

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: 150160	Period: From 01/01/2011 To 12/31/2011	Worksheet S Parts I-III Date/Time Prepared: 5/23/2012 2: 28 pm
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**PART I - COST REPORT STATUS**

Provider use only

1.  Electronically filed cost report Date: 5/23/2012 Time: 2: 28 pm

2.  Manually submitted cost report

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

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

Contractor use only

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

6. Date Received: Contractor No.

7. Contractor No.

8.  Initial Report for this Provider CCN

9.  Final Report for this Provider CCN

10. NPR Date:

11. Contractor's Vendor Code: 04

12.  If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by INDIANA ORTHOPAEDIC HOSPITAL, LLC for the cost reporting period beginning 01/01/2011 and ending 12/31/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 5/23/2012 Time: 2: 28 pm  
K: wWzhDYuPA2Q207bW1YI CksKl q: : 0  
7bqU0ambvXfYGYDgxFhtuRv09fxBg  
TQAb0Yj 20G0aPp1p

PI: Date: 5/23/2012 Time: 2: 28 pm  
eMe25gMSwbtJXBB6dfz3hH2awECV00  
ZZnGT0i ZN447ArYI G7aJKPR70cQQ6C  
IFnav06XI 60mRzKM

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

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

	Title XVIII			HIT	Title XIX	
	Title V	Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	0	0	0	1,392,989	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	0	0	0	1,392,989	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: 150160		Period: From 01/01/2011 To 12/31/2011		Worksheet S-2 Part I Date/Time Prepared: 5/22/2012 4:44 pm						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 8450 NORTHWEST BOULEVARD			PO Box:						1.00		
2.00	City: INDIANAPOLIS			State: IN		Zip Code: 46278		County: MARI ON		2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
				1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		INDIANA ORTHOPAEDIC HOSPITAL, LLC		150160	26900	1	03/23/2005	N	P	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF								N	N	N	7.00
8.00	Swing Beds - NF								N		N	8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF								N		N	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) 1											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:		To:			
							1.00		2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2011		12/31/2011		20.00	
21.00	Type of Control (see instructions)								5		21.00	
Inpatient PPS Information												
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N		N		22.00	
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.						2		N		23.00	
				In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.			0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.			0	0	0	0	0	0		25.00	
							Urban/Rural	S	Date of Geogr			
							1.00		2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.								1		26.00	
27.00	For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification (in column 2).								1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.								0		35.00	
							Beginning:		Ending:			
							1.00		2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscriber line 36 for number of periods in excess of one and enter subsequent dates.										36.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150160	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/22/2012 4:44 pm		
		Beginning:	Ending:			
		1.00	2.00			
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V	XVIII	XIX		
		1.00	2.00	3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
<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.				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	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. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	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	If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet S-2  
Part I  
Date/Time Prepared:  
5/22/2012 4:44 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
65.00	If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. Use subscripted lines 65.01 through 65.50 for each additional primary care program. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4.			0.00	0.00	0.000000	65.00	
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
				1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
67.00	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 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	67.00	
						1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS 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 report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	71.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150160		Period: From 01/01/2011 To 12/31/2011		Worksheet S-2 Part I Date/Time Prepared: 5/22/2012 4:44 pm	
				1.00	2.00	3.00	
<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.	N					75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0		76.00
				1.00			
<b>Long Term Care Hospital PPS</b>							
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "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)(i)? Enter "Y" for yes and "N" for no.				N		86.00
				V		XIX	
				1.00		2.00	
<b>Title V or XIX Inpatient 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)						106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)						107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N					108.00
		Physical		Occupational		Speech	
		1.00		2.00		3.00	
		4.00					
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		109.00
				1.00		2.00	
<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.	N					115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N					116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y					117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1			118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.		250,000		750,000		119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? 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? 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

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		1.00	2.00				
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.						134.00
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		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:			141.00
142.00	Street:	PO Box:		Zip Code:			142.00
143.00	City:	State:					143.00
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		N				144.00
145.00	If costs for renal services are claimed on Worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N				145.00
						1.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N				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		
				1.00	2.00		
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		155.00
156.00	Subprovider - IPF		N		N		156.00
157.00	Subprovider - IRF		N		N		157.00
158.00	SUBPROVIDER		N		N		158.00
159.00	SNF		N		N		159.00
160.00	HOME HEALTH AGENCY		N		N		160.00
161.00	CMHC				N		161.00
						1.00	
Multi campus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
							1.00
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150160	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part II Date/Time Prepared: 5/22/2012 4:44 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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.			Y	15.00
		Part A			
		Description	Y/N	Date	
		0	1.00	2.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	03/23/2012		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N			20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet S-2  
Part II  
Date/Time Prepared:  
5/22/2012 4:44 pm

		Part A			
		Description	Y/N	Date	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	N	2.00	21.00
					1.00
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		Y		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		Y		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		Y		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				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.		N		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
					Y/N
					Date
					1.00
					2.00
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				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

		Part B		
		Y/N	Date	
PS&R Data		3.00	4.00	
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	03/23/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/22/2012 4:44 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours		
	Line Number					
	1.00	2.00	3.00	4.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	38	14,166	0.00		1.00
2.00 HMO						2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		38	14,166	0.00		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)		38	14,166	0.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY	45.00	0	0			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)		38				27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/22/2012 4:44 pm

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	2,041	86	5,680		1.00
2.00 HMO		0	0			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,041	86	5,680		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	2,041	86	5,680		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY	0		0	0		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)						27.00
28.00 Observation Bed Days	0		23	771		28.00
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				0		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			0	0		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/22/2012 4:44 pm

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	813	1.00
2.00 HMO					0	2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	259.01	0.00	0	813	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY	0.00	0.00	0.00			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	259.01	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet S-3  
Part I  
Date/Time Prepared:  
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Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	34	2,304		1.00
2.00 HMO				2.00
3.00 HMO IPF				3.00
4.00 HMO IRF				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF				5.00
6.00 Hospital Adults & Peds. Swing Bed NF				6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)				7.00
8.00 INTENSIVE CARE UNIT				8.00
9.00 CORONARY CARE UNIT				9.00
10.00 BURN INTENSIVE CARE UNIT				10.00
11.00 SURGICAL INTENSIVE CARE UNIT				11.00
12.00 OTHER SPECIAL CARE (SPECIFY)				12.00
13.00 NURSERY				13.00
14.00 Total (see instructions)	34	2,304		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 150160		Period: From 01/01/2011 To 12/31/2011		Worksheet S-3 Part II Date/Time Prepared: 5/22/2012 4:44 pm	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4		
	1.00	2.00	3.00	4.00	5.00		
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	16,051,134	0	16,051,134	538,736.00	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	3.00
4.00	Physician-Part A		0	0	0	0.00	4.00
4.01	Physicians - Part A - direct teaching		0	0	0	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	7.00
7.01	Contracted interns and residents (in approved programs)		0	0	0	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	9.00
10.00	Excluded area salaries (see instructions)		0	0	0	0.00	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract labor (see instructions)		1,208,281	0	1,208,281	22,812.00	11.00
12.00	Management and administrative services		0	0	0	0.00	12.00
13.00	Contract labor: physician-Part A		0	0	0	0.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	14.00
15.00	Home office: physician Part A		0	0	0	0.00	15.00
16.00	Teaching physician salaries (see instructions)		0	0	0	0.00	16.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24		3,699,179	0	3,699,179		17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV Line 25		0	0	0		18.00
19.00	Excluded areas		0	0	0		19.00
20.00	Non-physician anesthetist Part A		0	0	0		20.00
21.00	Non-physician anesthetist Part B		0	0	0		21.00
22.00	Physician Part A		0	0	0		22.00
23.00	Physician Part B		0	0	0		23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0		24.00
25.00	Interns & residents (in an approved program)		0	0	0		25.00
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits	4.00	21,835	0	21,835	816.00	26.00
27.00	Administrative & General	5.00	1,901,904	0	1,901,904	78,306.00	27.00
28.00	Administrative & General under contract (see inst.)		208,441	0	208,441	6,801.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	32.00
33.00	Housekeeping under contract (see instructions)		561,836	0	561,836	37,040.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	34.00
35.00	Dietary under contract (see instructions)		738,442	0	738,442	39,360.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	37.00
38.00	Nursing Administration	13.00	0	0	0	0.00	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	307,782	0	307,782	16,777.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 150160	Period: From 01/01/2011 To 12/31/2011	Worksheet S-3 Part II Date/Time Prepared: 5/22/2012 4:44 pm
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		Average Hourly Wage (col. 4 ÷ col. 5)	
		6.00	
<b>PART II - WAGE DATA</b>			
<b>SALARIES</b>			
1.00	Total salaries (see instructions)	29.79	1.00
2.00	Non-physician anesthetist Part A	0.00	2.00
3.00	Non-physician anesthetist Part B	0.00	3.00
4.00	Physician-Part A	0.00	4.00
4.01	Physicians - Part A - direct teaching	0.00	4.01
5.00	Physician-Part B	0.00	5.00
6.00	Non-physician-Part B	0.00	6.00
7.00	Interns & residents (in an approved program)	0.00	7.00
7.01	Contracted interns and residents (in approved programs)	0.00	7.01
8.00	Home office personnel	0.00	8.00
9.00	SNF	0.00	9.00
10.00	Excluded area salaries (see instructions)	0.00	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>			
11.00	Contract labor (see instructions)	52.97	11.00
12.00	Management and administrative services	0.00	12.00
13.00	Contract labor: physician-Part A	0.00	13.00
14.00	Home office salaries & wage-related costs	0.00	14.00
15.00	Home office: physician Part A	0.00	15.00
16.00	Teaching physician salaries (see instructions)	0.00	16.00
<b>WAGE-RELATED COSTS</b>			
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24		17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV Line 25		18.00
19.00	Excluded areas		19.00
20.00	Non-physician anesthetist Part A		20.00
21.00	Non-physician anesthetist Part B		21.00
22.00	Physician Part A		22.00
23.00	Physician Part B		23.00
24.00	Wage-related costs (RHC/FOHC)		24.00
25.00	Interns & residents (in an approved program)		25.00
<b>OVERHEAD COSTS - DIRECT SALARIES</b>			
26.00	Employee Benefits	26.76	26.00
27.00	Administrative & General	24.29	27.00
28.00	Administrative & General under contract (see inst.)	30.65	28.00
29.00	Maintenance & Repairs	0.00	29.00
30.00	Operation of Plant	0.00	30.00
31.00	Laundry & Linen Service	0.00	31.00
32.00	Housekeeping	0.00	32.00
33.00	Housekeeping under contract (see instructions)	15.17	33.00
34.00	Dietary	0.00	34.00
35.00	Dietary under contract (see instructions)	18.76	35.00
36.00	Cafeteria	0.00	36.00
37.00	Maintenance of Personnel	0.00	37.00
38.00	Nursing Administration	0.00	38.00
39.00	Central Services and Supply	0.00	39.00
40.00	Pharmacy	0.00	40.00
41.00	Medical Records & Medical Records Library	18.35	41.00
42.00	Social Service	0.00	42.00
43.00	Other General Service	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/22/2012 4:44 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>						
1.00	Net salaries (see instructions)	17,559,853	0	17,559,853	621,937.00	1.00
2.00	Excluded area salaries (see instructions)	0	0	0	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	17,559,853	0	17,559,853	621,937.00	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,208,281	0	1,208,281	22,812.00	4.00
5.00	Subtotal wage-related costs (see inst.)	3,699,179	0	3,699,179	0.00	5.00
6.00	Total (sum of lines 3 thru 5)	22,467,313	0	22,467,313	644,749.00	6.00
7.00	Total overhead cost (see instructions)	3,740,240	0	3,740,240	179,100.00	7.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/22/2012 4:44 pm

		Average Hourly Wage (col. 4 ÷ col. 5)	
		6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>			
1.00	Net salaries (see instructions)	28.23	1.00
2.00	Excluded area salaries (see instructions)	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	28.23	3.00
4.00	Subtotal other wages & related costs (see inst.)	52.97	4.00
5.00	Subtotal wage-related costs (see inst.)	21.07	5.00
6.00	Total (sum of lines 3 thru 5)	34.85	6.00
7.00	Total overhead cost (see instructions)	20.88	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150160	Period: From 01/01/2011 To 12/31/2011	Worksheet S-3 Part IV Date/Time Prepared: 5/22/2012 4:44 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		469,380	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost		0	3.00
4.00	Prior Year Pension Service Cost		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)		1,800,314	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		24,833	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)		73,746	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		104,460	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
<b>TAXES</b>				
17.00	FICA-Employers Portion Only		1,144,731	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		81,715	20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		3,699,179	24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet S-3  
Part V  
Date/Time Prepared:  
5/22/2012 4:44 pm

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150160	Period: From 01/01/2011 To 12/31/2011	Worksheet S-10 Date/Time Prepared: 5/22/2012 4:44 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 200 column 3 divided by line 200 column 8)		0.353083		1.00	
<b>Medicaid (see instructions for each line)</b>						
2.00	Net revenue from Medicaid		958,086		2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N		3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0		5.00	
6.00	Medicaid charges		4,086,470		6.00	
7.00	Medicaid cost (line 1 times line 6)		1,442,863		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)		484,777		8.00	
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>						
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	
<b>Other state or local government indigent care program (see instructions for each line)</b>						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00	
<b>Uncompensated care (see instructions for each line)</b>						
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		484,777		19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility		1,616,132	0	1,616,132	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)		570,629	0	570,629	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)		570,629	0	570,629	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)				0 26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)				0 27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)				0 28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)				0 29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		570,629		570,629 30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,055,406		1,055,406 31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet A  
Date/Time Prepared:  
5/22/2012 4:44 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 NEW CAP REL COSTS-BLDG & FIXT		13,237,403	13,237,403	-781,163	12,456,240	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
4.00 EMPLOYEE BENEFITS	21,835	3,900,856	3,922,691	0	3,922,691	4.00
5.00 ADMINISTRATIVE & GENERAL	1,901,904	13,968,267	15,870,171	611,905	16,482,076	5.00
7.00 OPERATION OF PLANT	0	164,355	164,355	125,752	290,107	7.00
10.00 DIETARY	0	1,322,393	1,322,393	-1,152,925	169,468	10.00
11.00 CAFETERIA	0	0	0	1,137,337	1,137,337	11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	197,470	197,470	0	197,470	14.00
16.00 MEDICAL RECORDS & LIBRARY	307,782	87,337	395,119	0	395,119	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	3,366,675	545,077	3,911,752	0	3,911,752	30.00
45.00 NURSING FACILITY	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	7,473,717	6,162,151	13,635,868	43,506	13,679,374	50.00
53.00 ANESTHESIOLOGY	23,229	224,445	247,674	0	247,674	53.00
54.00 RADIOLOGY-DIAGNOSTIC	948,167	1,639,071	2,587,238	0	2,587,238	54.00
60.00 LABORATORY	0	832,153	832,153	0	832,153	60.00
66.00 PHYSICAL THERAPY	1,856,540	211,023	2,067,563	0	2,067,563	66.00
67.00 OCCUPATIONAL THERAPY	151,285	11,046	162,331	0	162,331	67.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	18,475,025	18,475,025	-15,230,112	3,244,913	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	15,230,112	15,230,112	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	2,104,555	2,104,555	0	2,104,555	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00 SUBTOTALS (SUM OF LINES 1-117)	16,051,134	63,082,627	79,133,761	-15,588	79,118,173	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	15,588	15,588	190.00
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	462,079	462,079	0	462,079	194.00
200.00 TOTAL (SUM OF LINES 118-199)	16,051,134	63,544,706	79,595,840	0	79,595,840	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet A  
Date/Time Prepared:  
5/22/2012 4:44 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	NEW CAP REL COSTS-BLDG & FIXT	588,608	13,044,848	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
4.00	EMPLOYEE BENEFITS	65,651	3,988,342	4.00
5.00	ADMINISTRATIVE & GENERAL	-3,504,869	12,977,207	5.00
7.00	OPERATION OF PLANT	0	290,107	7.00
10.00	DIETARY	-18,769	150,699	10.00
11.00	CAFETERIA	-274,117	863,220	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	NURSING ADMINISTRATION	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	197,470	14.00
16.00	MEDICAL RECORDS & LIBRARY	-17,167	377,952	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	-1,701	3,910,051	30.00
45.00	NURSING FACILITY	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	17,229	13,696,603	50.00
53.00	ANESTHESIOLOGY	0	247,674	53.00
54.00	RADIOLOGY-DIAGNOSTIC	-123,816	2,463,422	54.00
60.00	LABORATORY	0	832,153	60.00
66.00	PHYSICAL THERAPY	0	2,067,563	66.00
67.00	OCCUPATIONAL THERAPY	-292	162,039	67.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	231,459	3,476,372	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	15,230,112	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	2,104,555	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00	SUBTOTALS (SUM OF LINES 1-117)	-3,037,784	76,080,389	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,588	190.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	462,079	194.00
200.00	TOTAL (SUM OF LINES 118-199)	-3,037,784	76,558,056	200.00

RECLASSIFICATIONS

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet A-6

Date/Time Prepared:  
5/22/2012 4:44 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
<b>A - CAFETERIA EXPENSE</b>						
1.00	CAFETERIA	11.00	0	1,137,337	1.00	
	TOTALS		0	1,137,337		
<b>B - NON-CAPITAL SURGICAL EQUIPMENT EXPEN</b>						
1.00	OPERATING ROOM	50.00	0	43,506	1.00	
	TOTALS		0	43,506		
<b>C - A&amp;G EXPENSE</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	50,069	1.00	
	TOTALS		0	50,069		
<b>D - PLANT OPERATIONS EXPENSE</b>						
1.00	OPERATION OF PLANT	7.00	0	125,752	1.00	
	TOTALS		0	125,752		
<b>E - IMPLANTABLE DEVICES EXPENSE</b>						
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	15,230,112	1.00	
	TOTALS		0	15,230,112		
<b>F - GIFT SHOP EXPENSE</b>						
1.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	15,588	1.00	
	TOTALS		0	15,588		
<b>G - HOUSEKEEPING CONTRACT LABOR EXPENSE</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	561,836	1.00	
	TOTALS		0	561,836		
500.00	Grand Total: Increases		0	17,164,200	500.00	

RECLASSIFICATIONS

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet A-6  
Date/Time Prepared:  
5/22/2012 4:44 pm

Decreases						Wkst. A-7 Ref.		
Cost Center	Line #	Salary	Other					
6.00	7.00	8.00	9.00	10.00				
A - CAFETERIA EXPENSE								
1.00	DIETARY	10.00	0	1,137,337	0		1.00	
	TOTALS		0	1,137,337				
B - NON-CAPITAL SURGICAL EQUIPMENT EXPEN								
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	43,506	9		1.00	
	TOTALS		0	43,506				
C - A&G EXPENSE								
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	50,069	9		1.00	
	TOTALS		0	50,069				
D - PLANT OPERATIONS EXPENSE								
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	125,752	9		1.00	
	TOTALS		0	125,752				
E - IMPLANTABLE DEVICES EXPENSE								
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	15,230,112	0		1.00	
	TOTALS		0	15,230,112				
F - GIFT SHOP EXPENSE								
1.00	DIETARY	10.00	0	15,588	0		1.00	
	TOTALS		0	15,588				
G - HOUSEKEEPING CONTRACT LABOR EXPENSE								
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	561,836	9		1.00	
	TOTALS		0	561,836				
500.00	Grand Total: Decreases							500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
5/22/2012 4:44 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	778,901	0	0	0	0	1.00
2.00	Land Improvements	166,431	22,659	0	22,659	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	24,483,785	1,538,726	0	1,538,726	1,746,911	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	25,429,117	1,561,385	0	1,561,385	1,746,911	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	25,429,117	1,561,385	0	1,561,385	1,746,911	10.00
<b>SUMMARY OF CAPITAL</b>							
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)		
	9.00	10.00	11.00	12.00	13.00		
	<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	13,237,403	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	13,237,403	0	0	0	0	3.00
<b>COMPUTATION OF RATIOS</b>							
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
	<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	967,991	0	967,991	0.038346	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	24,275,600	0	24,275,600	0.961654	0	2.00
3.00	Total (sum of lines 1-2)	25,243,591	0	25,243,591	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
5/22/2012 4:44 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	778,901	0		1.00		
2.00	Land Improvements	189,090	0		2.00		
3.00	Buildings and Fixtures	0	0		3.00		
4.00	Building Improvements	0	0		4.00		
5.00	Fixed Equipment	0	0		5.00		
6.00	Movable Equipment	24,275,600	0		6.00		
7.00	HIT designated Assets	0	0		7.00		
8.00	Subtotal (sum of lines 1-7)	25,243,591	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	25,243,591	0		10.00		
<b>SUMMARY OF CAPITAL</b>							
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	13,237,403		1.00		
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00		
3.00	Total (sum of lines 1-2)	0	13,237,403		3.00		
<b>ALLOCATION OF OTHER CAPITAL</b>							
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	12,999,681	45,167	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	12,999,681	45,167	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
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Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	13,044,848	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	13,044,848	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet A-8

Date/Time Prepared:  
5/22/2012 4:44 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	
			Cost Center	Line #
			1.00	2.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-1,863	NEW CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00 2.00
3.00 Investment income - other (chapter 2)		0		0.00 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00 7.00
8.00 Television and radio service (chapter 21)		0		0.00 8.00
9.00 Parking lot (chapter 21)		0		0.00 9.00
10.00 Provider-based physician adjustment	A-8-2	0		10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	889,772		12.00
13.00 Laundry and linen service		0		0.00 13.00
14.00 Cafeteria-employees and guests	B	-274,117	CAFETERIA	11.00 14.00
15.00 Rental of quarters to employee and others		0		0.00 15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00 16.00
17.00 Sale of drugs to other than patients		0		0.00 17.00
18.00 Sale of medical records and abstracts	B	-1,667	MEDICAL RECORDS & LIBRARY	16.00 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00 19.00
20.00 Vending machines		0		0.00 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00 23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00 24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00 25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00 27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00 28.00
29.00 Physicians' assistant		0		0.00 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00 30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00 31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	0		0.00 32.00
33.00 LOBBYING EXPENSE	A	-103,579	ADMINISTRATIVE & GENERAL	5.00 33.00
34.00 MARKETING EXPENSE	A	-348,770	ADMINISTRATIVE & GENERAL	5.00 34.00
35.00 APPLICATION FEE REVENUE	B	-10,350	ADMINISTRATIVE & GENERAL	5.00 35.00
36.00 NON-ALLOWABLE BAD DEBT EXPENSE	A	-1,718,552	ADMINISTRATIVE & GENERAL	5.00 36.00
37.00 RADIOLOGY REVENUE	B	-123,816	RADIOLOGY-DIAGNOSTIC	54.00 37.00
38.00 CPNB TRAINING REVENUE	B	-745	ADMINISTRATIVE & GENERAL	5.00 38.00
39.00 CATERING SERVICE REVENUE	B	-18,769	DIETARY	10.00 39.00
40.00 MISCELLANEOUS MEDICARE REVENUE	B	-15,500	MEDICAL RECORDS & LIBRARY	16.00 40.00
41.00 GIFT AND DONATION EXPENSE	A	-4,277	ADMINISTRATIVE & GENERAL	5.00 41.00
42.00 GIFT AND DONATION EXPENSE	A	-1,701	ADULTS & PEDIATRICS	30.00 42.00
43.00 GIFT AND DONATION EXPENSE	A	-4,868	OPERATING ROOM	50.00 43.00
44.00 GIFT AND DONATION EXPENSE	A	-292	OCCUPATIONAL THERAPY	67.00 44.00
45.00 GIFT SHOP REVENUE	B	-27,630	ADMINISTRATIVE & GENERAL	5.00 45.00
46.00 IOH SOUTH CAPITALIZED START UP EXPEN	A	22,097	OPERATING ROOM	50.00 46.00
47.00 IOH SOUTH CAPITALIZED START UP EXPEN	A	231,459	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00 47.00
48.00 IOSC WRITE-OFF EXPENSE	A	-1,491,168	ADMINISTRATIVE & GENERAL	5.00 48.00
49.00 ST FRANCIS LEGAL FEES EXPENSE	A	-33,448	ADMINISTRATIVE & GENERAL	5.00 49.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,037,784		50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet A-8

Date/Time Prepared:  
5/22/2012 4:44 pm

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	9	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	LOBBYING EXPENSE	0	33.00
34.00	MARKETING EXPENSE	0	34.00
35.00	APPLICATION FEE REVENUE	0	35.00
36.00	NON-ALLOWABLE BAD DEBT EXPENSE	0	36.00
37.00	RADIOLOGY REVENUE	0	37.00
38.00	CPNB TRAINING REVENUE	0	38.00
39.00	CATERING SERVICE REVENUE	0	39.00
40.00	MISCELLANEOUS MEDICARE REVENUE	0	40.00
41.00	GIFT AND DONATION EXPENSE	0	41.00
42.00	GIFT AND DONATION EXPENSE	0	42.00
43.00	GIFT AND DONATION EXPENSE	0	43.00
44.00	GIFT AND DONATION EXPENSE	0	44.00
45.00	GIFT SHOP REVENUE	0	45.00
46.00	IOH SOUTH CAPITALIZED START UP EXPEN	0	46.00
47.00	IOH SOUTH CAPITALIZED START UP EXPEN	0	47.00
48.00	IOSC WRITE-OFF EXPENSE	0	48.00
49.00	ST FRANCIS LEGAL FEES EXPENSE	0	49.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

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

Provider CCN: 150160

Period: From 01/01/2011 To 12/31/2011

Worksheet A-8-1

Date/Time Prepared: 5/22/2012 4:44 pm

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	1.00	NEW CAP REL COSTS-BLDG & FIXT	OI CRC	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	OI A&G	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	OI CHARGEBACKS	3.00
4.00	1.00	NEW CAP REL COSTS-BLDG & FIXT	NNS	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	OIE MANAGEMENT FEE	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	OIE A&G	4.02
4.03	4.00	EMPLOYEE BENEFITS	OIE BENEFITS	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	OIE WAGES & PAYROLL TAXES	4.04
4.05	1.00	NEW CAP REL COSTS-BLDG & FIXT	OIE CRC	4.05
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5.00

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

	Symbol (1)	Name	Percentage of Ownership	
	1.00	2.00	3.00	
<b>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	C	OI PRACTICE	0.00	6.00
7.00	C	NNS	100.00	7.00
8.00	C	OI ENTERPRISES	0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:			100.00

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

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

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

Provider CCN: 150160

Period: From 01/01/2011 To 12/31/2011

Worksheet A-8-1

Date/Time Prepared: 5/22/2012 4:44 pm

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	4.00	5.00	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	535,267	0	535,267	9	1.00
2.00	1,393,732	0	1,393,732	0	2.00
3.00	2,618,394	2,618,394	0	0	3.00
4.00	428,503	383,336	45,167	10	4.00
4.01	3,860,153	5,287,562	-1,427,409	0	4.01
4.02	55,937	1,211	54,726	0	4.02
4.03	72,355	6,704	65,651	0	4.03
4.04	290,248	77,647	212,601	0	4.04
4.05	10,037	0	10,037	9	4.05
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	8,374,854	889,772		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			
Name	Percentage of Ownership	Type of Business	
4.00	5.00	6.00	

**B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:**

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

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

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

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

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet B  
Part I  
Date/Time Prepared:  
5/22/2012 4:44 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 NEW CAP REL COSTS-BLDG & FIXT	13,044,848	13,044,848				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0		0			2.00
4.00 EMPLOYEE BENEFITS	3,988,342	0	0	3,988,342		4.00
5.00 ADMINISTRATIVE & GENERAL	12,977,207	459,154	0	473,224	13,909,585	5.00
7.00 OPERATION OF PLANT	290,107	1,810,513	0	0	2,100,620	7.00
10.00 DIETARY	150,699	149,775	0	0	300,474	10.00
11.00 CAFETERIA	863,220	231,621	0	0	1,094,841	11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	197,470	199,936	0	0	397,406	14.00
16.00 MEDICAL RECORDS & LIBRARY	377,952	31,056	0	76,581	485,589	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	3,910,051	2,379,188	0	837,683	7,126,922	30.00
45.00 NURSING FACILITY	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	13,696,603	6,142,994	0	1,859,576	21,699,173	50.00
53.00 ANESTHESIOLOGY	247,674	0	0	5,780	253,454	53.00
54.00 RADIOLOGY-DIAGNOSTIC	2,463,422	645,803	0	235,919	3,345,144	54.00
60.00 LABORATORY	832,153	122,258	0	0	954,411	60.00
66.00 PHYSICAL THERAPY	2,067,563	754,538	0	461,937	3,284,038	66.00
67.00 OCCUPATIONAL THERAPY	162,039	0	0	37,642	199,681	67.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,476,372	0	0	0	3,476,372	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	15,230,112	0	0	0	15,230,112	72.00
73.00 DRUGS CHARGED TO PATIENTS	2,104,555	101,816	0	0	2,206,371	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
92.00 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00 SUBTOTALS (SUM OF LINES 1-117)	76,080,389	13,028,652	0	3,988,342	76,064,193	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,588	16,196	0	0	31,784	190.00
194.00 OTHER NONREIMBURSABLE COST CENTERS	462,079	0	0	0	462,079	194.00
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)	76,558,056	13,044,848	0	3,988,342	76,558,056	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet B  
Part I  
Date/Time Prepared:  
5/22/2012 4:44 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	
		5.00	7.00	10.00	11.00	12.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	13,909,585					5.00
7.00	OPERATION OF PLANT	466,392	2,567,012				7.00
10.00	DIETARY	66,713	35,682	402,869			10.00
11.00	CAFETERIA	243,083	55,180	0	1,393,104		11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	88,234	47,632	0	0	0	14.00
16.00	MEDICAL RECORDS & LIBRARY	107,813	7,399	0	50,852	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	1,582,362	566,803	402,869	345,862	0	30.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	4,817,777	1,463,468	0	745,651	0	50.00
53.00	ANESTHESIOLOGY	56,273	0	0	1,710	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	742,709	153,852	0	74,448	0	54.00
60.00	LABORATORY	211,904	29,126	0	0	0	60.00
66.00	PHYSICAL THERAPY	729,142	179,756	0	164,306	0	66.00
67.00	OCCUPATIONAL THERAPY	44,334	0	0	10,275	0	67.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	771,845	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	3,381,481	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	489,872	24,256	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	13,799,934	2,563,154	402,869	1,393,104	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,057	3,858	0	0	0	190.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	102,594	0	0	0	0	194.00
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)	13,909,585	2,567,012	402,869	1,393,104	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet B  
Part I  
Date/Time Prepared:  
5/22/2012 4:44 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	14.00	16.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
12.00	MAINTENANCE OF PERSONNEL						12.00
13.00	NURSING ADMINISTRATION	0					13.00
14.00	CENTRAL SERVICES & SUPPLY	0	533,272				14.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	651,653			16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	0	0	23,500	10,048,318	0	30.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0	0	368,564	29,094,633	0	50.00
53.00	ANESTHESIOLOGY	0	0	21,676	333,113	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	40,784	4,356,937	0	54.00
60.00	LABORATORY	0	0	8,811	1,204,252	0	60.00
66.00	PHYSICAL THERAPY	0	0	31,772	4,389,014	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	2,714	257,004	0	67.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	533,272	22,940	4,804,429	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	103,408	18,715,001	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	27,484	2,747,983	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	533,272	651,653	75,950,684	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	42,699	0	190.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	564,673	0	194.00
200.00	Cross Foot Adjustments				0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	533,272	651,653	76,558,056	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet B  
Part I  
Date/Time Prepared:  
5/22/2012 4:44 pm

Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	EMPLOYEE BENEFITS		4.00
5.00	ADMINISTRATIVE & GENERAL		5.00
7.00	OPERATION OF PLANT		7.00
10.00	DIETARY		10.00
11.00	CAFETERIA		11.00
12.00	MAINTENANCE OF PERSONNEL		12.00
13.00	NURSING ADMINISTRATION		13.00
14.00	CENTRAL SERVICES & SUPPLY		14.00
16.00	MEDICAL RECORDS & LIBRARY		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	ADULTS & PEDIATRICS	10,048,318	30.00
45.00	NURSING FACILITY	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	OPERATING ROOM	29,094,633	50.00
53.00	ANESTHESIOLOGY	333,113	53.00
54.00	RADIOLOGY-DIAGNOSTIC	4,356,937	54.00
60.00	LABORATORY	1,204,252	60.00
66.00	PHYSICAL THERAPY	4,389,014	66.00
67.00	OCCUPATIONAL THERAPY	257,004	67.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,804,429	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	18,715,001	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,747,983	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00	SUBTOTALS (SUM OF LINES 1-117)	75,950,684	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	42,699	190.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	564,673	194.00
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	76,558,056	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet B  
Part II  
Date/Time Prepared:  
5/22/2012 4:44 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	2A	4.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS	0	0	0	0	0	4.00
5.00 ADMINISTRATIVE & GENERAL	0	459,154	0	459,154	0	5.00
7.00 OPERATION OF PLANT	0	1,810,513	0	1,810,513	0	7.00
10.00 DIETARY	0	149,775	0	149,775	0	10.00
11.00 CAFETERIA	0	231,621	0	231,621	0	11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	199,936	0	199,936	0	14.00
16.00 MEDICAL RECORDS & LIBRARY	0	31,056	0	31,056	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	0	2,379,188	0	2,379,188	0	30.00
45.00 NURSING FACILITY	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	0	6,142,994	0	6,142,994	0	50.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	645,803	0	645,803	0	54.00
60.00 LABORATORY	0	122,258	0	122,258	0	60.00
66.00 PHYSICAL THERAPY	0	754,538	0	754,538	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	101,816	0	101,816	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
92.00 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	13,028,652	0	13,028,652	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,196	0	16,196	0	190.00
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
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	13,044,848	0	13,044,848	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150160	Period: From 01/01/2011 To 12/31/2011	Worksheet B Part II Date/Time Prepared: 5/22/2012 4:44 pm
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	
		5.00	7.00	10.00	11.00	12.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	459,154					5.00
7.00	OPERATION OF PLANT	15,395	1,825,908				7.00
10.00	DIETARY	2,202	25,380	177,357			10.00
11.00	CAFETERIA	8,024	39,249	0	278,894		11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	2,913	33,880	0	0	0	14.00
16.00	MEDICAL RECORDS & LIBRARY	3,559	5,263	0	10,180	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	52,233	403,165	177,357	69,240	0	30.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	159,037	1,040,961	0	149,278	0	50.00
53.00	ANESTHESIOLOGY	1,858	0	0	342	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	24,517	109,435	0	14,904	0	54.00
60.00	LABORATORY	6,995	20,717	0	0	0	60.00
66.00	PHYSICAL THERAPY	24,069	127,860	0	32,893	0	66.00
67.00	OCCUPATIONAL THERAPY	1,463	0	0	2,057	0	67.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,478	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	111,621	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	16,170	17,253	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	455,534	1,823,163	177,357	278,894	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	233	2,745	0	0	0	190.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	3,387	0	0	0	0	194.00
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)	459,154	1,825,908	177,357	278,894	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet B  
Part II  
Date/Time Prepared:  
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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	14.00	16.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
12.00	MAINTENANCE OF PERSONNEL						12.00
13.00	NURSING ADMINISTRATION	0					13.00
14.00	CENTRAL SERVICES & SUPPLY	0	236,729				14.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	50,058			16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	0	0	1,805	3,082,988	0	30.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0	0	28,317	7,520,587	0	50.00
53.00	ANESTHESIOLOGY	0	0	1,665	3,865	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	3,132	797,791	0	54.00
60.00	LABORATORY	0	0	677	150,647	0	60.00
66.00	PHYSICAL THERAPY	0	0	2,440	941,800	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	208	3,728	0	67.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	236,729	1,762	263,969	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	7,941	119,562	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	2,111	137,350	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	236,729	50,058	13,022,287	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	19,174	0	190.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	3,387	0	194.00
200.00	Cross Foot Adjustments				0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	236,729	50,058	13,044,848	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet B  
Part II  
Date/Time Prepared:  
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Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	EMPLOYEE BENEFITS		4.00
5.00	ADMINISTRATIVE & GENERAL		5.00
7.00	OPERATION OF PLANT		7.00
10.00	DIETARY		10.00
11.00	CAFETERIA		11.00
12.00	MAINTENANCE OF PERSONNEL		12.00
13.00	NURSING ADMINISTRATION		13.00
14.00	CENTRAL SERVICES & SUPPLY		14.00
16.00	MEDICAL RECORDS & LIBRARY		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	ADULTS & PEDIATRICS	3,082,988	30.00
45.00	NURSING FACILITY	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	OPERATING ROOM	7,520,587	50.00
53.00	ANESTHESIOLOGY	3,865	53.00
54.00	RADIOLOGY-DIAGNOSTIC	797,791	54.00
60.00	LABORATORY	150,647	60.00
66.00	PHYSICAL THERAPY	941,800	66.00
67.00	OCCUPATIONAL THERAPY	3,728	67.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	263,969	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	119,562	72.00
73.00	DRUGS CHARGED TO PATIENTS	137,350	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00	SUBTOTALS (SUM OF LINES 1-117)	13,022,287	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,174	190.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	3,387	194.00
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	13,044,848	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet B-1  
Date/Time Prepared:  
5/22/2012 4:44 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 NEW CAP REL COSTS-BLDG & FIXT	165,918					1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		0				2.00
4.00 EMPLOYEE BENEFITS	0	0	16,029,299			4.00
5.00 ADMINISTRATIVE & GENERAL	5,840	0	1,901,904	-13,909,585	62,648,471	5.00
7.00 OPERATION OF PLANT	23,028	0	0	0	2,100,620	7.00
10.00 DIETARY	1,905	0	0	0	300,474	10.00
11.00 CAFETERIA	2,946	0	0	0	1,094,841	11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	2,543	0	0	0	397,406	14.00
16.00 MEDICAL RECORDS & LIBRARY	395	0	307,782	0	485,589	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	30,261	0	3,366,675	0	7,126,922	30.00
45.00 NURSING FACILITY	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	78,133	0	7,473,717	0	21,699,173	50.00
53.00 ANESTHESIOLOGY	0	0	23,229	0	253,454	53.00
54.00 RADIOLOGY-DIAGNOSTIC	8,214	0	948,167	0	3,345,144	54.00
60.00 LABORATORY	1,555	0	0	0	954,411	60.00
66.00 PHYSICAL THERAPY	9,597	0	1,856,540	0	3,284,038	66.00
67.00 OCCUPATIONAL THERAPY	0	0	151,285	0	199,681	67.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,476,372	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	15,230,112	72.00
73.00 DRUGS CHARGED TO PATIENTS	1,295	0	0	0	2,206,371	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00 SUBTOTALS (SUM OF LINES 1-117)	165,712	0	16,029,299	-13,909,585	62,154,608	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	206	0	0	0	31,784	190.00
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	462,079	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	13,044,848	0	3,988,342		13,909,585	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	78.622259	0.000000	0.248816		0.222026	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			0		459,154	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000000		0.007329	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet B-1

Date/Time Prepared:  
5/22/2012 4:44 pm

Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	
	7.00	10.00	11.00	12.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT	137,050					7.00
10.00 DIETARY	1,905	100				10.00
11.00 CAFETERIA	2,946	0	459,614			11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	0	0		12.00
13.00 NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	2,543	0	0	0	0	14.00
16.00 MEDICAL RECORDS & LIBRARY	395	0	16,777	0	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	30,261	100	114,107	0	0	30.00
45.00 NURSING FACILITY	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	78,133	0	246,006	0	0	50.00
53.00 ANESTHESIOLOGY	0	0	564	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	8,214	0	24,562	0	0	54.00
60.00 LABORATORY	1,555	0	0	0	0	60.00
66.00 PHYSICAL THERAPY	9,597	0	54,208	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	3,390	0	0	67.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	1,295	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00 SUBTOTALS (SUM OF LINES 1-117)	136,844	100	459,614	0	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	206	0	0	0	0	190.00
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	2,567,012	402,869	1,393,104	0	0	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	18.730478	4,028.690000	3.031030	0.000000	0.000000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	1,825,908	177,357	278,894	0	0	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	13.322933	1,773.570000	0.606800	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet B-1  
Date/Time Prepared:  
5/22/2012 4:44 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		14.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	EMPLOYEE BENEFITS			4.00
5.00	ADMINISTRATIVE & GENERAL			5.00
7.00	OPERATION OF PLANT			7.00
10.00	DIETARY			10.00
11.00	CAFETERIA			11.00
12.00	MAINTENANCE OF PERSONNEL			12.00
13.00	NURSING ADMINISTRATION			13.00
14.00	CENTRAL SERVICES & SUPPLY	100		14.00
16.00	MEDICAL RECORDS & LIBRARY	0	218,508,274	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	0	7,880,595	30.00
45.00	NURSING FACILITY	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	0	123,575,504	50.00
53.00	ANESTHESIOLOGY	0	7,268,942	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	13,676,747	54.00
60.00	LABORATORY	0	2,954,872	60.00
66.00	PHYSICAL THERAPY	0	10,654,674	66.00
67.00	OCCUPATIONAL THERAPY	0	910,204	67.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	100	7,692,758	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	34,677,340	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	9,216,638	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00	SUBTOTALS (SUM OF LINES 1-117)	100	218,508,274	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
200.00	Cross Foot Adjustments			200.00
201.00	Negative Cost Centers			201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	533,272	651,653	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	5,332.720000	0.002982	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	236,729	50,058	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2,367.290000	0.000229	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150160		Period: From 01/01/2011 To 12/31/2011		Worksheet C Part I Date/Time Prepared: 5/22/2012 4:44 pm	
		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	10,048,318		10,048,318	0	10,048,318	30.00
45.00	NURSING FACILITY	0		0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	29,094,633		29,094,633	0	29,094,633	50.00
53.00	ANESTHESIOLOGY	333,113		333,113	0	333,113	53.00
54.00	RADIOLOGY-DIAGNOSTIC	4,356,937		4,356,937	0	4,356,937	54.00
60.00	LABORATORY	1,204,252		1,204,252	0	1,204,252	60.00
66.00	PHYSICAL THERAPY	4,389,014	0	4,389,014	0	4,389,014	66.00
67.00	OCCUPATIONAL THERAPY	257,004	0	257,004	0	257,004	67.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,804,429		4,804,429	0	4,804,429	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	18,715,001		18,715,001	0	18,715,001	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,747,983		2,747,983	0	2,747,983	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1,200,940		1,200,940		1,200,940	92.00
200.00	Subtotal (see instructions)	77,151,624	0	77,151,624	0	77,151,624	200.00
201.00	Less Observation Beds	1,200,940		1,200,940		1,200,940	201.00
202.00	Total (see instructions)	75,950,684	0	75,950,684	0	75,950,684	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet C  
Part I  
Date/Time Prepared:  
5/22/2012 4:44 pm

			Title XVIII		Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	ADULTS & PEDIATRICS	6,970,903		6,970,903			30.00	
45.00	NURSING FACILITY	0		0			45.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	OPERATING ROOM	46,595,650	76,979,854	123,575,504	0.235440	0.000000	50.00	
53.00	ANESTHESIOLOGY	1,636,864	5,632,078	7,268,942	0.045827	0.000000	53.00	
54.00	RADIOLOGY-DIAGNOSTIC	293,528	13,383,219	13,676,747	0.318565	0.000000	54.00	
60.00	LABORATORY	1,607,989	1,346,883	2,954,872	0.407548	0.000000	60.00	
66.00	PHYSICAL THERAPY	1,632,168	9,022,506	10,654,674	0.411933	0.000000	66.00	
67.00	OCCUPATIONAL THERAPY	141,165	769,039	910,204	0.282359	0.000000	67.00	
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,900,648	4,792,110	7,692,758	0.624539	0.000000	71.00	
72.00	IMPL. DEV. CHARGED TO PATIENT	13,075,514	21,601,826	34,677,340	0.539690	0.000000	72.00	
73.00	DRUGS CHARGED TO PATIENTS	3,249,495	5,967,143	9,216,638	0.298155	0.000000	73.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	909,692	909,692	1.320161	0.000000	92.00	
200.00	Subtotal (see instructions)	78,103,924	140,404,350	218,508,274			200.00	
201.00	Less Observation Beds						201.00	
202.00	Total (see instructions)	78,103,924	140,404,350	218,508,274			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150160	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/22/2012 4:44 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS			30.00
45.00	NURSING FACILITY			45.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	0.235440		50.00
53.00	ANESTHESIOLOGY	0.045827		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.318565		54.00
60.00	LABORATORY	0.407548		60.00
66.00	PHYSICAL THERAPY	0.411933		66.00
67.00	OCCUPATIONAL THERAPY	0.282359		67.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.624539		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.539690		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.298155		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.320161		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet C  
Part I  
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5/22/2012 4:44 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	10,048,318		10,048,318	0	0	30.00
45.00	NURSING FACILITY	0		0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	29,094,633		29,094,633	0	0	50.00
53.00	ANESTHESIOLOGY	333,113		333,113	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	4,356,937		4,356,937	0	0	54.00
60.00	LABORATORY	1,204,252		1,204,252	0	0	60.00
66.00	PHYSICAL THERAPY	4,389,014	0	4,389,014	0	0	66.00
67.00	OCCUPATIONAL THERAPY	257,004	0	257,004	0	0	67.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,804,429		4,804,429	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	18,715,001		18,715,001	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,747,983		2,747,983	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1,200,940		1,200,940		0	92.00
200.00	Subtotal (see instructions)	77,151,624	0	77,151,624	0	0	200.00
201.00	Less Observation Beds	1,200,940		1,200,940		0	201.00
202.00	Total (see instructions)	75,950,684	0	75,950,684	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet C  
Part I  
Date/Time Prepared:  
5/22/2012 4:44 pm

			Title XIX		Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	ADULTS & PEDIATRICS	6,970,903		6,970,903			30.00	
45.00	NURSING FACILITY	0		0			45.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	OPERATING ROOM	46,595,650	76,979,854	123,575,504	0.235440	0.000000	50.00	
53.00	ANESTHESIOLOGY	1,636,864	5,632,078	7,268,942	0.045827	0.000000	53.00	
54.00	RADIOLOGY-DIAGNOSTIC	293,528	13,383,219	13,676,747	0.318565	0.000000	54.00	
60.00	LABORATORY	1,607,989	1,346,883	2,954,872	0.407548	0.000000	60.00	
66.00	PHYSICAL THERAPY	1,632,168	9,022,506	10,654,674	0.411933	0.000000	66.00	
67.00	OCCUPATIONAL THERAPY	141,165	769,039	910,204	0.282359	0.000000	67.00	
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,900,648	4,792,110	7,692,758	0.624539	0.000000	71.00	
72.00	IMPL. DEV. CHARGED TO PATIENT	13,075,514	21,601,826	34,677,340	0.539690	0.000000	72.00	
73.00	DRUGS CHARGED TO PATIENTS	3,249,495	5,967,143	9,216,638	0.298155	0.000000	73.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	909,692	909,692	1.320161	0.000000	92.00	
200.00	Subtotal (see instructions)	78,103,924	140,404,350	218,508,274			200.00	
201.00	Less Observation Beds						201.00	
202.00	Total (see instructions)	78,103,924	140,404,350	218,508,274			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150160	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/22/2012 4:44 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS			30.00
45.00	NURSING FACILITY			45.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	0.000000		50.00
53.00	ANESTHESIOLOGY	0.000000		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	LABORATORY	0.000000		60.00
66.00	PHYSICAL THERAPY	0.000000		66.00
67.00	OCCUPATIONAL THERAPY	0.000000		67.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150160		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part I Date/Time Prepared: 5/22/2012 4:44 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)	PPS
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,082,988	0	3,082,988	6,451	477.91	30.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30-199)	3,082,988		3,082,988	6,451		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150160		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part I Date/Time Prepared: 5/22/2012 4:44 pm	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Title XVIII	Hospital	PPS	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>	6.00	7.00				
30.00	ADULTS & PEDIATRICS	2,041	975,414				30.00
45.00	NURSING FACILITY	0	0				45.00
200.00	Total (lines 30-199)	2,041	975,414				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150160		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part II Date/Time Prepared: 5/22/2012 4:44 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	PPS 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	OPERATING ROOM	7,520,587	123,575,504	0.060858	12,119,171	737,549	50.00
53.00	ANESTHESIOLOGY	3,865	7,268,942	0.000532	545,667	290	53.00
54.00	RADIOLOGY-DIAGNOSTIC	797,791	13,676,747	0.058332	185,464	10,818	54.00
60.00	LABORATORY	150,647	2,954,872	0.050983	469,677	23,946	60.00
66.00	PHYSICAL THERAPY	941,800	10,654,674	0.088393	599,145	52,960	66.00
67.00	OCCUPATIONAL THERAPY	3,728	910,204	0.004096	51,467	211	67.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	263,969	7,692,758	0.034314	955,899	32,801	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	119,562	34,677,340	0.003448	7,642,315	26,351	72.00
73.00	DRUGS CHARGED TO PATIENTS	137,350	9,216,638	0.014902	1,065,660	15,880	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	368,468	909,692	0.405047	0	0	92.00
200.00	Total (lines 50-199)	10,307,767	211,537,371		23,634,465	900,806	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150160		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part III Date/Time Prepared: 5/22/2012 4:44 pm	
Cost Center Description		Title XVIII		Hospital		PPS	
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
200.00	Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150160		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part III Date/Time Prepared: 5/22/2012 4:44 pm	
Cost Center Description		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PPS	
		6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	6,451	0.00	2,041	0	30.00	
45.00	NURSING FACILITY	0	0.00	0	0	45.00	
200.00	Total (lines 30-199)	6,451		2,041	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet D  
Part IV  
Date/Time Prepared:  
5/22/2012 4:44 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	OPERATING ROOM	0	0	0	0	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	60.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet D  
Part IV  
Date/Time Prepared:  
5/22/2012 4:44 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	123,575,504	0.000000	0.000000	12,119,171	50.00
53.00	ANESTHESIOLOGY	0	7,268,942	0.000000	0.000000	545,667	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	13,676,747	0.000000	0.000000	185,464	54.00
60.00	LABORATORY	0	2,954,872	0.000000	0.000000	469,677	60.00
66.00	PHYSICAL THERAPY	0	10,654,674	0.000000	0.000000	599,145	66.00
67.00	OCCUPATIONAL THERAPY	0	910,204	0.000000	0.000000	51,467	67.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,692,758	0.000000	0.000000	955,899	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	34,677,340	0.000000	0.000000	7,642,315	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	9,216,638	0.000000	0.000000	1,065,660	73.00
OUTPATIENT SERVICE COST CENTERS							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	909,692	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	211,537,371			23,634,465	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150160	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/22/2012 4:44 pm
Title XVIII		Hospital	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 OPERATING ROOM	0	12,433,892	0	50.00
53.00 ANESTHESIOLOGY	0	838,367	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	2,835,509	0	54.00
60.00 LABORATORY	0	69,962	0	60.00
66.00 PHYSICAL THERAPY	0	3,966	0	66.00
67.00 OCCUPATIONAL THERAPY	0	5,494	0	67.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	568,529	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	999,139	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	871,708	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	106,180	0	92.00
200.00 Total (lines 50-199)	0	18,732,746	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150160	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/22/2012 4:44 pm		
		Title XVIII	Hospital	PPS		
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
	1.00	2.00	3.00	4.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	0.235440	12,433,892	0	0	50.00
53.00	ANESTHESIOLOGY	0.045827	838,367	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.318565	2,835,509	0	0	54.00
60.00	LABORATORY	0.407548	69,962	0	0	60.00
66.00	PHYSICAL THERAPY	0.411933	3,966	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0.282359	5,494	0	0	67.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.624539	568,529	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.539690	999,139	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.298155	871,708	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.320161	106,180	0	0	92.00
200.00	Subtotal (see instructions)		18,732,746	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		18,732,746	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150160		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part V Date/Time Prepared: 5/22/2012 4:44 pm	
		Title XVIII		Hospital		PPS	
Cost Center Description	Costs						
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)				
	5.00	6.00	7.00				
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	2,927,436	0	0			50.00
53.00	ANESTHESIOLOGY	38,420	0	0			53.00
54.00	RADIOLOGY-DIAGNOSTIC	903,294	0	0			54.00
60.00	LABORATORY	28,513	0	0			60.00
66.00	PHYSICAL THERAPY	1,634	0	0			66.00
67.00	OCCUPATIONAL THERAPY	1,551	0	0			67.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	355,069	0	0			71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	539,225	0	0			72.00
73.00	DRUGS CHARGED TO PATIENTS	259,904	0	0			73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	140,175	0	0			92.00
200.00	Subtotal (see instructions)	5,195,221	0	0			200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0			201.00
202.00	Net Charges (line 200 +/- line 201)	5,195,221	0	0			202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150160		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part V Date/Time Prepared: 5/22/2012 4:44 pm	
		Title XIX		Hospital		Cost	
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges					
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
		1.00	2.00	3.00	4.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0.235440	0	1,442,189	0		50.00
53.00	ANESTHESIOLOGY	0.045827	0	127,251	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.318565	0	481,573	0		54.00
60.00	LABORATORY	0.407548	0	26,494	0		60.00
66.00	PHYSICAL THERAPY	0.411933	0	156,404	0		66.00
67.00	OCCUPATIONAL THERAPY	0.282359	0	14,563	0		67.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.624539	0	104,831	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.539690	0	477,564	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.298155	0	196,372	0		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.320161	0	0	0		92.00
200.00	Subtotal (see instructions)		0	3,027,241	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		0	3,027,241	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150160		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part V Date/Time Prepared: 5/22/2012 4:44 pm	
		Title XIX		Hospital		Cost	
Cost Center Description	Costs						
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)				
	5.00	6.00	7.00				
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0	339,549	0			50.00
53.00	ANESTHESIOLOGY	0	5,832	0			53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	153,412	0			54.00
60.00	LABORATORY	0	10,798	0			60.00
66.00	PHYSICAL THERAPY	0	64,428	0			66.00
67.00	OCCUPATIONAL THERAPY	0	4,112	0			67.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	65,471	0			71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	257,737	0			72.00
73.00	DRUGS CHARGED TO PATIENTS	0	58,549	0			73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0			92.00
200.00	Subtotal (see instructions)	0	959,888	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	959,888	0			202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150160	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/22/2012 4:44 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)		6,451	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,451	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		6,451	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,041	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)		10,048,318	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)		10,048,318	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		7,880,595	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		7,880,595	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.275071	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)		1,221.61	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)		10,048,318	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)		1,557.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,179,143	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)		3,179,143	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150160	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/22/2012 4:44 pm
Title XVIII			Hospital		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)					8,429,391 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					11,608,534 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)					975,414 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					900,806 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,876,220 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					9,732,314 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)					771 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,557.64 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,200,940 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150160		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 5/22/2012 4:44 pm	
Title XVIII		Hospital		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	3,082,988	10,048,318	0.306816	1,200,940	368,468	90.00
91.00	Nursing School cost	0	10,048,318	0.000000	1,200,940	0	91.00
92.00	Allied health cost	0	10,048,318	0.000000	1,200,940	0	92.00
93.00	All other Medical Education	0	10,048,318	0.000000	1,200,940	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150160	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/22/2012 4:44 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)		6,451	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,451	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		6,451	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)		86	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)		10,048,318	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)		10,048,318	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		7,880,595	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		7,880,595	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.275071	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)		1,221.61	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)		10,048,318	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)		1,557.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		133,957	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)		133,957	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150160	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/22/2012 4:44 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)				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)				299,144 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				433,101 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				0 54.00
55.00	Target amount per discharge				0.00 55.00
56.00	Target amount (line 54 x line 55)				0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0 57.00
58.00	Bonus payment (see instructions)				0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0 61.00
62.00	Relief payment (see instructions)				0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)				70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				71.00
72.00	Program routine service cost (line 9 x line 71)				72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				76.00
77.00	Program capital-related costs (line 9 x line 76)				77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				80.00
81.00	Inpatient routine service cost per diem limitation				81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				82.00
83.00	Reasonable inpatient routine service costs (see instructions)				83.00
84.00	Program inpatient ancillary services (see instructions)				84.00
85.00	Utilization review - physician compensation (see instructions)				85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)				771 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,557.64 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				1,200,940 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150160		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 5/22/2012 4:44 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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150160	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/22/2012 4:44 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		2,407,928		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.235440	12,119,171	2,853,338	50.00
53.00	ANESTHESIOLOGY	0.045827	545,667	25,006	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.318565	185,464	59,082	54.00
60.00	LABORATORY	0.407548	469,677	191,416	60.00
66.00	PHYSICAL THERAPY	0.411933	599,145	246,808	66.00
67.00	OCCUPATIONAL THERAPY	0.282359	51,467	14,532	67.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.624539	955,899	596,996	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.539690	7,642,315	4,124,481	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.298155	1,065,660	317,732	73.00
OUTPATIENT SERVICE COST CENTERS					
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.320161	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		23,634,465	8,429,391	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)		23,634,465		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150160	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/22/2012 4:44 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		130,579		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.235440	510,716	120,243	50.00
53.00	ANESTHESIOLOGY	0.045827	21,955	1,006	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.318565	90,648	28,877	54.00
60.00	LABORATORY	0.407548	22,386	9,123	60.00
66.00	PHYSICAL THERAPY	0.411933	22,896	9,432	66.00
67.00	OCCUPATIONAL THERAPY	0.282359	2,848	804	67.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.624539	37,130	23,189	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.539690	169,149	91,288	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.298155	50,919	15,182	73.00
OUTPATIENT SERVICE COST CENTERS					
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.320161	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		928,647	299,144	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)		928,647		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150160	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part A Date/Time Prepared: 5/22/2012 4:44 pm
		Title XVII I	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER PPS</b>				
1.00	DRG Amounts Other than Outlier Payments		8,733,337	1.00
2.00	Outlier payments for discharges. (see instructions)		0	2.00
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)		36.70	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)		0.00	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		0.00	31.00
32.00	Sum of lines 30 and 31		0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00
34.00	Disproportionate share adjustment (see instructions)		0	34.00
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0	46.00
47.00	Subtotal (see instructions)		8,733,337	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)		8,733,337	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		706,627	50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0	56.00
57.00	Routine service other pass through costs		0	57.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150160	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part A Date/Time Prepared: 5/22/2012 4:44 pm
		Title XVIII	Hospital	PPS
				1.00
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)			9,439,964 59.00
60.00	Primary payer payments			25,633 60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			9,414,331 61.00
62.00	Deductibles billed to program beneficiaries			856,796 62.00
63.00	Coinsurance billed to program beneficiaries			0 63.00
64.00	Allowable bad debts (see instructions)			0 64.00
65.00	Adjusted reimbursable bad debts (see instructions)			0 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)			8,557,535 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			0 69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 70.00
70.95	Recovery of Accelerated Depreciation			0 70.95
70.96	Low Volume Payment-1			0 70.96
70.97	Low Volume Payment-2			0 70.97
70.98	Low Volume Payment-3			0 70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			8,557,535 71.00
72.00	Interim payments			8,557,535 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)			0 74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 75.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Operating outlier amount from Worksheet E, Part A line 2			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: 150160	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/22/2012 4:44 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			0 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			5,195,221 2.00
3.00	PPS payments			4,609,938 3.00
4.00	Outlier payment (see instructions)			20,049 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			0 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			0 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			4,629,987 24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)			0 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,049,275 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			3,580,712 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			3,580,712 30.00
31.00	Primary payer payments			8,795 31.00
32.00	Subtotal (line 30 minus line 31)			3,571,917 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)			3,571,917 37.00
38.00	MSP-LCC reconciliation amount from PS&R			22 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			3,571,895 40.00
41.00	Interim payments			3,571,895 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: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/22/2012 4:44 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		8,557,535		3,571,895	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		8,557,535		3,571,895	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		8,557,535		3,571,895	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: 150160	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part VII Date/Time Prepared: 5/22/2012 4:44 pm
		Title XIX	Hospital	Cost
				1.00
<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		433,101	1.00
2.00	Medical and other services		959,888	2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1,392,989	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)		1,392,989	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable Charges</b>				
8.00	Routine service charges		130,579	8.00
9.00	Ancillary service charges		3,955,888	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)		4,086,467	12.00
<b>CUSTOMARY CHRGES</b>				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		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	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		4,086,467	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		2,693,478	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		1,392,989	21.00
<b>PROSPECTIVE PAYMENT AMOUNT</b>				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		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	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX enter the sum of lines 27 and 21.		1,392,989	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1,392,989	31.00
32.00	Deductibles		0	32.00
33.00	Coinsurance		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)		1,392,989	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		1,392,989	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)		1,392,989	40.00
41.00	Interim payments		0	41.00
42.00	Balance due provider/program (line 40 minus 41)		1,392,989	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		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: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet G

Date/Time Prepared:  
5/22/2012 4:44 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	14,837,077	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	30,079,061	0	0	0	4.00
5.00	Other receivable	95	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-14,190,379	0	0	0	6.00
7.00	Inventory	1,097,323	0	0	0	7.00
8.00	Prepaid expenses	227,977	0	0	0	8.00
9.00	Other current assets	65,000	0	0	0	9.00
10.00	Due from other funds	18,670	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	32,134,824	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	4,171,823	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	2,290,087	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	24,244,322	0	0	0	23.00
24.00	Accumulated depreciation	-16,554,474	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)	14,151,758	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	102,053	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	102,053	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	46,388,635	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	5,316,703	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,053,661	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	63,891	0	0	0	43.00
44.00	Other current liabilities	2,576,672	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,010,927	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	749,747	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	2,840,316	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,590,063	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	14,600,990	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	31,787,645				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)	31,787,645	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	46,388,635	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet G-1

Date/Time Prepared:  
5/22/2012 4:44 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
1.00	Fund balances at beginning of period		28,837,166		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		41,410,765			2.00
3.00	Total (sum of line 1 and line 2)		70,247,931		0	3.00
4.00	MEMBERSHIP ISSUED	1,024,000		0		4.00
5.00	ROUNDING	1		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)		1,024,001		0	10.00
11.00	Subtotal (line 3 plus line 10)		71,271,932		0	11.00
12.00	DISTRIBUTIONS & MEMBERSHIP REDEEMED	39,484,287		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)		39,484,287		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		31,787,645		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet G-1

Date/Time Prepared:  
5/22/2012 4:44 pm

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
1.00 Fund balances at beginning of period			0		0	1.00
2.00 Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00 Total (sum of line 1 and line 2)			0		0	3.00
4.00 MEMBERSHIP ISSUED	0			0		4.00
5.00 ROUNDING	0			0		5.00
6.00	0			0		6.00
7.00	0			0		7.00
8.00	0			0		8.00
9.00	0			0		9.00
10.00 Total additions (sum of line 4-9)			0		0	10.00
11.00 Subtotal (line 3 plus line 10)			0		0	11.00
12.00 DISTRIBUTIONS & MEMBERSHIP REDEEMED	0			0		12.00
13.00	0			0		13.00
14.00	0			0		14.00
15.00	0			0		15.00
16.00	0			0		16.00
17.00	0			0		17.00
18.00 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: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet G-2 Parts

Date/Time Prepared:  
5/22/2012 4:44 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	7,880,595		7,880,595	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				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				7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	7,880,595		7,880,595	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	7,880,595		7,880,595	17.00
18.00	Ancillary services	71,133,018	139,494,658	210,627,676	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	79,013,613	139,494,658	218,508,271	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		79,595,840		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)		79,595,840		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150160

Period:  
From 01/01/2011  
To 12/31/2011

Worksheet G-3

Date/Time Prepared:  
5/22/2012 4:44 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	218,508,271	1.00
2.00	Less contractual allowances and discounts on patients' accounts	98,789,231	2.00
3.00	Net patient revenues (line 1 minus line 2)	119,719,040	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	79,595,840	4.00
5.00	Net income from service to patients (line 3 minus line 4)	40,123,200	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	818,013	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	301,746	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 MISCELLANEOUS REVENUE	167,806	24.00
25.00	Total other income (sum of lines 6-24)	1,287,565	25.00
26.00	Total (line 5 plus line 25)	41,410,765	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)	41,410,765	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150160	Period: From 01/01/2011 To 12/31/2011	Worksheet L Parts I-III Date/Time Prepared: 5/22/2012 4:44 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		706,627	1.00
2.00	Capital DRG outlier payments		0	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		15.56	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		706,627	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