733,864	5,838,616	0.266948	0.000000	0.266948	55.00
57.00	05700	CT SCAN	7,470,450	9,217,117	0.041583	0.000000	0.041583	57.00
57.01	03630	ULTRA SOUND	1,996,240	2,307,459	0.102973	0.000000	0.102973	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,101,315	3,508,684	0.084219	0.000000	0.084219	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,718,710	11,418,455	0.124612	0.000000	0.126656	59.00
60.00	06000	LABORATORY	23,824,198	34,590,920	0.194247	0.000000	0.194247	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	656,765	2,058,761	0.509505	0.000000	0.509505	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	675,665	4,102,014	0.379919	0.000000	0.379919	65.00
66.00	06600	PHYSICAL THERAPY	9,744,698	16,848,905	0.399096	0.000000	0.399096	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	7,391,725	9,477,387	0.255230	0.000000	0.264160	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,399,769	43,778,979	0.317886	0.000000	0.317886	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,999,726	6,168,532	0.242775	0.000000	0.242775	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,887,943	20,928,329	0.399552	0.000000	0.399552	73.00
74.00	07400	RENAL DIALYSIS	2,068	423,411	0.837097	0.000000	0.837097	74.00
76.00	03020	OTHER ANCILLARY	0	0	0.000000	0.000000	0.000000	76.00
76.01	03021	CARDIAC REHAB	1,348,230	1,633,797	0.465169	0.000000	0.465169	76.01
76.02	03022	WOMEN'S CENTER	3,543,997	3,549,302	0.316218	0.000000	0.316218	76.02
76.03	03330	ENDOSCOPY	5,325,129	6,255,852	0.231392	0.000000	0.231392	76.03
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0.000000	0.000000	90.00
90.01	09001	OUTPATIENT	650,411	840,295	0.595458	0.000000	0.596817	90.01
91.00	09100	EMERGENCY	16,902,079	20,074,525	0.263685	0.000000	0.263685	91.00
91.01	09101	SHORT STAY	0	0	0.000000	0.000000	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,614,087	3,251,709	0.558999	0.000000	0.558999	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	111,506	111,506	0.931448	0.000000	0.931448	95.00
200.00		Subtotal (see instructions)	163,477,125	298,254,039				200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	163,477,125	298,254,039				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150059

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/29/2013 12:24 pm

			Title XIX		Hospital		Cost		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			
			Total Costs	RCE Diallowance	Total Costs	Inpatient			
			1.00	2.00	3.00	4.00	5.00	6.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00	03000	ADULTS & PEDIATRICS	17,749,877		17,749,877	0	0	22,920,013	30.00
31.00	03100	INTENSIVE CARE UNIT	3,397,561		3,397,561	0	0	6,026,578	31.00
41.00	04100	SUBPROVIDER - I RF	4,175,078		4,175,078	0	0	5,675,264	41.00
43.00	04300	NURSERY	0		0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,838,249		2,838,249	0	0	2,479,572	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	8,427,904		8,427,904	0	0	18,554,848	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,222,991		4,222,991	0	0	1,834,659	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,558,606		1,558,606	0	0	104,752	55.00
57.00	05700	CT SCAN	383,277		383,277	0	0	1,746,667	57.00
57.01	03630	ULTRA SOUND	237,605		237,605	0	0	311,219	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	295,497		295,497	0	0	407,369	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,422,871		1,422,871	0	0	4,699,745	59.00
60.00	06000	LABORATORY	6,719,173		6,719,173	0	0	10,766,722	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,048,948		1,048,948	0	0	1,401,996	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,558,434	0	1,558,434	0	0	3,426,349	65.00
66.00	06600	PHYSICAL THERAPY	6,724,328	0	6,724,328	0	0	7,104,207	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,418,910		2,418,910	0	0	2,085,662	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,916,728		13,916,728	0	0	25,379,210	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,497,564		1,497,564	0	0	2,168,806	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,361,960		8,361,960	0	0	12,040,386	73.00
74.00	07400	RENAL DIALYSIS	354,436		354,436	0	0	421,343	74.00
76.00	03020	OTHER ANCILLARY	0		0	0	0	0	76.00
76.01	03021	CARDIAC REHAB	759,992		759,992	0	0	285,567	76.01
76.02	03022	WOMEN'S CENTER	1,122,352		1,122,352	0	0	5,305	76.02
76.03	03330	ENDOSCOPY	1,447,556		1,447,556	0	0	930,723	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>									
90.00	09000	CLINIC	0		0	0	0	0	90.00
90.01	09001	OUTPATIENT	500,360		500,360	0	0	189,884	90.01
91.00	09100	EMERGENCY	5,293,344		5,293,344	0	0	3,172,446	91.00
91.01	09101	SHORT STAY	0		0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,817,702		1,817,702	0	0	637,622	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>									
95.00	09500	AMBULANCE SERVICES	103,862		103,862	0	0	0	95.00
200.00		Subtotal (see instructions)	98,355,165	0	98,355,165	0	0	134,776,914	200.00
201.00		Less Observation Beds	1,817,702		1,817,702	0	0		201.00
202.00		Total (see instructions)	96,537,463	0	96,537,463	0	0	134,776,914	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150059

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		Charges		Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	Hospital		
		Outpatient	Total (col. 6 + col. 7)				Cost		
		7.00	8.00				9.00	10.00	11.00
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS		22,920,013					30.00
31.00	03100	INTENSIVE CARE UNIT		6,026,578					31.00
41.00	04100	SUBPROVIDER - IRF		5,675,264					41.00
43.00	04300	NURSERY		0					43.00
44.00	04400	SKILLED NURSING FACILITY		2,479,572					44.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	22,797,000	41,351,848	0.203810	0.000000	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,581,550	13,416,209	0.314768	0.000000	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,733,864	5,838,616	0.266948	0.000000	0.000000		55.00
57.00	05700	CT SCAN	7,470,450	9,217,117	0.041583	0.000000	0.000000		57.00
57.01	03630	ULTRA SOUND	1,996,240	2,307,459	0.102973	0.000000	0.000000		57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,101,315	3,508,684	0.084219	0.000000	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	6,718,710	11,418,455	0.124612	0.000000	0.000000		59.00
60.00	06000	LABORATORY	23,824,198	34,590,920	0.194247	0.000000	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	656,765	2,058,761	0.509505	0.000000	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	675,665	4,102,014	0.379919	0.000000	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	9,744,698	16,848,905	0.399096	0.000000	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	7,391,725	9,477,387	0.255230	0.000000	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,399,769	43,778,979	0.317886	0.000000	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,999,726	6,168,532	0.242775	0.000000	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,887,943	20,928,329	0.399552	0.000000	0.000000		73.00
74.00	07400	RENAL DIALYSIS	2,068	423,411	0.837097	0.000000	0.000000		74.00
76.00	03020	OTHER ANCILLARY	0	0	0.000000	0.000000	0.000000		76.00
76.01	03021	CARDIAC REHAB	1,348,230	1,633,797	0.465169	0.000000	0.000000		76.01
76.02	03022	WOMEN'S CENTER	3,543,997	3,549,302	0.316218	0.000000	0.000000		76.02
76.03	03330	ENDOSCOPY	5,325,129	6,255,852	0.231392	0.000000	0.000000		76.03
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0.000000	0.000000	0.000000		90.00
90.01	09001	OUTPATIENT	650,411	840,295	0.595458	0.000000	0.000000		90.01
91.00	09100	EMERGENCY	16,902,079	20,074,525	0.263685	0.000000	0.000000		91.00
91.01	09101	SHORT STAY	0	0	0.000000	0.000000	0.000000		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,614,087	3,251,709	0.558999	0.000000	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	111,506	111,506	0.931448	0.000000	0.000000		95.00
200.00		Subtotal (see instructions)	163,477,125	298,254,039					200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	163,477,125	298,254,039					202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 150059

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

Worksheet D  
Part I  
Date/Time Prepared:  
5/29/2013 12:24 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	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,732,134	0	3,732,134	16,620	224.56	30.00
31.00	INTENSIVE CARE UNIT	304,372		304,372	2,974	102.34	31.00
41.00	SUBPROVIDER - IRF	661,851	0	661,851	5,759	114.92	41.00
43.00	NURSERY	0		0	0	0.00	43.00
44.00	SKILLED NURSING FACILITY	453,873		453,873	5,106	88.89	44.00
200.00	Total (lines 30-199)	5,152,230		5,152,230	30,459		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	6,365	1,429,324				
31.00	INTENSIVE CARE UNIT	1,498	153,305				
41.00	SUBPROVIDER - IRF	3,952	454,164				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	3,414	303,470				
200.00	Total (lines 30-199)	15,229	2,340,263				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150059

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

Worksheet D  
Part II  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		Title XVIII			Hospital	PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	1,472,860	41,351,848	0.035618	9,120,047	324,838	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	658,030	13,416,209	0.049047	1,349,715	66,199	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	323,760	5,838,616	0.055451	73,870	4,096	55.00
57.00	05700 CT SCAN	4,968	9,217,117	0.000539	902,322	486	57.00
57.01	03630 ULTRA SOUND	2,539	2,307,459	0.001100	125,708	138	57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	3,795	3,508,684	0.001082	205,613	222	58.00
59.00	05900 CARDIAC CATHETERIZATION	141,646	11,418,455	0.012405	1,286,097	15,954	59.00
60.00	06000 LABORATORY	405,256	34,590,920	0.011716	5,174,557	60,625	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	164,593	2,058,761	0.079948	378,909	30,293	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	82,316	4,102,014	0.020067	1,065,154	21,374	65.00
66.00	06600 PHYSICAL THERAPY	99,286	16,848,905	0.005893	809,349	4,769	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	818,771	9,477,387	0.086392	926,132	80,010	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	259,547	43,778,979	0.005929	11,949,213	70,847	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	9,541	6,168,532	0.001547	1,101,575	1,704	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	209,149	20,928,329	0.009994	4,979,519	49,765	73.00
74.00	07400 RENAL DIALYSIS	25,143	423,411	0.059382	220,685	13,105	74.00
76.00	03020 OTHER ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03021 CARDIAC REHAB	11,089	1,633,797	0.006787	56,801	386	76.01
76.02	03022 WOMEN'S CENTER	362,729	3,549,302	0.102197	0	0	76.02
76.03	03330 ENDOSCOPY	323,840	6,255,852	0.051766	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
90.01	09001 OUTPATIENT	55,357	840,295	0.065878	0	0	90.01
91.00	09100 EMERGENCY	785,965	20,074,525	0.039152	1,499,030	58,690	91.00
91.01	09101 SHORT STAY	0	0	0.000000	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	382,195	3,251,709	0.117537	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	6,602,375	261,041,106		41,224,296	803,501	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150059		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part III Date/Time Prepared: 5/29/2013 12:24 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	16,620	0.00	6,365	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,974	0.00	1,498	0		31.00
41.00	04100	SUBPROVIDER - IRF	5,759	0.00	3,952	0		41.00
43.00	04300	NURSERY	0	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	5,106	0.00	3,414	0		44.00
200.00		Total (lines 30-199)	30,459		15,229	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150059

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		Title XVIII				Hospital	PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
57.01	03630	ULTRA SOUND	0	0	0	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0	0	0	0	76.00
76.01	03021	CARDIAC REHAB	0	0	0	0	76.01
76.02	03022	WOMEN'S CENTER	0	0	0	0	76.02
76.03	03330	ENDOSCOPY	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	OUTPATIENT	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	91.00
91.01	09101	SHORT STAY	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150059	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/29/2013 12:24 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	41,351,848	0.000000	0.000000	9,120,047	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	13,416,209	0.000000	0.000000	1,349,715	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	5,838,616	0.000000	0.000000	73,870	55.00
57.00	05700 CT SCAN	0	9,217,117	0.000000	0.000000	902,322	57.00
57.01	03630 ULTRA SOUND	0	2,307,459	0.000000	0.000000	125,708	57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	3,508,684	0.000000	0.000000	205,613	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	11,418,455	0.000000	0.000000	1,286,097	59.00
60.00	06000 LABORATORY	0	34,590,920	0.000000	0.000000	5,174,557	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	2,058,761	0.000000	0.000000	378,909	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	4,102,014	0.000000	0.000000	1,065,154	65.00
66.00	06600 PHYSICAL THERAPY	0	16,848,905	0.000000	0.000000	809,349	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	9,477,387	0.000000	0.000000	926,132	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	43,778,979	0.000000	0.000000	11,949,213	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	6,168,532	0.000000	0.000000	1,101,575	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	20,928,329	0.000000	0.000000	4,979,519	73.00
74.00	07400 RENAL DIALYSIS	0	423,411	0.000000	0.000000	220,685	74.00
76.00	03020 OTHER ANCILLARY	0	0	0.000000	0.000000	0	76.00
76.01	03021 CARDIAC REHAB	0	1,633,797	0.000000	0.000000	56,801	76.01
76.02	03022 WOMEN'S CENTER	0	3,549,302	0.000000	0.000000	0	76.02
76.03	03330 ENDOSCOPY	0	6,255,852	0.000000	0.000000	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001 OUTPATIENT	0	840,295	0.000000	0.000000	0	90.01
91.00	09100 EMERGENCY	0	20,074,525	0.000000	0.000000	1,499,030	91.00
91.01	09101 SHORT STAY	0	0	0.000000	0.000000	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3,251,709	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0	0				95.00
200.00	Total (Lines 50-199)	0	261,041,106			41,224,296	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150059

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0	7,473,825	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	4,033,224	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	2,613,161	0	55.00
57.00	05700 CT SCAN	0	2,961,293	0	57.00
57.01	03630 ULTRA SOUND	0	442,963	0	57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1,088,662	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	2,225,208	0	59.00
60.00	06000 LABORATORY	0	361,172	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	313,751	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	250,483	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	1,688,076	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,475,321	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	1,685,860	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3,661,449	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
76.00	03020 OTHER ANCILLARY	0	0	0	76.00
76.01	03021 CARDIAC REHAB	0	635,044	0	76.01
76.02	03022 WOMEN'S CENTER	0	0	0	76.02
76.03	03330 ENDOSCOPY	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 OUTPATIENT	0	0	0	90.01
91.00	09100 EMERGENCY	0	2,457,251	0	91.00
91.01	09101 SHORT STAY	0	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,176,671	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES	0	0	0	95.00
200.00	Total (Lines 50-199)	0	37,543,414	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150059	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/29/2013 12:24 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.203810	7,473,825	0	0	1,523,240	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.314768	4,033,224	0	0	1,269,530	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.266948	2,613,161	0	0	697,578	55.00
57.00	05700 CT SCAN	0.041583	2,961,293	0	0	123,139	57.00
57.01	03630 ULTRA SOUND	0.102973	442,963	0	0	45,613	57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.084219	1,088,662	0	0	91,686	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.124612	2,225,208	0	0	277,288	59.00
60.00	06000 LABORATORY	0.194247	361,172	0	0	70,157	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.509505	313,751	0	0	159,858	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.379919	250,483	0	0	95,163	65.00
66.00	06600 PHYSICAL THERAPY	0.399096	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.255230	1,688,076	0	0	430,848	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.317886	4,475,321	0	0	1,422,642	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.242775	1,685,860	0	0	409,285	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.399552	3,661,449	0	8,617	1,462,939	73.00
74.00	07400 RENAL DIALYSIS	0.837097	0	0	0	0	74.00
76.00	03020 OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03021 CARDIAC REHAB	0.465169	635,044	0	0	295,403	76.01
76.02	03022 WOMEN'S CENTER	0.316218	0	0	0	0	76.02
76.03	03330 ENDOSCOPY	0.231392	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	09001 OUTPATIENT	0.595458	0	0	0	0	90.01
91.00	09100 EMERGENCY	0.263685	2,457,251	0	0	647,940	91.00
91.01	09101 SHORT STAY	0.000000	0	0	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.558999	1,176,671	0	0	657,758	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0.931448	0	0	0	0	95.00
200.00	Subtotal (see instructions)		37,543,414	0	8,617	9,680,067	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		37,543,414	0	8,617	9,680,067	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150059	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/29/2013 12:24 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00 05700 CT SCAN	0	0		57.00
57.01 03630 ULTRA SOUND	0	0		57.01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	3,443		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03020 OTHER ANCILLARY	0	0		76.00
76.01 03021 CARDIAC REHAB	0	0		76.01
76.02 03022 WOMEN'S CENTER	0	0		76.02
76.03 03330 ENDOSCOPY	0	0		76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 OUTPATIENT	0	0		90.01
91.00 09100 EMERGENCY	0	0		91.00
91.01 09101 SHORT STAY	0	0		91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00 09500 AMBULANCE SERVICES	0			95.00
200.00 Subtotal (see instructions)	0	3,443		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	3,443		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150059 Component CCN: 15T059		Period: From 01/01/2012 To 12/31/2012		Worksheet D Part II Date/Time Prepared: 5/29/2013 12:24 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	1,472,860	41,351,848	0.035618	77,065	2,745	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	658,030	13,416,209	0.049047	98,200	4,816	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	323,760	5,838,616	0.055451	0	0	55.00
57.00	05700 CT SCAN	4,968	9,217,117	0.000539	46,967	25	57.00
57.01	03630 ULTRA SOUND	2,539	2,307,459	0.001100	5,803	6	57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	3,795	3,508,684	0.001082	7,574	8	58.00
59.00	05900 CARDIAC CATHETERIZATION	141,646	11,418,455	0.012405	7,560	94	59.00
60.00	06000 LABORATORY	405,256	34,590,920	0.011716	571,655	6,698	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	164,593	2,058,761	0.079948	11,139	891	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	82,316	4,102,014	0.020067	203,435	4,082	65.00
66.00	06600 PHYSICAL THERAPY	99,286	16,848,905	0.005893	3,025,563	17,830	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	818,771	9,477,387	0.086392	24,486	2,115	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	259,547	43,778,979	0.005929	621,809	3,687	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	9,541	6,168,532	0.001547	6,191	10	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	209,149	20,928,329	0.009994	713,712	7,133	73.00
74.00	07400 RENAL DIALYSIS	25,143	423,411	0.059382	114,528	6,801	74.00
76.00	03020 OTHER ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03021 CARDIAC REHAB	11,089	1,633,797	0.006787	0	0	76.01
76.02	03022 WOMEN'S CENTER	362,729	3,549,302	0.102197	0	0	76.02
76.03	03330 ENDOSCOPY	323,840	6,255,852	0.051766	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
90.01	09001 OUTPATIENT	55,357	840,295	0.065878	0	0	90.01
91.00	09100 EMERGENCY	785,965	20,074,525	0.039152	29,941	1,172	91.00
91.01	09101 SHORT STAY	0	0	0.000000	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3,251,709	0.000000	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	6,220,180	261,041,106		5,565,628	58,113	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150059 Component CCN: 15T059	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/29/2013 12:24 pm
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
57.01	03630 ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020 OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03021 CARDIAC REHAB	0	0	0	0	0	76.01
76.02	03022 WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330 ENDOSCOPY	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 OUTPATIENT	0	0	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
91.01	09101 SHORT STAY	0	0	0	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150059 Component CCN: 15T059	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/29/2013 12:24 pm
Title XVIII		Subprovider - IRF	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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	41,351,848	0.000000	0.000000	77,065	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	13,416,209	0.000000	0.000000	98,200	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	5,838,616	0.000000	0.000000	0	55.00
57.00 05700 CT SCAN	0	9,217,117	0.000000	0.000000	46,967	57.00
57.01 03630 ULTRA SOUND	0	2,307,459	0.000000	0.000000	5,803	57.01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	3,508,684	0.000000	0.000000	7,574	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	11,418,455	0.000000	0.000000	7,560	59.00
60.00 06000 LABORATORY	0	34,590,920	0.000000	0.000000	571,655	60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	2,058,761	0.000000	0.000000	11,139	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	4,102,014	0.000000	0.000000	203,435	65.00
66.00 06600 PHYSICAL THERAPY	0	16,848,905	0.000000	0.000000	3,025,563	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	9,477,387	0.000000	0.000000	24,486	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	43,778,979	0.000000	0.000000	621,809	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	6,168,532	0.000000	0.000000	6,191	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	20,928,329	0.000000	0.000000	713,712	73.00
74.00 07400 RENAL DIALYSIS	0	423,411	0.000000	0.000000	114,528	74.00
76.00 03020 OTHER ANCILLARY	0	0	0.000000	0.000000	0	76.00
76.01 03021 CARDIAC REHAB	0	1,633,797	0.000000	0.000000	0	76.01
76.02 03022 WOMEN'S CENTER	0	3,549,302	0.000000	0.000000	0	76.02
76.03 03330 ENDOSCOPY	0	6,255,852	0.000000	0.000000	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0.000000	0.000000	0	90.00
90.01 09001 OUTPATIENT	0	840,295	0.000000	0.000000	0	90.01
91.00 09100 EMERGENCY	0	20,074,525	0.000000	0.000000	29,941	91.00
91.01 09101 SHORT STAY	0	0	0.000000	0.000000	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3,251,709	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	261,041,106			5,565,628	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150059 Component CCN: 15T059	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/29/2013 12:24 pm
Title XVII I		Subprovider - IRF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	272	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
57.00	05700 CT SCAN	0	0	0	57.00
57.01	03630 ULTRA SOUND	0	0	0	57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	2,365	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	510	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	149	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,052	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	49	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
76.00	03020 OTHER ANCILLARY	0	0	0	76.00
76.01	03021 CARDIAC REHAB	0	0	0	76.01
76.02	03022 WOMEN'S CENTER	0	0	0	76.02
76.03	03330 ENDOSCOPY	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 OUTPATIENT	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	0	91.00
91.01	09101 SHORT STAY	0	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (lines 50-199)	0	6,397	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150059	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/29/2013 12:24 pm
		Component CCN: 15T059	Title XVIII	Subprovider - IRF PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0.203810	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.314768	272	0	0	86 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.266948	0	0	0	55.00
57.00	05700	CT SCAN	0.041583	0	0	0	57.00
57.01	03630	ULTRA SOUND	0.102973	0	0	0	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.084219	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.124612	0	0	0	59.00
60.00	06000	LABORATORY	0.194247	2,365	0	0	459 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.509505	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.379919	510	0	0	194 65.00
66.00	06600	PHYSICAL THERAPY	0.399096	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.255230	149	0	0	38 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.317886	3,052	0	0	970 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.242775	49	0	0	12 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.399552	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.837097	0	0	0	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	0	0	76.00
76.01	03021	CARDIAC REHAB	0.465169	0	0	0	76.01
76.02	03022	WOMEN'S CENTER	0.316218	0	0	0	76.02
76.03	03330	ENDOSCOPY	0.231392	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0.000000	0	0	0	90.00
90.01	09001	OUTPATIENT	0.595458	0	0	0	90.01
91.00	09100	EMERGENCY	0.263685	0	0	0	91.00
91.01	09101	SHORT STAY	0.000000	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.558999	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0.931448	0	0	0	95.00
200.00		Subtotal (see instructions)		6,397	0	0	1,759 200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		6,397	0	0	1,759 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150059	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part V Date/Time Prepared: 5/29/2013 12:24 pm
	Component CCN: 15T059	Title XVIII	Subprovider - IRF

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 05000 OPERATING ROOM	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00 05700 CT SCAN	0	0	57.00
57.01 03630 ULTRA SOUND	0	0	57.01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03020 OTHER ANCILLARY	0	0	76.00
76.01 03021 CARDIAC REHAB	0	0	76.01
76.02 03022 WOMEN'S CENTER	0	0	76.02
76.03 03330 ENDOSCOPY	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00 09000 CLINIC	0	0	90.00
90.01 09001 OUTPATIENT	0	0	90.01
91.00 09100 EMERGENCY	0	0	91.00
91.01 09101 SHORT STAY	0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
95.00 09500 AMBULANCE SERVICES	0	0	95.00
200.00	Subtotal (see instructions)	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	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150059 Component CCN: 155669	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/29/2013 12:24 pm
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
57.01	03630 ULTRA SOUND	0	0	0	0	0	57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020 OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03021 CARDIAC REHAB	0	0	0	0	0	76.01
76.02	03022 WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	03330 ENDOSCOPY	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 OUTPATIENT	0	0	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
91.01	09101 SHORT STAY	0	0	0	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150059 Component CCN: 155669	Period: From 01/01/2012 To 12/31/2012	Worksheet D Part IV Date/Time Prepared: 5/29/2013 12:24 pm
		Title XVIII	Skilled Nursing Facility PPS

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	41,351,848	0.000000	0.000000	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	13,416,209	0.000000	0.000000	32,527	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	5,838,616	0.000000	0.000000	0	55.00
57.00 05700 CT SCAN	0	9,217,117	0.000000	0.000000	0	57.00
57.01 03630 ULTRA SOUND	0	2,307,459	0.000000	0.000000	0	57.01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	3,508,684	0.000000	0.000000	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	11,418,455	0.000000	0.000000	0	59.00
60.00 06000 LABORATORY	0	34,590,920	0.000000	0.000000	405,391	60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	2,058,761	0.000000	0.000000	14,036	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	4,102,014	0.000000	0.000000	6,418	65.00
66.00 06600 PHYSICAL THERAPY	0	16,848,905	0.000000	0.000000	941,490	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	9,477,387	0.000000	0.000000	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	43,778,979	0.000000	0.000000	235,417	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	6,168,532	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	20,928,329	0.000000	0.000000	623,032	73.00
74.00 07400 RENAL DIALYSIS	0	423,411	0.000000	0.000000	0	74.00
76.00 03020 OTHER ANCILLARY	0	0	0.000000	0.000000	0	76.00
76.01 03021 CARDIAC REHAB	0	1,633,797	0.000000	0.000000	0	76.01
76.02 03022 WOMEN'S CENTER	0	3,549,302	0.000000	0.000000	0	76.02
76.03 03330 ENDOSCOPY	0	6,255,852	0.000000	0.000000	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0.000000	0.000000	0	90.00
90.01 09001 OUTPATIENT	0	840,295	0.000000	0.000000	0	90.01
91.00 09100 EMERGENCY	0	20,074,525	0.000000	0.000000	0	91.00
91.01 09101 SHORT STAY	0	0	0.000000	0.000000	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3,251,709	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	261,041,106			2,258,311	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150059  
Component CCN: 155669

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/29/2013 12:24 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	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
57.00	05700 CT SCAN	0	0	0	57.00
57.01	03630 ULTRA SOUND	0	0	0	57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	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
76.00	03020 OTHER ANCILLARY	0	0	0	76.00
76.01	03021 CARDIAC REHAB	0	0	0	76.01
76.02	03022 WOMEN'S CENTER	0	0	0	76.02
76.03	03330 ENDOSCOPY	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 OUTPATIENT	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	0	91.00
91.01	09101 SHORT STAY	0	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/29/2013 12:24 pm
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		16,620	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		16,620	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)		14,918	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)		6,365	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		17,749,877	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)		17,749,877	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		25,727,962	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		25,727,962	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.689906	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)		1,724.63	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)		17,749,877	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,067.98	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,797,693	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		6,797,693	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150059	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/29/2013 12:24 pm		
Cost Center Description			Title XVIII		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	3,397,561	2,974	1,142.42	1,498	1,711,345	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)					11,366,452	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					19,875,490	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,582,629	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					803,501	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,386,130	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					17,489,360	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)					1,702	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,067.98	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,817,702	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/29/2013 12:24 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,732,134	17,749,877	0.210263	1,817,702	382,195	90.00
91.00	Nursing School cost	0	17,749,877	0.000000	1,817,702	0	91.00
92.00	Allied health cost	0	17,749,877	0.000000	1,817,702	0	92.00
93.00	All other Medical Education	0	17,749,877	0.000000	1,817,702	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Component CCN: 15T059		Date/Time Prepared: 5/29/2013 12:24 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,759	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,759	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,759	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)		3,952	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,175,078	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)		4,175,078	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		5,675,264	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		5,675,264	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.735662	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)		985.46	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)		4,175,078	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		724.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,865,081	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,865,081	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1	
		Component CCN: 15T059				Date/Time Prepared: 5/29/2013 12:24 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
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
<b>Cost Center Description</b>							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,046,826		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,911,907		49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					454,164		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					58,113		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					512,277		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,399,630		53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059 Component CCN: 15T059		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/29/2013 12:24 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	661,851	4,175,078	0.158524	0	0	90.00
91.00	Nursing School cost	0	4,175,078	0.000000	0	0	91.00
92.00	Allied health cost	0	4,175,078	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,175,078	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059 Component CCN: 155669	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/29/2013 12:24 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,106	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,106	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,106	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)		3,414	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,059,838	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)		3,059,838	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,479,572	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,479,572	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.234019	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)		485.62	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)		3,059,838	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1	
		Component CCN: 155669				Date/Time Prepared: 5/29/2013 12:24 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)						3,059,838 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						599.26 71.00
72.00	Program routine service cost (line 9 x line 71)						2,045,874 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)						2,045,874 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)						2,045,874 83.00
84.00	Program inpatient ancillary services (see instructions)						798,088 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)						2,843,962 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: 150059 Component CCN: 155669		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/29/2013 12:24 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: 150059	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/29/2013 12:24 pm
Cost Center Description		Cost		
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	16,620	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	16,620	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)	14,918	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)	1,009	9.00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00	
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00	
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00	
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00	
15.00	Total nursery days (title V or XIX only)	0	15.00	
16.00	Nursery days (title V or XIX only)	0	16.00	
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00	
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00	
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00	
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00	
21.00	Total general inpatient routine service cost (see instructions)	17,749,877	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)	17,749,877	27.00	
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)	25,727,962	28.00	
29.00	Private room charges (excluding swing-bed charges)	0	29.00	
30.00	Semi-private room charges (excluding swing-bed charges)	25,727,962	30.00	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.689906	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)	1,724.63	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)	17,749,877	37.00	
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,067.98	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,077,592	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)	1,077,592	41.00	

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150059	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/29/2013 12:24 pm	
Cost Center Description			Title XIX	Hospital	Cost	
	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	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,397,561	2,974	1,142.42	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)				788,200	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				1,865,792	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
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge				0.00	55.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00	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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)				1,702	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,067.98	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				1,817,702	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/29/2013 12:24 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1
		Component CCN: 15T059		Date/Time Prepared: 5/29/2013 12:24 pm
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,759	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,759	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,759	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)		124	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,175,078	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)		4,175,078	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		5,675,264	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		5,675,264	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.735662	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)		985.46	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)		4,175,078	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		724.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		89,896	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)		89,896	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1	
		Component CCN: 15T059				Date/Time Prepared: 5/29/2013 12:24 pm	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					88,552		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					178,448		49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0		53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059 Component CCN: 15T059		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/29/2013 12:24 pm	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059 Component CCN: 155669	Period: From 01/01/2012 To 12/31/2012	Worksheet D-1 Date/Time Prepared: 5/29/2013 12:24 pm
		Title XIX	Skilled Nursing Facility	
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,106	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,106	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,106	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,838,249	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)		2,838,249	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,479,572	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,479,572	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.144653	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)		485.62	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)		2,838,249	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059 Component CCN: 155669		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/29/2013 12:24 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						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)					2,838,249	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					555.87	71.00
72.00	Program routine service cost (line 9 x line 71)					0	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					453,873	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					88.89	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					0	83.00
84.00	Program inpatient ancillary services (see instructions)					0	84.00
85.00	Utilization review - physician compensation (see instructions)					0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					0	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059 Component CCN: 155669		Period: From 01/01/2012 To 12/31/2012		Worksheet D-1 Date/Time Prepared: 5/29/2013 12:24 pm	
		Title XIX		Skilled Nursing Facility			
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: 150059	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/29/2013 12:24 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		7,645,165	30.00
31.00	03100	INTENSIVE CARE UNIT		2,979,710	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.203810	9,120,047	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.314768	1,349,715	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.266948	73,870	55.00
57.00	05700	CT SCAN	0.041583	902,322	57.00
57.01	03630	ULTRA SOUND	0.102973	125,708	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.084219	205,613	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.126656	1,286,097	59.00
60.00	06000	LABORATORY	0.194247	5,174,557	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.509505	378,909	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.379919	1,065,154	65.00
66.00	06600	PHYSICAL THERAPY	0.399096	809,349	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.264160	926,132	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.317886	11,949,213	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.242775	1,101,575	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.399552	4,979,519	73.00
74.00	07400	RENAL DIALYSIS	0.837097	220,685	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	76.00
76.01	03021	CARDIAC REHAB	0.465169	56,801	76.01
76.02	03022	WOMEN'S CENTER	0.316218	0	76.02
76.03	03330	ENDOSCOPY	0.231392	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09001	OUTPATIENT	0.596817	0	90.01
91.00	09100	EMERGENCY	0.263685	1,499,030	91.00
91.01	09101	SHORT STAY	0.000000	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.558999	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		41,224,296	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)		41,224,296	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150059 Component CCN: 15T059	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/29/2013 12:24 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
41.00	04100 SUBPROVIDER - IRF		3,893,049	41.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.203810	77,065	15,707 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0 52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.314768	98,200	30,910 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.266948	0	0 55.00
57.00	05700 CT SCAN	0.041583	46,967	1,953 57.00
57.01	03630 ULTRA SOUND	0.102973	5,803	598 57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.084219	7,574	638 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.126656	7,560	958 59.00
60.00	06000 LABORATORY	0.194247	571,655	111,042 60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0 60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.509505	11,139	5,675 63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	0.379919	203,435	77,289 65.00
66.00	06600 PHYSICAL THERAPY	0.399096	3,025,563	1,207,490 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.264160	24,486	6,468 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.317886	621,809	197,664 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.242775	6,191	1,503 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.399552	713,712	285,165 73.00
74.00	07400 RENAL DIALYSIS	0.837097	114,528	95,871 74.00
76.00	03020 OTHER ANCILLARY	0.000000	0	0 76.00
76.01	03021 CARDIAC REHAB	0.465169	0	0 76.01
76.02	03022 WOMEN'S CENTER	0.316218	0	0 76.02
76.03	03330 ENDOSCOPY	0.231392	0	0 76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000	0	0 90.00
90.01	09001 OUTPATIENT	0.596817	0	0 90.01
91.00	09100 EMERGENCY	0.263685	29,941	7,895 91.00
91.01	09101 SHORT STAY	0.000000	0	0 91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.558999	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES			
200.00	Total (sum of lines 50-94 and 96-98)		5,565,628	2,046,826 200.00
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)		5,565,628	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150059 Component CCN: 155669	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/29/2013 12:24 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY		0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.203810	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.314768	32,527	10,238	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.266948	0	0	55.00
57.00	05700 CT SCAN	0.041583	0	0	57.00
57.01	03630 ULTRA SOUND	0.102973	0	0	57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.084219	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.124612	0	0	59.00
60.00	06000 LABORATORY	0.194247	405,391	78,746	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.509505	14,036	7,151	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.379919	6,418	2,438	65.00
66.00	06600 PHYSICAL THERAPY	0.399096	941,490	375,745	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.255230	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.317886	235,417	74,836	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.242775	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.399552	623,032	248,934	73.00
74.00	07400 RENAL DIALYSIS	0.837097	0	0	74.00
76.00	03020 OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03021 CARDIAC REHAB	0.465169	0	0	76.01
76.02	03022 WOMEN'S CENTER	0.316218	0	0	76.02
76.03	03330 ENDOSCOPY	0.231392	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09001 OUTPATIENT	0.595458	0	0	90.01
91.00	09100 EMERGENCY	0.263685	0	0	91.00
91.01	09101 SHORT STAY	0.000000	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.558999	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		2,258,311	798,088	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		2,258,311		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150059	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/29/2013 12:24 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		1,064,593	30.00
31.00	03100	INTENSIVE CARE UNIT		155,437	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.203810	634,967	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.314768	54,690	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.266948	0	55.00
57.00	05700	CT SCAN	0.041583	69,253	57.00
57.01	03630	ULTRA SOUND	0.102973	12,233	57.01
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.084219	19,131	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.124612	130,265	59.00
60.00	06000	LABORATORY	0.194247	426,148	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.509505	16,802	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.379919	118,394	65.00
66.00	06600	PHYSICAL THERAPY	0.399096	33,113	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.255230	59,584	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.317886	764,589	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.242775	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.399552	395,920	73.00
74.00	07400	RENAL DIALYSIS	0.837097	13,896	74.00
76.00	03020	OTHER ANCILLARY	0.000000	0	76.00
76.01	03021	CARDIAC REHAB	0.465169	0	76.01
76.02	03022	WOMEN'S CENTER	0.316218	0	76.02
76.03	03330	ENDOSCOPY	0.231392	35,133	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09001	OUTPATIENT	0.595458	11,486	90.01
91.00	09100	EMERGENCY	0.263685	102,407	91.00
91.01	09101	SHORT STAY	0.000000	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.558999	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		2,898,011	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		2,898,011	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150059 Component CCN: 15T059	Period: From 01/01/2012 To 12/31/2012	Worksheet D-3 Date/Time Prepared: 5/29/2013 12:24 pm
		Title XIX	Subprovider - IRF	Cost
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
41.00	04100 SUBPROVIDER - IRF		137,908	41.00
43.00	04300 NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.203810	8,520	1,736 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0 52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.314768	1,180	371 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.266948	0	0 55.00
57.00	05700 CT SCAN	0.041583	940	39 57.00
57.01	03630 ULTRA SOUND	0.102973	0	0 57.01
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.084219	830	70 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.124612	9,068	1,130 59.00
60.00	06000 LABORATORY	0.194247	34,040	6,612 60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0 60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.509505	1,085	553 63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	0.379919	16,022	6,087 65.00
66.00	06600 PHYSICAL THERAPY	0.399096	103,338	41,242 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.255230	1,170	299 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.317886	36,915	11,735 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.242775	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.399552	35,069	14,012 73.00
74.00	07400 RENAL DIALYSIS	0.837097	2,316	1,939 74.00
76.00	03020 OTHER ANCILLARY	0.000000	0	0 76.00
76.01	03021 CARDIAC REHAB	0.465169	210	98 76.01
76.02	03022 WOMEN'S CENTER	0.316218	0	0 76.02
76.03	03330 ENDOSCOPY	0.231392	1,654	383 76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000	0	0 90.00
90.01	09001 OUTPATIENT	0.595458	3,772	2,246 90.01
91.00	09100 EMERGENCY	0.263685	0	0 91.00
91.01	09101 SHORT STAY	0.000000	0	0 91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.558999	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES			
200.00	Total (sum of lines 50-94 and 96-98)		256,129	88,552 200.00
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)		256,129	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150059	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/29/2013 12:24 pm
		Title VIII	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER PPS</b>				
1.00	DRG Amounts Other than Outlier Payments		13,793,480	1.00
2.00	Outlier payments for discharges. (see instructions)		166,911	2.00
2.01	Outlier reconciliation amount		0	2.01
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		100.35	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.82	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		16.13	31.00
32.00	Sum of lines 30 and 31		18.95	32.00
33.00	Allowable disproportionate share percentage (see instructions)		5.06	33.00
34.00	Disproportionate share adjustment (see instructions)		697,950	34.00
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0	46.00
47.00	Subtotal (see instructions)		14,658,341	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		14,658,341	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		1,190,173	50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0	56.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150059	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part A Date/Time Prepared: 5/29/2013 12:24 pm
		Title XVIII	Hospital	PPS
		1.00		
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).			0 57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)			0 58.00
59.00	Total (sum of amounts on lines 49 through 58)			15,848,514 59.00
60.00	Primary payer payments			15,937 60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			15,832,577 61.00
62.00	Deductibles billed to program beneficiaries			1,498,924 62.00
63.00	Coinurance billed to program beneficiaries			9,826 63.00
64.00	Allowable bad debts (see instructions)			97,059 64.00
65.00	Adjusted reimbursable bad debts (see instructions)			67,941 65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			14,391,768 67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)			0 68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)			0 69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 70.00
70.93	HVBP incentive payment (see instructions)			270 70.93
70.94	Hospital readmissions reduction adjustment (see instructions)			0 70.94
70.95	Recovery of Accelerated Depreciation			0 70.95
70.96	Low Volume Payment-1			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)			14,392,038 71.00
72.00	Interim payments			14,507,103 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)			-115,065 74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			358,169 75.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)			0 90.00
91.00	Capital outlier from Worksheet L, Part I, line 2			0 91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0 92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0 93.00
94.00	The rate used to calculate the Time Value of Money			0.00 94.00
95.00	Time Value of Money for operating expenses(see instructions)			0 95.00
96.00	Time Value of Money for capital related expenses (see instructions)			0 96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150059	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/29/2013 12:24 pm
		Title XVII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		3,443	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		9,680,067	2.00
3.00	PPS payments		8,497,573	3.00
4.00	Outlier payment (see instructions)		43,048	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)		3,443	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		8,617	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)		8,617	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		8,617	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		5,174	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)		3,443	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		8,540,621	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,007,926	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)		6,536,138	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)		6,536,138	30.00
31.00	Primary payer payments		2,453	31.00
32.00	Subtotal (line 30 minus line 31)		6,533,685	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		138,607	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		97,025	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)		6,630,710	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-53	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	AB Re-billing demo amount (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		6,630,763	40.00
41.00	Interim payments		6,727,267	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)		-96,504	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150059	Period: From 01/01/2012 To 12/31/2012	Worksheet E Part B Date/Time Prepared: 5/29/2013 12:24 pm
		Component CCN: 15T059	Title XVII I	Subprovider - IRF
		PPS		
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,759	2.00
3.00	PPS payments		417	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		417	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		87	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)		330	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)		330	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		330	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		330	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	AB Re-billing demo amount (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		330	40.00
41.00	Interim payments		330	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150059

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/29/2013 12:24 pm

Title XVIII

Hospital

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		14,286,759		6,533,115	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	01/01/2012	167,144	01/01/2012	158,652	3.01
3.02		08/29/2012	53,200	08/29/2012	35,500	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)		220,344		194,152	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)		14,507,103		6,727,267	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		115,065		96,504	6.02
7.00	Total Medicare program liability (see instructions)		14,392,038		6,630,763	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: 150059  
Component CCN: 15T059

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/29/2013 12:24 pm  
PPS

Title XVIII

Subprovider -  
IRF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					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		4,970,134		330	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)		4,970,134		330	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		6,239		0	6.02
7.00	Total Medicare program liability (see instructions)		4,963,895		330	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: 150059  
Component CCN: 155669

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/29/2013 12:24 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		1,543,414		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
<b>Program to Provider</b>						
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
<b>Provider to Program</b>						
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)		1,543,414		0	4.00
<b>TO BE COMPLETED BY CONTRACTOR</b>						
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
<b>Program to Provider</b>						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
<b>Provider to Program</b>						
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)		1,543,414		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: 150059	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part III Date/Time Prepared: 5/29/2013 12:24 pm
		Component CCN: 15T059	Title XVIIII	Subprovider - IRF PPS
				1.00
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)		4,892,914	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0392	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		158,755	3.00
4.00	Outlier Payments		45,870	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	5.01
6.00	New Teaching program adjustment. (see instructions)		0.00	6.00
7.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)		0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)		0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)		0.00	9.00
10.00	Average Daily Census (see instructions)		15.734973	10.00
11.00	Medical Education Adjustment Factor {{{(1 + (line 9/line 10)) raised to the power of .6876 -1}}.		0.000000	11.00
12.00	Medical Education Adjustment (line 1 multiplied by line 11).		0	12.00
13.00	Total PPS Payment (sum of lines 1, 3, 4 and 12)		5,097,539	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)		5,097,539	17.00
18.00	Primary payer payments		10,000	18.00
19.00	Subtotal (line 17 less line 18).		5,087,539	19.00
20.00	Deductibles		98,212	20.00
21.00	Subtotal (line 19 minus line 20)		4,989,327	21.00
22.00	Coinsurance		25,432	22.00
23.00	Subtotal (line 21 minus line 22)		4,963,895	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)		4,963,895	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)		4,963,895	32.00
33.00	Interim payments		4,970,134	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)		-6,239	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		107,617	36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4		45,870	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: 150059 Component CCN: 155669	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part VI Date/Time Prepared: 5/29/2013 12:24 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)		1,635,316	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)		1,635,316	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		91,902	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)		1,543,414	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)		1,543,414	15.00
16.00	Interim payments		1,543,414	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150059	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2013 12:24 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		1,865,792		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1,865,792	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		1,865,792	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		1,220,030		8.00
9.00	Ancillary service charges		2,898,011	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		4,118,041	0	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		4,118,041	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		2,252,249	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		1,865,792	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		1,865,792	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1,865,792	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		1,865,792	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		1,865,792	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		1,865,792	0	40.00
41.00	Interim payments		3,712,110	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		-1,846,318	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150059 Component CCN: 15T059	Period: From 01/01/2012 To 12/31/2012	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2013 12:24 pm
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>				
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient hospital/SNF/NF services	178,448		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	178,448	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	178,448	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable Charges</b>				
8.00	Routine service charges	137,908		8.00
9.00	Ancillary service charges	256,129	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	394,037	0	12.00
<b>CUSTOMARY CHARGES</b>				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	394,037	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	215,589	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	178,448	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	178,448	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	178,448	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	178,448	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	178,448	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	178,448	0	40.00
41.00	Interim payments	355,195	0	41.00
42.00	Balance due provider/program (line 40 minus 41)	-176,747	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	0	43.00

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

Provider CCN: 150059

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

Worksheet G

Date/Time Prepared:  
5/29/2013 12:24 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	24,897,579	0	0	0	1.00
2.00	Temporary investments	3,536,030	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	38,287,896	0	0	0	4.00
5.00	Other receivable	333,590	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,994,543	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	19,580,520	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	89,630,158	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	9,814,610	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	198,304,275	0	0	0	15.00
16.00	Accumulated depreciation	-119,615,136	0	0	0	16.00
17.00	Leasehold improvements	3,839,661	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	92,343,410	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	40,143,316	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	3,093,451	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	43,236,767	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	225,210,335	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	12,886,475	0	0	0	37.00
38.00	Salaries, wages, and fees payable	8,216,800	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	30,507,196	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	51,610,471	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	39,736,353	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	39,736,353	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	91,346,824	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	133,863,511				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)	133,863,511	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	225,210,335	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150059

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

Worksheet G-1

Date/Time Prepared:  
5/29/2013 12:24 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		116,921,003		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		16,942,509			2.00
3.00	Total (sum of line 1 and line 2)		133,863,512		0	3.00
4.00		0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		133,863,512		0	11.00
12.00	ROUNDING	1		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		1		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		133,863,511		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00			0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	ROUNDING		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150059

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/29/2013 12:24 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	25,727,962		25,727,962	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	5,675,264		5,675,264	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	2,479,572		2,479,572	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)	33,882,798		33,882,798	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	6,307,780		6,307,780	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)	6,307,780		6,307,780	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	40,190,578		40,190,578	17.00
18.00	Ancillary services	94,964,603	141,637,272	236,601,875	18.00
19.00	Outpatient services	3,362,330	17,552,490	20,914,820	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	111,506	111,506	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN OFFICES	16,306	47,996,529	48,012,835	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	138,533,817	207,297,797	345,831,614	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		157,945,126		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)		157,945,126		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150059

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

Worksheet G-3

Date/Time Prepared:  
5/29/2013 12:24 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	345,831,614	1.00
2.00	Less contractual allowances and discounts on patients' accounts	196,392,768	2.00
3.00	Net patient revenues (line 1 minus line 2)	149,438,846	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	157,945,126	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-8,506,280	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	8,445,740	24.00
24.01	INVESTMENT GAIN (LOSS)	3,976,071	24.01
24.02	CONTRIBUTIONS AND OTHER NONOPERATING	350,710	24.02
24.03	OTHER REVENUE-HOSPITAL OP REVENUE	2,185	24.03
24.04	NON CONTROLLING INTEREST	116,713	24.04
24.05	ADJUSTMENT - LTC	12,557,370	24.05
25.00	Total other income (sum of lines 6-24)	25,448,789	25.00
26.00	Total (line 5 plus line 25)	16,942,509	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)	16,942,509	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150059	Period: From 01/01/2012 To 12/31/2012	Worksheet L Parts I-III Date/Time Prepared: 5/29/2013 12:24 pm
		Title XVII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		1,107,099	1.00
2.00	Capital DRG outlier payments		39,786	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		48.89	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)		2.82	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		16.13	8.00
9.00	Sum of lines 7 and 8		18.95	9.00
10.00	Allowable disproportionate share percentage (see instructions)		3.91	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		43,288	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		1,190,173	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00