

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: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet S Parts I-III Date/Time Prepared: 5/28/2012 8:43 pm
--	----------------------	---	--

PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/28/2012	Time: 8:43 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above 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 STARKE MEMORIAL HOSPITAL 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.

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

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

Cost Center Description	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	8,617	-528,150	0	1,190,482	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	8,617	-528,150	0	1,190,482	200.00

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

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet S Parts I-III Date/Time Prepared: 5/28/2012 8:43 pm
--	----------------------	---------------------------------------	---

**PART I - COST REPORT STATUS**

Provider use only  
 1.  Electronically filed cost report Date: 5/28/2012 Time: 8:43 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:  
 7. Contractor No.  
 8.  Initial Report for this Provider CCN  
 9.  Final Report for this Provider CCN  
 10. NPR Date:  
 11. Contractor's Vendor Code: 4  
 12.  If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by STARKE MEMORIAL HOSPITAL 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: 5/28/2012 Time: 8:43 pm  
 LCKdv4XWN1e93snK8Kar7KFOYGHiwO  
 6h7ro0t7H4iVJXJaEvSSCrv4I9vmdM  
 Q5I003qzANOR2R6f  
 PI: Date: 5/28/2012 Time: 8:43 pm  
 j4zGedx5P2DQh5jED.EGE8I99BcTZO  
 aVbmp0tW1EIIhNqLznU8zder5:nGBB  
 FNw5N: : 7tb066CIZ

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

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	8,617	-528,150	0	1,190,482	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	8,617	-528,150	0	1,190,482	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: 150102			Period: From 01/01/2011 To 12/31/2011		Worksheet S-2 Part I Date/Time Prepared: 5/28/2012 8:16 pm			
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: STARKE MEMORIAL HOSPITAL			PO Box:						1.00
2.00	City: KNOX			State: IN		Zip Code: 46534-		County: STARKE		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	STARKE MEMORIAL HOSPITAL	150102	23844	1	07/11/1966	N	P	P	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	STARKE MEMORIAL SWING BED	15U102	23844		09/06/1989	N	P	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF						N		N	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						N	N	N	15.00
16.00	Hospital-Based Health Clinic - FQHC						N	N	N	16.00
17.00	Hospital-Based (CMHC) 1									17.00
17.10	Hospital-Based (CORF) 1						N	N	N	17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:		To:		
						1.00		2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2011		12/31/2011		20.00
21.00	Type of Control (see instructions)							2		21.00
Inpatient PPS Information										
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y		N		22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.							3		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.	169	152	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.							2		26.00
27.00	For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification (in column 2).							2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							0		35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/28/2012 8:16 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	1			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.	01/01/2011	12/31/2011		38.00	
		V 1.00	XVIII 2.00	XIX 3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	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.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	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 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00	
		Program Name 1.00	Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 150102

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

Worksheet S-2  
Part I  
Date/Time Prepared:  
5/28/2012 8:16 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: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/28/2012 8:16 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.			Y	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	97.00
<b>Rural Providers</b>					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
			Physical	Occupational	Speech
			1.00	2.00	3.00
			Respiratory		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
			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.		N		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		0
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		Y
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 150102		Period: From 01/01/2011 To 12/31/2011		Worksheet S-2 Part I Date/Time Prepared: 5/28/2012 8:16 pm		
			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	15H059		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: INDIANA UNIVERSITY HEALTH, LLC		Contractor's Name: NGS		Contractor's Number: 0130			141.00	
142.00	Street: 340 W. 10TH STREET		PO Box:					142.00	
143.00	City: INDIANAPOLIS		State: IN		Zip Code: 46204			143.00	
							1.00		
144.00	Are provider based physicians' costs included in Worksheet A?						Y	144.00	
145.00	If costs for renal services are claimed on Worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.						N	145.00	
			1.00	2.00					
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N	146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	149.00	
					Part A	Part B			
					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		
161.10	CORF					N	161.10		
						1.00			
Multi campus									
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5							0.00	166.00
							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	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part II Date/Time Prepared: 5/28/2012 8:16 pm
		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
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	Type	Date
		1.00	2.00	3.00
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	Legal Oper.	
		1.00	2.00	
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.		Y	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		
		Description	Y/N	Date
		0	1.00	2.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		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)	Y		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: 150102

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
5/28/2012 8:16 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.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		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.		Y		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		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?		Y		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.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00

		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)	N		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)	Y		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150102

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/28/2012 8:16 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	49	17,885	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)		49	17,885	0.00		7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	0.00		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		53	19,345	0.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0			17.00
18.00 SUBPROVIDER	42.00	0	0			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
25.10 CMHC - CORF	99.10					25.10
26.00 RURAL HEALTH CLINIC	88.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00					26.25
27.00 Total (sum of lines 14-26)		53				27.00
28.00 Observation Bed Days						28.00
28.02 SUBPROVIDER - IRF	41.00					28.02
28.03 SUBPROVIDER	42.00					28.03
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: 150102

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/28/2012 8:16 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	1,516	169	2,003		1.00
2.00 HMO		27	159			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	70	0	91		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	1,586	169	2,094		7.00
8.00 INTENSIVE CARE UNIT	0	212	0	492		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	1,798	169	2,586		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0		17.00
18.00 SUBPROVIDER	0	0	0	0		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
25.10 CMHC - CORF	0	0	0	0		25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0		26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	556		28.00
28.02 SUBPROVIDER - IRF				0		28.02
28.03 SUBPROVIDER				0		28.03
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: 150102

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/28/2012 8:16 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	483	1.00
2.00 HMO					9	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	150.04	0.00	0	483	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0.00	0.00	0	0	17.00
18.00 SUBPROVIDER	0.00	0.00	0.00	0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY	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
25.10 CMHC - CORF	0.00	0.00	0.00			25.10
26.00 RURAL HEALTH CLINIC	0.00	0.00	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00 Total (sum of lines 14-26)	0.00	150.04	0.00			27.00
28.00 Observation Bed Days						28.00
28.02 SUBPROVIDER - IRF						28.02
28.03 SUBPROVIDER						28.03
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: 150102

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/28/2012 8:16 pm

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	138	862		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)	138	862		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF	0	0		17.00
18.00 SUBPROVIDER	0	0		18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
25.10 CMHC - CORF				25.10
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
28.02 SUBPROVIDER - IRF				28.02
28.03 SUBPROVIDER				28.03
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: 150102

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/28/2012 8:16 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 II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	7,768,237	0	7,768,237	312,489.92	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)		30,675	0	30,675	2,250.21	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract labor (see instructions)		0	0	0	0.00	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		1,253,250	0	1,253,250		17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV Line 25		0	0	0		18.00
19.00	Excluded areas		7,169	0	7,169		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	35,669	0	35,669	1,840.72	26.00
27.00	Administrative & General	5.00	1,462,268	0	1,462,268	52,184.40	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	29.00
30.00	Operation of Plant	7.00	296,732	0	296,732	15,684.52	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	31.00
32.00	Housekeeping	9.00	145,584	0	145,584	12,599.44	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	33.00
34.00	Dietary	10.00	237,100	-186,827	50,273	3,388.60	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	35.00
36.00	Cafeteria	11.00	0	186,827	186,827	12,593.10	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	37.00
38.00	Nursing Administration	13.00	321,018	0	321,018	9,360.94	38.00
39.00	Central Services and Supply	14.00	0	0	0	4,259.01	39.00
40.00	Pharmacy	15.00	0	0	0	5,748.46	40.00
41.00	Medical Records & Medical Records Library	16.00	261,670	0	261,670	16,538.23	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: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet S-3 Part II Date/Time Prepared: 5/28/2012 8:16 pm
---------------------------------	--	----------------------	---	--

		Average Hourly Wage (col. 4 ÷ col. 5)	
		6.00	
<b>PART II - WAGE DATA</b>			
<b>SALARIES</b>			
1.00	Total salaries (see instructions)	24.86	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)	13.63	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>			
11.00	Contract labor (see instructions)	0.00	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	19.38	26.00
27.00	Administrative & General	28.02	27.00
28.00	Administrative & General under contract (see inst.)	0.00	28.00
29.00	Maintenance & Repairs	0.00	29.00
30.00	Operation of Plant	18.92	30.00
31.00	Laundry & Linen Service	0.00	31.00
32.00	Housekeeping	11.55	32.00
33.00	Housekeeping under contract (see instructions)	0.00	33.00
34.00	Dietary	14.84	34.00
35.00	Dietary under contract (see instructions)	0.00	35.00
36.00	Cafeteria	14.84	36.00
37.00	Maintenance of Personnel	0.00	37.00
38.00	Nursing Administration	34.29	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	15.82	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: 150102		Period: From 01/01/2011 To 12/31/2011		Worksheet S-3 Part III Date/Time Prepared: 5/28/2012 8:16 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)	7,768,237	0	7,768,237	312,489.92		1.00
2.00	Excluded area salaries (see instructions)	30,675	0	30,675	2,250.21		2.00
3.00	Subtotal salaries (line 1 minus line 2)	7,737,562	0	7,737,562	310,239.71		3.00
4.00	Subtotal other wages & related costs (see inst.)	0	0	0	0.00		4.00
5.00	Subtotal wage-related costs (see inst.)	1,253,250	0	1,253,250	0.00		5.00
6.00	Total (sum of lines 3 thru 5)	8,990,812	0	8,990,812	310,239.71		6.00
7.00	Total overhead cost (see instructions)	2,760,041	0	2,760,041	134,197.42		7.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150102

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/28/2012 8:16 pm

		Average Hourly Wage (col. 4 ÷ col. 5)	
		6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>			
1.00	Net salaries (see instructions)	24.86	1.00
2.00	Excluded area salaries (see instructions)	13.63	2.00
3.00	Subtotal salaries (line 1 minus line 2)	24.94	3.00
4.00	Subtotal other wages & related costs (see inst.)	0.00	4.00
5.00	Subtotal wage-related costs (see inst.)	16.20	5.00
6.00	Total (sum of lines 3 thru 5)	28.98	6.00
7.00	Total overhead cost (see instructions)	20.57	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet S-3 Part IV Date/Time Prepared: 5/28/2012 8:16 pm
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
Part A - Core List				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions			0 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	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)		607,801	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		34,688	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		11,731	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)		14,819	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		11,589	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		559,943	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		19,068	19.00
20.00	State or Federal Unemployment Taxes		0	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		780	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		1,260,419	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: 150102

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

Worksheet S-3  
Part V  
Date/Time Prepared:  
5/28/2012 8:16 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	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF	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	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis			17.00
18.00		0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 150102

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

Worksheet S-7  
Date/Time Prepared:  
5/28/2012 8:16 pm

		1.00	2.00		
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.				1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.				2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	0 3.00
4.00		RUL	0	0	0 4.00
5.00		RVX	0	0	0 5.00
6.00		RVL	0	0	0 6.00
7.00		RHX	0	0	0 7.00
8.00		RHL	0	0	0 8.00
9.00		RMX	0	0	0 9.00
10.00		RML	0	0	0 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	0	0	0 12.00
13.00		RUB	0	0	0 13.00
14.00		RUA	0	0	0 14.00
15.00		RVC	0	0	0 15.00
16.00		RVB	0	0	0 16.00
17.00		RVA	0	0	0 17.00
18.00		RHC	0	0	0 18.00
19.00		RHB	0	0	0 19.00
20.00		RHA	0	0	0 20.00
21.00		RMC	0	0	0 21.00
22.00		RMB	0	0	0 22.00
23.00		RMA	0	0	0 23.00
24.00		RLB	0	0	0 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	0	0	0 27.00
28.00		ES1	0	0	0 28.00
29.00		HE2	0	0	0 29.00
30.00		HE1	0	23	23 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	0	7	7 32.00
33.00		HC2	0	0	0 33.00
34.00		HC1	0	0	0 34.00
35.00		HB2	0	0	0 35.00
36.00		HB1	0	0	0 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	0	0	0 38.00
39.00		LD2	0	0	0 39.00
40.00		LD1	0	0	0 40.00
41.00		LC2	0	0	0 41.00
42.00		LC1	0	0	0 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	0	0	0 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	0	0	0 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	0	5	5 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	0	0	0 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	0	3	3 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	0	27	27 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	5	5 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 150102

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

Worksheet S-7

Date/Time Prepared:  
5/28/2012 8:16 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	70	70	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
SNF SERVICES						
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).					201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		0			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet S-10 Date/Time Prepared: 5/28/2012 8:16 pm
---	----------------------	---	--

				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)		0.295937		1.00	
<b>Medicaid (see instructions for each line)</b>						
2.00	Net revenue from Medicaid		1,972,346		2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0		5.00	
6.00	Medicaid charges		10,668,585		6.00	
7.00	Medicaid cost (line 1 times line 6)		3,157,229		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)		1,184,883		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)		1,184,883		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		1,275,477	0		1,275,477
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)		377,461	0		377,461
22.00	Partial payment by patients approved for charity care		0	0		0
23.00	Cost of charity care (line 21 minus line 22)		377,461	0		377,461
				1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?					24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit					0
26.00	Total bad debt expense for the entire hospital complex (see instructions)					0
27.00	Medicare bad debts for the entire hospital complex (see instructions)					123,076
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)					-123,076
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)					-36,423
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)					341,038
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)					1,525,921

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150102

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

Worksheet A  
Date/Time Prepared:  
5/28/2012 8:16 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		0	0	107,323	107,323	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		0	0	312,515	312,515	2.00
4.00 EMPLOYEE BENEFITS	35,669	750,962	786,631	0	786,631	4.00
5.00 ADMINISTRATIVE & GENERAL	1,462,268	7,266,317	8,728,585	-109,688	8,618,897	5.00
7.00 OPERATION OF PLANT	296,732	662,938	959,670	-5,643	954,027	7.00
8.00 LAUNDRY & LINEN SERVICE	0	641	641	0	641	8.00
9.00 HOUSEKEEPING	145,584	98,984	244,568	-5,288	239,280	9.00
10.00 DIETARY	237,100	130,576	367,676	-298,043	69,633	10.00
11.00 CAFETERIA	0	0	0	289,717	289,717	11.00
13.00 NURSING ADMINISTRATION	321,018	64,611	385,629	-757	384,872	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	533,597	533,597	14.00
16.00 MEDICAL RECORDS & LIBRARY	261,670	72,615	334,285	-1,016	333,269	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	816,852	155,471	972,323	-78,816	893,507	30.00
31.00 INTENSIVE CARE UNIT	442,992	64,741	507,733	-23,093	484,640	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
45.00 NURSING FACILITY	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	648,113	912,945	1,561,058	-447,042	1,114,016	50.00
51.00 RECOVERY ROOM	0	554	554	0	554	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	470,222	470,222	-6,766	463,456	53.00
54.00 RADIOLOGY-DIAGNOSTIC	745,648	1,084,398	1,830,046	-132,227	1,697,819	54.00
57.00 CT SCAN	0	230,751	230,751	-21,177	209,574	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	129,255	359,334	488,589	-4,571	484,018	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	455,972	614,300	1,070,272	-159,170	911,102	60.00
65.00 RESPIRATORY THERAPY	353,222	116,632	469,854	-44,837	425,017	65.00
66.00 PHYSICAL THERAPY	136,196	17,559	153,755	-3,798	149,957	66.00
67.00 OCCUPATIONAL THERAPY	93,509	7,159	100,668	-993	99,675	67.00
68.00 SPEECH PATHOLOGY	20,253	1,825	22,078	0	22,078	68.00
69.00 ELECTROCARDIOLOGY	99,624	14,996	114,620	-747	113,873	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	82,876	570,189	653,065	-31,859	621,206	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	138,167	138,167	72.00
73.00 DRUGS CHARGED TO PATIENTS	222,290	512,335	734,625	47,587	782,212	73.00
76.97 CARDIAC REHABILITATION	5,923	1,072	6,995	-1	6,994	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 EMERGENCY	724,796	2,176,718	2,901,514	-53,374	2,848,140	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	7,737,562	16,358,845	24,096,407	0	24,096,407	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 WELLNESS CENTER	4,040	24,616	28,656	0	28,656	193.01
194.00 OTHER NONREIMBURSABLE COST CENTERS	26,635	67,960	94,595	0	94,595	194.00
194.01 VACANT SPACE	0	0	0	0	0	194.01
200.00 TOTAL (SUM OF LINES 118-199)	7,768,237	16,451,421	24,219,658	0	24,219,658	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150102

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

Worksheet A  
Date/Time Prepared:  
5/28/2012 8:16 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	71,318	178,641	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	58,029	370,544	2.00
4.00	EMPLOYEE BENEFITS	1,708,934	2,495,565	4.00
5.00	ADMINISTRATIVE & GENERAL	-4,551,513	4,067,384	5.00
7.00	OPERATION OF PLANT	77,512	1,031,539	7.00
8.00	LAUNDRY & LINEN SERVICE	0	641	8.00
9.00	HOUSEKEEPING	21,619	260,899	9.00
10.00	DIETARY	-73,350	-3,717	10.00
11.00	CAFETERIA	2,578	292,295	11.00
13.00	NURSING ADMINISTRATION	0	384,872	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	533,597	14.00
16.00	MEDICAL RECORDS & LIBRARY	-1,195	332,074	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	0	893,507	30.00
31.00	INTENSIVE CARE UNIT	0	484,640	31.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
45.00	NURSING FACILITY	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	0	1,114,016	50.00
51.00	RECOVERY ROOM	0	554	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	ANESTHESIOLOGY	-465,538	-2,082	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	1,697,819	54.00
57.00	CT SCAN	0	209,574	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	484,018	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	-182,735	728,367	60.00
65.00	RESPIRATORY THERAPY	0	425,017	65.00
66.00	PHYSICAL THERAPY	0	149,957	66.00
67.00	OCCUPATIONAL THERAPY	0	99,675	67.00
68.00	SPEECH PATHOLOGY	0	22,078	68.00
69.00	ELECTROCARDIOLOGY	0	113,873	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	621,206	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	138,167	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	782,212	73.00
76.97	CARDIAC REHABILITATION	0	6,994	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	RURAL HEALTH CLINIC	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	EMERGENCY	-1,214,621	1,633,519	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	CORF	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
109.00	PANCREAS ACQUISITION	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	110.00
111.00	ISLET ACQUISITION	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-4,548,962	19,547,445	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	RESEARCH	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	NONPAID WORKERS	0	0	193.00
193.01	WELLNESS CENTER	-779	27,877	193.01
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	94,595	194.00
194.01	VACANT SPACE	0	0	194.01
200.00	TOTAL (SUM OF LINES 118-199)	-4,549,741	19,669,917	200.00

RECLASSIFICATIONS

Provider CCN: 150102

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

Worksheet A-6

Date/Time Prepared:  
5/28/2012 8:16 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>B - MEALS</b>					
1.00	CAFETERIA	11.00	186,827	102,890	1.00
	TOTALS		186,827	102,890	
<b>C - DRUGS</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	523,640	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	TOTALS		0	523,640	
<b>D - BILLABLE MED SUPPLIES</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	144,114	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	144,114	
<b>E - IMPLANT DEVICES</b>					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	138,167	1.00
	TOTALS		0	138,167	
<b>F - NON-BILLABLE MED SUPPLIES</b>					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	533,597	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
	TOTALS		0	533,597	
<b>G - RENTAL COSTS</b>					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	312,515	1.00
2.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	91,444	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
	TOTALS		0	403,959	
<b>H - INTEREST EXPENSE</b>					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	15,879	1.00
	TOTALS		0	15,879	
500.00	Grand Total: Increases		186,827	1,862,246	500.00

RECLASSIFICATIONS

Provider CCN: 150102

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

Worksheet A-6  
Date/Time Prepared:  
5/28/2012 8:16 pm

Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
<b>B - MEALS</b>							
1.00	DIETARY	10.00	186,827	102,890	0		1.00
	TOTALS		186,827	102,890			
<b>C - DRUGS</b>							
1.00	ADULTS & PEDIATRICS	30.00	0	415	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	20	0		2.00
3.00	OPERATING ROOM	50.00	0	20	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,633	0		4.00
5.00	LABORATORY	60.00	0	73,559	0		5.00
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	447,973	0		6.00
7.00	EMERGENCY	91.00	0	20	0		7.00
	TOTALS		0	523,640			
<b>D - BILLABLE MED SUPPLIES</b>							
1.00	OPERATING ROOM	50.00	0	144,112	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2	0		2.00
	TOTALS		0	144,114			
<b>E - IMPLANT DEVICES</b>							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	138,167	0		1.00
	TOTALS		0	138,167			
<b>F - NON-BILLABLE MED SUPPLIES</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,419	0		1.00
2.00	OPERATION OF PLANT	7.00	0	5,160	0		2.00
3.00	HOUSEKEEPING	9.00	0	5,288	0		3.00
4.00	DIETARY	10.00	0	8,326	0		4.00
5.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	12,062	0		5.00
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	18,121	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	248	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	37,470	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	6,631	0		9.00
10.00	OPERATING ROOM	50.00	0	262,519	0		10.00
11.00	ANESTHESIOLOGY	53.00	0	176	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	25,151	0		12.00
13.00	CT SCAN	57.00	0	20,432	0		13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	2,965	0		14.00
15.00	LABORATORY	60.00	0	36,152	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	21,164	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	2,603	0		17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	702	0		18.00
19.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	25,744	0		19.00
20.00	CARDIAC REHABILITATION	76.97	0	1	0		20.00
21.00	EMERGENCY	91.00	0	33,263	0		21.00
	TOTALS		0	533,597			
<b>G - RENTAL COSTS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	84,390	9		1.00
2.00	OPERATION OF PLANT	7.00	0	483	9		2.00
3.00	NURSING ADMINISTRATION	13.00	0	757	9		3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	768	9		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	40,931	9		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	16,442	9		6.00
7.00	OPERATING ROOM	50.00	0	40,391	9		7.00
8.00	ANESTHESIOLOGY	53.00	0	6,590	9		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	105,441	9		9.00
10.00	CT SCAN	57.00	0	745	9		10.00
11.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,606	9		11.00
12.00	LABORATORY	60.00	0	49,459	9		12.00
13.00	RESPIRATORY THERAPY	65.00	0	23,673	9		13.00
14.00	PHYSICAL THERAPY	66.00	0	1,195	9		14.00
15.00	OCCUPATIONAL THERAPY	67.00	0	291	9		15.00
16.00	ELECTROCARDIOLOGY	69.00	0	747	9		16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	9,959	9		17.00
18.00	EMERGENCY	91.00	0	20,091	9		18.00
19.00		0.00	0	0	9		19.00
	TOTALS		0	403,959			
<b>H - INTEREST EXPENSE</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	15,879	11		1.00
	TOTALS		0	15,879			
500.00	Grand Total: Decreases		186,827	1,862,246			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150102

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
5/28/2012 8:16 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	142,789	0	0	0	0	1.00
2.00	Land Improvements	4,448	0	0	0	0	2.00
3.00	Buildings and Fixtures	1,509,571	0	0	0	0	3.00
4.00	Building Improvements	4,472,680	44,366	0	44,366	0	4.00
5.00	Fixed Equipment	6,651	345,941	0	345,941	0	5.00
6.00	Movable Equipment	2,943,881	4,492,223	0	4,492,223	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	9,080,020	4,882,530	0	4,882,530	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	9,080,020	4,882,530	0	4,882,530	0	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	0	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)	0	0	0	0	0	3.00
Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL	Insurance	
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)		
		1.00	2.00	3.00	4.00		
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	6,526,446	0	6,526,446	0.467425	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	7,436,104	0	7,436,104	0.532575	0	2.00
3.00	Total (sum of lines 1-2)	13,962,550	0	13,962,550	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150102

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
5/28/2012 8:16 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	142,789	0		1.00		
2.00	Land Improvements	4,448	0		2.00		
3.00	Buildings and Fixtures	1,509,571	0		3.00		
4.00	Building Improvements	4,517,046	0		4.00		
5.00	Fixed Equipment	352,592	0		5.00		
6.00	Movable Equipment	7,436,104	0		6.00		
7.00	HIT designated Assets	0	0		7.00		
8.00	Subtotal (sum of lines 1-7)	13,962,550	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	13,962,550	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	0		1.00		
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00		
3.00	Total (sum of lines 1-2)	0	0		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	91,444	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	312,515	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	403,959	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150102

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
5/28/2012 8:16 pm

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	87,197	0	0	0	178,641	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	58,029	0	0	0	370,544	2.00
3.00	Total (sum of lines 1-2)	145,226	0	0	0	549,185	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150102

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

Worksheet A-8

Date/Time Prepared:  
5/28/2012 8:16 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)			NEW CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			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)	A	-238	OPERATION OF PLANT	7.00 8.00
9.00 Parking lot (chapter 21)		0		0.00 9.00
10.00 Provider-based physician adjustment	A-8-2	-1,707,008		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	932,511		12.00
13.00 Laundry and linen service		0		0.00 13.00
14.00 Cafeteria-employees and guests	B	-73,350	DIETARY	10.00 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	-1,195	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		RESPIRATORY THERAPY	65.00 23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00 24.00
25.00 Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***	114.00 25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP	2.00 27.00
28.00 Non-physician Anesthetist			*** Cost Center Deleted ***	19.00 28.00
29.00 Physicians' assistant				0.00 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00 30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY	68.00 31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	0		0.00 32.00
33.00 MARKETING AND ADVERTISING	A	-43,982	ADMINISTRATIVE & GENERAL	5.00 33.00
34.00 EMPLOYEE BENEFITS	A	364,578	EMPLOYEE BENEFITS	4.00 34.00
35.00 PENSION	A	137,499	EMPLOYEE BENEFITS	4.00 35.00
36.00 OTHER BENEFITS	A	999,814	EMPLOYEE BENEFITS	4.00 36.00
37.00 PATIENT PHONES	A	-10,354	OPERATION OF PLANT	7.00 37.00
38.00 PATIENT PHONES	A	-29,575	ADMINISTRATIVE & GENERAL	5.00 38.00
39.00 OTHER MISCELLANEOUS INCOME	B	-48,770	ADMINISTRATIVE & GENERAL	5.00 39.00
40.00 BAD DEBT	A	-5,064,666	ADMINISTRATIVE & GENERAL	5.00 40.00
41.00 PATIENT PHONES	A	-5,005	EMPLOYEE BENEFITS	4.00 41.00
42.00		0		0.00 42.00
43.00		0		0.00 43.00
44.00		0		0.00 44.00
45.00		0		0.00 45.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,549,741		50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150102

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

Worksheet A-8

Date/Time Prepared:  
5/28/2012 8:16 pm

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0	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	MARKETING AND ADVERTISING	0	33.00
34.00	EMPLOYEE BENEFITS	0	34.00
35.00	PENSION	0	35.00
36.00	OTHER BENEFITS	0	36.00
37.00	PATIENT PHONES	0	37.00
38.00	PATIENT PHONES	0	38.00
39.00	OTHER MISCELLANEOUS INCOME	0	39.00
40.00	BAD DEBT	0	40.00
41.00	PATIENT PHONES	0	41.00
42.00		0	42.00
43.00		0	43.00
44.00		0	44.00
45.00		0	45.00
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: 150102

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

Worksheet A-8-1

Date/Time Prepared:  
5/28/2012 8:16 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	NEW CAP REL COSTS-BLDG & FIXT	1.00
2.00	2.00	NEW CAP REL COSTS-MVBLE EQUIP	NEW CAP REL COSTS-MVBLE EQUIP	2.00
3.00	4.00	EMPLOYEE BENEFITS	EMPLOYEE BENEFITS	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE & GENERAL	4.00
4.01	7.00	OPERATION OF PLANT	OPERATION OF PLANT	4.01
4.02	9.00	HOUSEKEEPING	HOUSEKEEPING	4.02
4.03	11.00	CAFETERIA	CAFETERIA	4.03
4.04	60.00	LABORATORY	LABORATORY	4.04
4.05	193.01	WELLNESS CENTER	OTHER NONREIMBURSABLE COST CENTERS	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	B		0.00	6.00
7.00	B		0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:			100.00

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

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

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

Provider CCN: 150102

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

Worksheet A-8-1

Date/Time Prepared: 5/28/2012 8:16 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	71,318	0	71,318	11	1.00
2.00	58,029	0	58,029	11	2.00
3.00	220,488	8,440	212,048	0	3.00
4.00	800,920	138,591	662,329	0	4.00
4.01	88,104	0	88,104	0	4.01
4.02	21,619	0	21,619	0	4.02
4.03	2,578	0	2,578	0	4.03
4.04	39,758	222,493	-182,735	0	4.04
4.05	170	949	-779	0	4.05
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	1,302,984	370,473	932,511	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	IU HEALTH, INC	0.00	HEALTH SYSTEM	6.00
7.00	LAPORTE REGIONAL HEALTH	0.00	HEALTH SYSTEM	7.00
8.00		0.00		8.00
9.00		0.00		9.00
10.00		0.00		10.00
100.00	G. Other (financial or non-financial) specify:			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150102

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

Worksheet A-8-2

Date/Time Prepared:  
5/28/2012 8:16 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	26,849	26,849	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	465,538	465,538	3.00
4.00	60.00	LABORATORY	20,000	0	4.00
5.00	91.00	EMERGENCY	1,887,625	0	5.00
6.00	0.00		0	0	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00			2,400,012	492,387	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150102

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

Worksheet A-8-2

Date/Time Prepared:  
5/28/2012 8:16 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	20,000	208,000	236	23,600	1,180	4.00
5.00	1,887,625	159,800	8,760	673,004	33,650	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	1,907,625		8,996	696,604	34,830	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150102

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

Worksheet A-8-2

Date/Time Prepared:  
5/28/2012 8:16 pm

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 16.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	23,600	4.00
5.00	0	0	0	0	673,004	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	0	0	0	0	696,604	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150102

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

Worksheet A-8-2

Date/Time Prepared:  
5/28/2012 8:16 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	26,849	1.00
2.00	0	0	2.00
3.00	0	465,538	3.00
4.00	0	0	4.00
5.00	1,214,621	1,214,621	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	1,214,621	1,707,008	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150102

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/28/2012 8:16 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	178,641	178,641				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	370,544		370,544			2.00
4.00 EMPLOYEE BENEFITS	2,495,565	732	1,519	2,497,816		4.00
5.00 ADMINISTRATIVE & GENERAL	4,067,384	12,832	26,617	464,570	4,571,403	5.00
7.00 OPERATION OF PLANT	1,031,539	62,089	128,777	96,220	1,318,625	7.00
8.00 LAUNDRY & LINEN SERVICE	641	922	1,913	0	3,476	8.00
9.00 HOUSEKEEPING	260,899	879	1,824	47,208	310,810	9.00
10.00 DIETARY	-3,717	1,315	2,728	16,302	16,628	10.00
11.00 CAFETERIA	292,295	4,883	10,129	60,582	367,889	11.00
13.00 NURSING ADMINISTRATION	384,872	195	405	104,095	489,567	13.00
14.00 CENTRAL SERVICES & SUPPLY	533,597	0	0	0	533,597	14.00
16.00 MEDICAL RECORDS & LIBRARY	332,074	3,066	6,359	84,851	426,350	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	893,507	19,725	40,915	264,877	1,219,024	30.00
31.00 INTENSIVE CARE UNIT	484,640	3,806	7,895	143,647	639,988	31.00
41.00 SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
45.00 NURSING FACILITY	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	1,114,016	16,574	34,379	210,161	1,375,130	50.00
51.00 RECOVERY ROOM	554	823	1,708	0	3,085	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	-2,082	0	0	0	-2,082	53.00
54.00 RADIOLOGY-DIAGNOSTIC	1,697,819	9,039	18,750	241,788	1,967,396	54.00
57.00 CT SCAN	209,574	986	2,046	0	212,606	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	484,018	919	1,907	41,913	528,757	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	728,367	5,175	10,733	147,856	892,131	60.00
65.00 RESPIRATORY THERAPY	425,017	5,797	12,025	114,538	557,377	65.00
66.00 PHYSICAL THERAPY	149,957	4,121	8,549	44,164	206,791	66.00
67.00 OCCUPATIONAL THERAPY	99,675	593	1,231	30,322	131,821	67.00
68.00 SPEECH PATHOLOGY	22,078	593	1,231	6,567	30,469	68.00
69.00 ELECTROCARDIOLOGY	113,873	1,144	2,373	32,305	149,695	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	621,206	3,603	7,473	26,874	659,156	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	138,167	0	0	0	138,167	72.00
73.00 DRUGS CHARGED TO PATIENTS	782,212	1,425	2,955	72,081	858,673	73.00
76.97 CARDIAC REHABILITATION	6,994	2,186	4,535	1,921	15,636	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 EMERGENCY	1,633,519	7,206	14,947	235,027	1,890,699	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	19,547,445	170,628	353,923	2,487,869	19,512,864	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	572	1,186	0	1,758	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 WELLNESS CENTER	27,877	0	0	1,310	29,187	193.01
194.00 OTHER NONREIMBURSABLE COST CENTERS	94,595	0	0	0	94,595	194.00
194.01 VACANT SPACE	0	7,441	15,435	8,637	31,513	194.01
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	19,669,917	178,641	370,544	2,497,816	19,669,917	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150102

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/28/2012 8:16 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<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	4,571,403					5.00
7.00	OPERATION OF PLANT	399,187	1,717,812				7.00
8.00	LAUNDRY & LINEN SERVICE	1,052	15,380	19,908			8.00
9.00	HOUSEKEEPING	94,092	14,667	0	419,569		9.00
10.00	DIETARY	5,034	21,933	0	5,453	49,048	10.00
11.00	CAFETERIA	111,371	81,448	0	20,248	0	11.00
13.00	NURSING ADMINISTRATION	148,207	3,254	0	809	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	161,536	0	0	0	0	14.00
16.00	MEDICAL RECORDS & LIBRARY	129,069	51,134	0	12,712	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	369,035	329,003	13,070	81,789	32,201	30.00
31.00	INTENSIVE CARE UNIT	193,744	63,482	3,210	15,781	7,909	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	416,293	276,442	0	68,722	0	50.00
51.00	RECOVERY ROOM	934	13,731	0	3,413	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	595,589	150,771	0	37,481	0	54.00
57.00	CT SCAN	64,362	16,450	0	4,089	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	160,071	15,336	0	3,812	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	270,075	86,307	0	21,456	0	60.00
65.00	RESPIRATORY THERAPY	168,735	96,695	0	24,038	0	65.00
66.00	PHYSICAL THERAPY	62,602	68,743	0	17,089	0	66.00
67.00	OCCUPATIONAL THERAPY	39,906	9,897	0	2,460	0	67.00
68.00	SPEECH PATHOLOGY	9,224	9,897	0	2,460	0	68.00
69.00	ELECTROCARDIOLOGY	45,317	19,080	0	4,743	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	199,546	60,094	0	14,939	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	41,827	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	259,946	23,761	0	5,907	0	73.00
76.97	CARDIAC REHABILITATION	4,733	36,467	0	9,065	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	572,371	120,188	3,628	29,878	8,938	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	4,523,858	1,584,160	19,908	386,344	49,048	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	532	9,540	0	2,372	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	WELLNESS CENTER	8,836	0	0	0	0	193.01
194.00	OTHER NONREIMBURSABLE COST CENTERS	28,637	0	0	0	0	194.00
194.01	VACANT SPACE	9,540	124,112	0	30,853	0	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	4,571,403	1,717,812	19,908	419,569	49,048	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150102

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/28/2012 8:16 pm

Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	
	11.00	13.00	14.00	16.00	24.00	
<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
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA	580,956					11.00
13.00 NURSING ADMINISTRATION	25,387	667,224				13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	695,133			14.00
16.00 MEDICAL RECORDS & LIBRARY	44,849	48,729	341	713,184		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	103,861	152,118	51,522	38,685	2,390,308	30.00
31.00 INTENSIVE CARE UNIT	46,203	82,496	9,118	9,118	1,071,049	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
45.00 NURSING FACILITY	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	61,323	120,695	360,971	79,277	2,758,853	50.00
51.00 RECOVERY ROOM	0	0	0	9,014	30,177	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	242	15,782	13,942	53.00
54.00 RADIOLOGY-DIAGNOSTIC	68,544	0	34,583	84,719	2,939,083	54.00
57.00 CT SCAN	0	0	28,094	98,694	424,295	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	9,985	0	4,077	33,979	756,017	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	51,788	0	49,710	79,864	1,451,331	60.00
65.00 RESPIRATORY THERAPY	31,761	65,779	29,101	11,509	984,995	65.00
66.00 PHYSICAL THERAPY	16,360	25,363	3,579	10,500	411,027	66.00
67.00 OCCUPATIONAL THERAPY	6,093	17,414	965	3,969	212,525	67.00
68.00 SPEECH PATHOLOGY	1,975	0	0	396	54,421	68.00
69.00 ELECTROCARDIOLOGY	6,995	18,552	0	21,420	265,802	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	11,565	0	38,586	15,039	998,925	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	13,398	8,213	201,605	72.00
73.00 DRUGS CHARGED TO PATIENTS	15,570	0	24,917	66,572	1,255,346	73.00
76.97 CARDIAC REHABILITATION	1,128	1,103	1	28	68,161	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 EMERGENCY	71,477	134,975	45,737	126,406	3,004,297	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	574,864	667,224	694,942	713,184	19,292,159	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	14,202	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 WELLNESS CENTER	338	0	0	0	38,361	193.01
194.00 OTHER NONREIMBURSABLE COST CENTERS	5,754	0	191	0	129,177	194.00
194.01 VACANT SPACE	0	0	0	0	196,018	194.01
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	580,956	667,224	695,133	713,184	19,669,917	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150102

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/28/2012 8:16 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	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
8.00	LAUNDRY & LINEN SERVICE			8.00
9.00	HOUSEKEEPING			9.00
10.00	DIETARY			10.00
11.00	CAFETERIA			11.00
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	0	2,390,308	30.00
31.00	INTENSIVE CARE UNIT	0	1,071,049	31.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
45.00	NURSING FACILITY	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	0	2,758,853	50.00
51.00	RECOVERY ROOM	0	30,177	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	ANESTHESIOLOGY	0	13,942	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	2,939,083	54.00
57.00	CT SCAN	0	424,295	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	756,017	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	0	1,451,331	60.00
65.00	RESPIRATORY THERAPY	0	984,995	65.00
66.00	PHYSICAL THERAPY	0	411,027	66.00
67.00	OCCUPATIONAL THERAPY	0	212,525	67.00
68.00	SPEECH PATHOLOGY	0	54,421	68.00
69.00	ELECTROCARDIOLOGY	0	265,802	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	998,925	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	201,605	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,255,346	73.00
76.97	CARDIAC REHABILITATION	0	68,161	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	RURAL HEALTH CLINIC	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	EMERGENCY	0	3,004,297	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	CORF	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
109.00	PANCREAS ACQUISITION	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	110.00
111.00	ISLET ACQUISITION	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	19,292,159	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,202	190.00
191.00	RESEARCH	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	NONPAID WORKERS	0	0	193.00
193.01	WELLNESS CENTER	0	38,361	193.01
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	129,177	194.00
194.01	VACANT SPACE	0	196,018	194.01
200.00	Cross Foot Adjustments	0	0	200.00
201.00	Negative Cost Centers	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	19,669,917	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150102

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/28/2012 8:16 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			
<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	732	1,519	2,251	2,251 4.00
5.00	ADMINISTRATIVE & GENERAL	0	12,832	26,617	39,449	418 5.00
7.00	OPERATION OF PLANT	0	62,089	128,777	190,866	87 7.00
8.00	LAUNDRY & LINEN SERVICE	0	922	1,913	2,835	0 8.00
9.00	HOUSEKEEPING	0	879	1,824	2,703	43 9.00
10.00	DIETARY	0	1,315	2,728	4,043	15 10.00
11.00	CAFETERIA	0	4,883	10,129	15,012	55 11.00
13.00	NURSING ADMINISTRATION	0	195	405	600	94 13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0 14.00
16.00	MEDICAL RECORDS & LIBRARY	0	3,066	6,359	9,425	76 16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS	0	19,725	40,915	60,640	239 30.00
31.00	INTENSIVE CARE UNIT	0	3,806	7,895	11,701	129 31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0 41.00
42.00	SUBPROVIDER	0	0	0	0	0 42.00
45.00	NURSING FACILITY	0	0	0	0	0 45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	0	16,574	34,379	50,953	189 50.00
51.00	RECOVERY ROOM	0	823	1,708	2,531	0 51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	9,039	18,750	27,789	218 54.00
57.00	CT SCAN	0	986	2,046	3,032	0 57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	919	1,907	2,826	38 58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00	LABORATORY	0	5,175	10,733	15,908	133 60.00
65.00	RESPIRATORY THERAPY	0	5,797	12,025	17,822	103 65.00
66.00	PHYSICAL THERAPY	0	4,121	8,549	12,670	40 66.00
67.00	OCCUPATIONAL THERAPY	0	593	1,231	1,824	27 67.00
68.00	SPEECH PATHOLOGY	0	593	1,231	1,824	6 68.00
69.00	ELECTROCARDIOLOGY	0	1,144	2,373	3,517	29 69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,603	7,473	11,076	24 71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,425	2,955	4,380	65 73.00
76.97	CARDIAC REHABILITATION	0	2,186	4,535	6,721	2 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
91.00	EMERGENCY	0	7,206	14,947	22,153	212 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	CORF	0	0	0	0	0 99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00	PANCREAS ACQUISITION	0	0	0	0	0 109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00	ISLET ACQUISITION	0	0	0	0	0 111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	170,628	353,923	524,551	2,242 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	572	1,186	1,758	0 190.00
191.00	RESEARCH	0	0	0	0	0 191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
193.00	NONPAID WORKERS	0	0	0	0	0 193.00
193.01	WELLNESS CENTER	0	0	0	0	1 193.01
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.00
194.01	VACANT SPACE	0	7,441	15,435	22,876	8 194.01
200.00	Cross Foot Adjustments				0	0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	178,641	370,544	549,185	2,251 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150102

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/28/2012 8:16 pm

Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	5.00	7.00	8.00	9.00	10.00	
<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	39,867					5.00
7.00 OPERATION OF PLANT	3,481	194,434				7.00
8.00 LAUNDRY & LINEN SERVICE	9	1,741	4,585			8.00
9.00 HOUSEKEEPING	821	1,660	0	5,227		9.00
10.00 DIETARY	44	2,483	0	68	6,184	10.00
11.00 CAFETERIA	971	9,219	0	252	0	11.00
13.00 NURSING ADMINISTRATION	1,292	368	0	10	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	1,409	0	0	0	0	14.00
16.00 MEDICAL RECORDS & LIBRARY	1,126	5,788	0	158	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	3,218	37,237	3,010	1,019	4,060	30.00
31.00 INTENSIVE CARE UNIT	1,690	7,185	739	197	997	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
45.00 NURSING FACILITY	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	3,630	31,290	0	856	0	50.00
51.00 RECOVERY ROOM	8	1,554	0	43	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	5,197	17,065	0	467	0	54.00
57.00 CT SCAN	561	1,862	0	51	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	1,396	1,736	0	47	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	2,355	9,769	0	267	0	60.00
65.00 RESPIRATORY THERAPY	1,471	10,945	0	299	0	65.00
66.00 PHYSICAL THERAPY	546	7,781	0	213	0	66.00
67.00 OCCUPATIONAL THERAPY	348	1,120	0	31	0	67.00
68.00 SPEECH PATHOLOGY	80	1,120	0	31	0	68.00
69.00 ELECTROCARDIOLOGY	395	2,160	0	59	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,740	6,802	0	186	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	365	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	2,267	2,689	0	74	0	73.00
76.97 CARDIAC REHABILITATION	41	4,128	0	113	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 EMERGENCY	4,991	13,604	836	372	1,127	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	39,452	179,306	4,585	4,813	6,184	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5	1,080	0	30	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 WELLNESS CENTER	77	0	0	0	0	193.01
194.00 OTHER NONREIMBURSABLE COST CENTERS	250	0	0	0	0	194.00
194.01 VACANT SPACE	83	14,048	0	384	0	194.01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	469	201.00
202.00 TOTAL (sum lines 118-201)	39,867	194,434	4,585	5,227	6,653	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150102

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/28/2012 8:16 pm

Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	Subtotal	
	11.00	13.00	14.00	16.00	24.00	
<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
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA	25,509					11.00
13.00 NURSING ADMINISTRATION	1,115	3,479				13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	1,409			14.00
16.00 MEDICAL RECORDS & LIBRARY	1,969	254	1	18,797		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	4,558	793	104	1,020	115,898	30.00
31.00 INTENSIVE CARE UNIT	2,029	430	18	240	25,355	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
45.00 NURSING FACILITY	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	2,693	629	733	2,091	93,064	50.00
51.00 RECOVERY ROOM	0	0	0	238	4,374	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	416	416	53.00
54.00 RADIOLOGY-DIAGNOSTIC	3,010	0	70	2,234	56,050	54.00
57.00 CT SCAN	0	0	57	2,603	8,166	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	438	0	8	896	7,385	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	2,274	0	101	2,106	32,913	60.00
65.00 RESPIRATORY THERAPY	1,395	343	59	303	32,740	65.00
66.00 PHYSICAL THERAPY	718	132	7	277	22,384	66.00
67.00 OCCUPATIONAL THERAPY	268	91	2	105	3,816	67.00
68.00 SPEECH PATHOLOGY	87	0	0	10	3,158	68.00
69.00 ELECTROCARDIOLOGY	307	97	0	565	7,129	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	508	0	78	397	20,811	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	27	217	609	72.00
73.00 DRUGS CHARGED TO PATIENTS	684	0	51	1,755	11,965	73.00
76.97 CARDIAC REHABILITATION	50	6	0	1	11,062	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 EMERGENCY	3,138	704	93	3,323	50,553	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	25,241	3,479	1,409	18,797	507,848	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	2,873	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 WELLNESS CENTER	15	0	0	0	93	193.01
194.00 OTHER NONREIMBURSABLE COST CENTERS	253	0	0	0	503	194.00
194.01 VACANT SPACE	0	0	0	0	37,399	194.01
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers	0	0	0	0	469	201.00
202.00 TOTAL (sum lines 118-201)	25,509	3,479	1,409	18,797	549,185	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150102

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/28/2012 8:16 pm

Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	25.00	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
8.00 LAUNDRY & LINEN SERVICE			8.00
9.00 HOUSEKEEPING			9.00
10.00 DIETARY			10.00
11.00 CAFETERIA			11.00
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	0	115,898	30.00
31.00 INTENSIVE CARE UNIT	0	25,355	31.00
41.00 SUBPROVIDER - IRF	0	0	41.00
42.00 SUBPROVIDER	0	0	42.00
45.00 NURSING FACILITY	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 OPERATING ROOM	0	93,064	50.00
51.00 RECOVERY ROOM	0	4,374	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 ANESTHESIOLOGY	0	416	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	56,050	54.00
57.00 CT SCAN	0	8,166	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	7,385	58.00
59.00 CARDIAC CATHETERIZATION	0	0	59.00
60.00 LABORATORY	0	32,913	60.00
65.00 RESPIRATORY THERAPY	0	32,740	65.00
66.00 PHYSICAL THERAPY	0	22,384	66.00
67.00 OCCUPATIONAL THERAPY	0	3,816	67.00
68.00 SPEECH PATHOLOGY	0	3,158	68.00
69.00 ELECTROCARDIOLOGY	0	7,129	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	20,811	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	609	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	11,965	73.00
76.97 CARDIAC REHABILITATION	0	11,062	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00 RURAL HEALTH CLINIC	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00 EMERGENCY	0	50,553	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
99.10 CORF	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>			
109.00 PANCREAS ACQUISITION	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	110.00
111.00 ISLET ACQUISITION	0	0	111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	507,848	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,873	190.00
191.00 RESEARCH	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00 NONPAID WORKERS	0	0	193.00
193.01 WELLNESS CENTER	0	93	193.01
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	503	194.00
194.01 VACANT SPACE	0	37,399	194.01
200.00 Cross Foot Adjustments	0	0	200.00
201.00 Negative Cost Centers	0	469	201.00
202.00 TOTAL (sum lines 118-201)	0	549,185	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150102

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

Worksheet B-1  
Date/Time Prepared:  
5/28/2012 8:16 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 NEW CAP REL COSTS-BLDG & FIXT	66,836						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		66,836					2.00
4.00 EMPLOYEE BENEFITS	274	274	7,702,993				4.00
5.00 ADMINISTRATIVE & GENERAL	4,801	4,801	1,432,693	-4,571,403	15,100,596		5.00
7.00 OPERATION OF PLANT	23,228	23,228	296,732	0	1,318,625		7.00
8.00 LAUNDRY & LINEN SERVICE	345	345	0	0	3,476		8.00
9.00 HOUSEKEEPING	329	329	145,584	0	310,810		9.00
10.00 DIETARY	492	492	50,273	0	16,628		10.00
11.00 CAFETERIA	1,827	1,827	186,827	0	367,889		11.00
13.00 NURSING ADMINISTRATION	73	73	321,018	0	489,567		13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0	533,597		14.00
16.00 MEDICAL RECORDS & LIBRARY	1,147	1,147	261,670	0	426,350		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 ADULTS & PEDIATRICS	7,380	7,380	816,852	0	1,219,024		30.00
31.00 INTENSIVE CARE UNIT	1,424	1,424	442,992	0	639,988		31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0		41.00
42.00 SUBPROVIDER	0	0	0	0	0		42.00
45.00 NURSING FACILITY	0	0	0	0	0		45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 OPERATING ROOM	6,201	6,201	648,113	0	1,375,130		50.00
51.00 RECOVERY ROOM	308	308	0	0	3,085		51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0		52.00
53.00 ANESTHESIOLOGY	0	0	0	2,082	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	3,382	3,382	745,648	0	1,967,396		54.00
57.00 CT SCAN	369	369	0	0	212,606		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	344	344	129,255	0	528,757		58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0		59.00
60.00 LABORATORY	1,936	1,936	455,972	0	892,131		60.00
65.00 RESPIRATORY THERAPY	2,169	2,169	353,222	0	557,377		65.00
66.00 PHYSICAL THERAPY	1,542	1,542	136,196	0	206,791		66.00
67.00 OCCUPATIONAL THERAPY	222	222	93,509	0	131,821		67.00
68.00 SPEECH PATHOLOGY	222	222	20,253	0	30,469		68.00
69.00 ELECTROCARDIOLOGY	428	428	99,624	0	149,695		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,348	1,348	82,876	0	659,156		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	138,167		72.00
73.00 DRUGS CHARGED TO PATIENTS	533	533	222,290	0	858,673		73.00
76.97 CARDIAC REHABILITATION	818	818	5,923	0	15,636		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 RURAL HEALTH CLINIC	0	0	0	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0		89.00
91.00 EMERGENCY	2,696	2,696	724,796	0	1,890,699		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)							92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10 CORF	0	0	0	0	0		99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00 PANCREAS ACQUISITION	0	0	0	0	0		109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0		110.00
111.00 ISLET ACQUISITION	0	0	0	0	0		111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	63,838	63,838	7,672,318	-4,569,321	14,943,543		118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	214	214	0	0	1,758		190.00
191.00 RESEARCH	0	0	0	0	0		191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0		192.00
193.00 NONPAID WORKERS	0	0	0	0	0		193.00
193.01 WELLNESS CENTER	0	0	4,040	0	29,187		193.01
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	94,595		194.00
194.01 VACANT SPACE	2,784	2,784	26,635	0	31,513		194.01
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)	178,641	370,544	2,497,816		4,571,403		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	2.672826	5.544078	0.324266		0.302730		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			2,251		39,867		204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000292		0.002640		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150102

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

Worksheet B-1  
Date/Time Prepared:  
5/28/2012 8:16 pm

Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE' s)	
	7.00	8.00	9.00	10.00	11.00	
<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	38,533					7.00
8.00 LAUNDRY & LINEN SERVICE	345	3,051				8.00
9.00 HOUSEKEEPING	329	0	37,859			9.00
10.00 DIETARY	492	0	492	3,051		10.00
11.00 CAFETERIA	1,827	0	1,827	0	10,298	11.00
13.00 NURSING ADMINISTRATION	73	0	73	0	450	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00 MEDICAL RECORDS & LIBRARY	1,147	0	1,147	0	795	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	7,380	2,003	7,380	2,003	1,841	30.00
31.00 INTENSIVE CARE UNIT	1,424	492	1,424	492	819	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
45.00 NURSING FACILITY	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	6,201	0	6,201	0	1,087	50.00
51.00 RECOVERY ROOM	308	0	308	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	3,382	0	3,382	0	1,215	54.00
57.00 CT SCAN	369	0	369	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	344	0	344	0	177	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	1,936	0	1,936	0	918	60.00
65.00 RESPIRATORY THERAPY	2,169	0	2,169	0	563	65.00
66.00 PHYSICAL THERAPY	1,542	0	1,542	0	290	66.00
67.00 OCCUPATIONAL THERAPY	222	0	222	0	108	67.00
68.00 SPEECH PATHOLOGY	222	0	222	0	35	68.00
69.00 ELECTROCARDIOLOGY	428	0	428	0	124	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,348	0	1,348	0	205	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	533	0	533	0	276	73.00
76.97 CARDIAC REHABILITATION	818	0	818	0	20	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 EMERGENCY	2,696	556	2,696	556	1,267	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	35,535	3,051	34,861	3,051	10,190	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	214	0	214	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 WELLNESS CENTER	0	0	0	0	6	193.01
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	102	194.00
194.01 VACANT SPACE	2,784	0	2,784	0	0	194.01
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)	1,717,812	19,908	419,569	49,048	580,956	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	44.580282	6.525074	11.082411	16.076041	56.414449	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	194,434	4,585	5,227	6,653	25,509	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	5.045909	1.502786	0.138065	2.026876	2.477083	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150102

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

Worksheet B-1  
Date/Time Prepared:  
5/28/2012 8:16 pm

Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
	(NURSING SALARIES)			
	13.00	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
8.00 LAUNDRY & LINEN SERVICE				8.00
9.00 HOUSEKEEPING				9.00
10.00 DIETARY				10.00
11.00 CAFETERIA				11.00
13.00 NURSING ADMINISTRATION	3,582,897			13.00
14.00 CENTRAL SERVICES & SUPPLY	0	505,543		14.00
16.00 MEDICAL RECORDS & LIBRARY	261,670	248	66,221,293	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00 ADULTS & PEDIATRICS	816,852	37,470	3,591,936	30.00
31.00 INTENSIVE CARE UNIT	442,992	6,631	846,612	31.00
41.00 SUBPROVIDER - IRF	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	42.00
45.00 NURSING FACILITY	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 OPERATING ROOM	648,113	262,519	7,360,922	50.00
51.00 RECOVERY ROOM	0	0	836,990	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	176	1,465,344	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	25,151	7,866,169	54.00
57.00 CT SCAN	0	20,432	9,163,765	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	2,965	3,154,961	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 LABORATORY	0	36,152	7,415,436	60.00
65.00 RESPIRATORY THERAPY	353,222	21,164	1,068,625	65.00
66.00 PHYSICAL THERAPY	136,196	2,603	974,926	66.00
67.00 OCCUPATIONAL THERAPY	93,509	702	368,564	67.00
68.00 SPEECH PATHOLOGY	0	0	36,788	68.00
69.00 ELECTROCARDIOLOGY	99,624	0	1,988,901	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	28,062	1,396,342	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	9,744	762,580	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	18,121	6,181,249	73.00
76.97 CARDIAC REHABILITATION	5,923	1	2,600	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00 EMERGENCY	724,796	33,263	11,738,583	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10 CORF	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
109.00 PANCREAS ACQUISITION	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	3,582,897	505,404	66,221,293	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
191.00 RESEARCH	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	193.00
193.01 WELLNESS CENTER	0	0	0	193.01
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	139	0	194.00
194.01 VACANT SPACE	0	0	0	194.01
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)	667,224	695,133	713,184	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.186225	1.375023	0.010770	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	3,479	1,409	18,797	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.000971	0.002787	0.000284	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150102

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/28/2012 8:16 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		2,390,308	0	2,390,308	30.00	
31.00	INTENSIVE CARE UNIT		1,071,049	0	1,071,049	31.00	
41.00	SUBPROVIDER - IRF		0	0	0	41.00	
42.00	SUBPROVIDER		0	0	0	42.00	
45.00	NURSING FACILITY		0	0	0	45.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM		2,758,853	0	2,758,853	50.00	
51.00	RECOVERY ROOM		30,177	0	30,177	51.00	
52.00	DELIVERY ROOM & LABOR ROOM		0	0	0	52.00	
53.00	ANESTHESIOLOGY		13,942	0	13,942	53.00	
54.00	RADIOLOGY-DIAGNOSTIC		2,939,083	0	2,939,083	54.00	
57.00	CT SCAN		424,295	0	424,295	57.00	
58.00	MAGNETIC RESONANCE IMAGING (MRI)		756,017	0	756,017	58.00	
59.00	CARDIAC CATHETERIZATION		0	0	0	59.00	
60.00	LABORATORY		1,451,331	0	1,451,331	60.00	
65.00	RESPIRATORY THERAPY	0	984,995	0	984,995	65.00	
66.00	PHYSICAL THERAPY	0	411,027	0	411,027	66.00	
67.00	OCCUPATIONAL THERAPY	0	212,525	0	212,525	67.00	
68.00	SPEECH PATHOLOGY	0	54,421	0	54,421	68.00	
69.00	ELECTROCARDIOLOGY		265,802	0	265,802	69.00	
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		998,925	0	998,925	71.00	
72.00	IMPL. DEV. CHARGED TO PATIENT		201,605	0	201,605	72.00	
73.00	DRUGS CHARGED TO PATIENTS		1,255,346	0	1,255,346	73.00	
76.97	CARDIAC REHABILITATION		68,161	0	68,161	76.97	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC		0	0	0	88.00	
89.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00	
91.00	EMERGENCY		3,004,297	1,214,621	4,218,918	91.00	
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		519,348	0	519,348	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF		0	0	0	99.10	
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	PANCREAS ACQUISITION		0	0	0	109.00	
110.00	INTESTINAL ACQUISITION		0	0	0	110.00	
111.00	ISLET ACQUISITION		0	0	0	111.00	
200.00	Subtotal (see instructions)	0	19,811,507	1,214,621	21,026,128	200.00	
201.00	Less Observation Beds		519,348	0	519,348	201.00	
202.00	Total (see instructions)	0	19,292,159	1,214,621	20,506,780	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/28/2012 8:16 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			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	3,591,936		3,591,936			30.00
31.00 INTENSIVE CARE UNIT	846,612		846,612			31.00
41.00 SUBPROVIDER - IRF	0		0			41.00
42.00 SUBPROVIDER	0		0			42.00
45.00 NURSING FACILITY	0		0			45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	1,416,646	5,944,276	7,360,922	0.374797	0.000000	50.00
51.00 RECOVERY ROOM	132,033	704,957	836,990	0.036054	0.000000	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00 ANESTHESIOLOGY	268,920	1,196,424	1,465,344	0.009514	0.000000	53.00
54.00 RADIOLOGY-DIAGNOSTIC	483,804	7,382,365	7,866,169	0.373636	0.000000	54.00
57.00 CT SCAN	1,287,093	7,876,672	9,163,765	0.046301	0.000000	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	105,435	3,049,526	3,154,961	0.239628	0.000000	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00 LABORATORY	1,701,586	5,713,850	7,415,436	0.195718	0.000000	60.00
65.00 RESPIRATORY THERAPY	726,694	341,931	1,068,625	0.921741	0.000000	65.00
66.00 PHYSICAL THERAPY	77,465	897,461	974,926	0.421598	0.000000	66.00
67.00 OCCUPATIONAL THERAPY	37,914	330,650	368,564	0.576630	0.000000	67.00
68.00 SPEECH PATHOLOGY	8,451	28,337	36,788	1.479314	0.000000	68.00
69.00 ELECTROCARDIOLOGY	360,741	1,628,160	1,988,901	0.133643	0.000000	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	600,051	796,291	1,396,342	0.715387	0.000000	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	667,609	94,971	762,580	0.264372	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	3,192,255	2,988,994	6,181,249	0.203089	0.000000	73.00
76.97 CARDIAC REHABILITATION	0	2,600	2,600	26.215769	0.000000	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 RURAL HEALTH CLINIC	0	0	0			88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
91.00 EMERGENCY	1,186,296	10,552,287	11,738,583	0.255934	0.000000	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	52,466	671,356	723,822	0.717508	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 CORF	0	0	0			99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 PANCREAS ACQUISITION	0	0	0			109.00
110.00 INTESTINAL ACQUISITION	0	0	0			110.00
111.00 ISLET ACQUISITION	0	0	0			111.00
200.00 Subtotal (see instructions)	16,744,007	50,201,108	66,945,115			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	16,744,007	50,201,108	66,945,115			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/28/2012 8:16 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS			30.00
31.00	INTENSIVE CARE UNIT			31.00
41.00	SUBPROVIDER - IRF			41.00
42.00	SUBPROVIDER			42.00
45.00	NURSING FACILITY			45.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	0.374797		50.00
51.00	RECOVERY ROOM	0.036054		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	ANESTHESIOLOGY	0.009514		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.373636		54.00
57.00	CT SCAN	0.046301		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.239628		58.00
59.00	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	LABORATORY	0.195718		60.00
65.00	RESPIRATORY THERAPY	0.921741		65.00
66.00	PHYSICAL THERAPY	0.421598		66.00
67.00	OCCUPATIONAL THERAPY	0.576630		67.00
68.00	SPEECH PATHOLOGY	1.479314		68.00
69.00	ELECTROCARDIOLOGY	0.133643		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.715387		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.264372		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.203089		73.00
76.97	CARDIAC REHABILITATION	26.215769		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	RURAL HEALTH CLINIC			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER			89.00
91.00	EMERGENCY	0.359406		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.717508		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	CORF			99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
109.00	PANCREAS ACQUISITION			109.00
110.00	INTESTINAL ACQUISITION			110.00
111.00	ISLET ACQUISITION			111.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150102

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/28/2012 8:16 pm

		Title XIX		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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	2,390,308		2,390,308	0	2,390,308	30.00
31.00	INTENSIVE CARE UNIT	1,071,049		1,071,049	0	1,071,049	31.00
41.00	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	SUBPROVIDER	0		0	0	0	42.00
45.00	NURSING FACILITY	0		0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	2,758,853		2,758,853	0	2,758,853	50.00
51.00	RECOVERY ROOM	30,177		30,177	0	30,177	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	ANESTHESIOLOGY	13,942		13,942	0	13,942	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,939,083		2,939,083	0	2,939,083	54.00
57.00	CT SCAN	424,295		424,295	0	424,295	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	756,017		756,017	0	756,017	58.00
59.00	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	LABORATORY	1,451,331		1,451,331	0	1,451,331	60.00
65.00	RESPIRATORY THERAPY	984,995	0	984,995	0	984,995	65.00
66.00	PHYSICAL THERAPY	411,027	0	411,027	0	411,027	66.00
67.00	OCCUPATIONAL THERAPY	212,525	0	212,525	0	212,525	67.00
68.00	SPEECH PATHOLOGY	54,421	0	54,421	0	54,421	68.00
69.00	ELECTROCARDIOLOGY	265,802		265,802	0	265,802	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	998,925		998,925	0	998,925	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	201,605		201,605	0	201,605	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,255,346		1,255,346	0	1,255,346	73.00
76.97	CARDIAC REHABILITATION	68,161		68,161	0	68,161	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	EMERGENCY	3,004,297		3,004,297	1,214,621	4,218,918	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	519,348		519,348		519,348	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF	0		0		0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	PANCREAS ACQUISITION	0		0		0	109.00
110.00	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	ISLET ACQUISITION	0		0		0	111.00
200.00	Subtotal (see instructions)	19,811,507	0	19,811,507	1,214,621	21,026,128	200.00
201.00	Less Observation Beds	519,348		519,348		519,348	201.00
202.00	Total (see instructions)	19,292,159	0	19,292,159	1,214,621	20,506,780	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150102

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/28/2012 8:16 pm

		Title XIX			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	3,591,936		3,591,936			30.00
31.00	INTENSIVE CARE UNIT	846,612		846,612			31.00
41.00	SUBPROVIDER - IRF	0		0			41.00
42.00	SUBPROVIDER	0		0			42.00
45.00	NURSING FACILITY	0		0			45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	1,416,646	5,944,276	7,360,922	0.374797	0.000000	50.00
51.00	RECOVERY ROOM	132,033	704,957	836,990	0.036054	0.000000	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	ANESTHESIOLOGY	268,920	1,196,424	1,465,344	0.009514	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	483,804	7,382,365	7,866,169	0.373636	0.000000	54.00
57.00	CT SCAN	1,287,093	7,876,672	9,163,765	0.046301	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	105,435	3,049,526	3,154,961	0.239628	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	LABORATORY	1,701,586	5,713,850	7,415,436	0.195718	0.000000	60.00
65.00	RESPIRATORY THERAPY	726,694	341,931	1,068,625	0.921741	0.000000	65.00
66.00	PHYSICAL THERAPY	77,465	897,461	974,926	0.421598	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	37,914	330,650	368,564	0.576630	0.000000	67.00
68.00	SPEECH PATHOLOGY	8,451	28,337	36,788	1.479314	0.000000	68.00
69.00	ELECTROCARDIOLOGY	360,741	1,628,160	1,988,901	0.133643	0.000000	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	600,051	796,291	1,396,342	0.715387	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	667,609	94,971	762,580	0.264372	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	3,192,255	2,988,994	6,181,249	0.203089	0.000000	73.00
76.97	CARDIAC REHABILITATION	0	2,600	2,600	26.215769	0.000000	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
91.00	EMERGENCY	1,186,296	10,552,287	11,738,583	0.255934	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	52,466	671,356	723,822	0.717508	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF	0	0	0			99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	PANCREAS ACQUISITION	0	0	0			109.00
110.00	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	ISLET ACQUISITION	0	0	0			111.00
200.00	Subtotal (see instructions)	16,744,007	50,201,108	66,945,115			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	16,744,007	50,201,108	66,945,115			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/28/2012 8:16 pm
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS			30.00
31.00	INTENSIVE CARE UNIT			31.00
41.00	SUBPROVIDER - IRF			41.00
42.00	SUBPROVIDER			42.00
45.00	NURSING FACILITY			45.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	0.374797		50.00
51.00	RECOVERY ROOM	0.036054		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	ANESTHESIOLOGY	0.009514		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.373636		54.00
57.00	CT SCAN	0.046301		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.239628		58.00
59.00	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	LABORATORY	0.195718		60.00
65.00	RESPIRATORY THERAPY	0.921741		65.00
66.00	PHYSICAL THERAPY	0.421598		66.00
67.00	OCCUPATIONAL THERAPY	0.576630		67.00
68.00	SPEECH PATHOLOGY	1.479314		68.00
69.00	ELECTROCARDIOLOGY	0.133643		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.715387		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.264372		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.203089		73.00
76.97	CARDIAC REHABILITATION	26.215769		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	RURAL HEALTH CLINIC	0.000000		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
91.00	EMERGENCY	0.359406		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.717508		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	CORF			99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
109.00	PANCREAS ACQUISITION			109.00
110.00	INTESTINAL ACQUISITION			110.00
111.00	ISLET ACQUISITION			111.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 150102

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

Worksheet C Part II Date/Time Prepared: 5/28/2012 8:16 pm

Cost Center Description		Title XIX			Hospital	PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	2,758,853	93,064	2,665,789	0	0	50.00
51.00	RECOVERY ROOM	30,177	4,374	25,803	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	13,942	416	13,526	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,939,083	56,050	2,883,033	0	0	54.00
57.00	CT SCAN	424,295	8,166	416,129	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	756,017	7,385	748,632	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	1,451,331	32,913	1,418,418	0	0	60.00
65.00	RESPIRATORY THERAPY	984,995	32,740	952,255	0	0	65.00
66.00	PHYSICAL THERAPY	411,027	22,384	388,643	0	0	66.00
67.00	OCCUPATIONAL THERAPY	212,525	3,816	208,709	0	0	67.00
68.00	SPEECH PATHOLOGY	54,421	3,158	51,263	0	0	68.00
69.00	ELECTROCARDIOLOGY	265,802	7,129	258,673	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	998,925	20,811	978,114	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	201,605	609	200,996	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,255,346	11,965	1,243,381	0	0	73.00
76.97	CARDIAC REHABILITATION	68,161	11,062	57,099	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	3,004,297	50,553	2,953,744	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	519,348	25,182	494,166	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
200.00	Subtotal (sum of lines 50 thru 199)	16,350,150	391,777	15,958,373	0	0	200.00
201.00	Less Observation Beds	519,348	25,182	494,166	0	0	201.00
202.00	Total (line 200 minus line 201)	15,830,802	366,595	15,464,207	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 150102

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

Worksheet C  
Part II  
Date/Time Prepared:  
5/28/2012 8:16 pm

Cost Center Description		Title XIX			Hospital	PPS
		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
		6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	2,758,853	7,360,922	0.374797		50.00
51.00	RECOVERY ROOM	30,177	836,990	0.036054		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000		52.00
53.00	ANESTHESIOLOGY	13,942	1,465,344	0.009514		53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,939,083	7,866,169	0.373636		54.00
57.00	CT SCAN	424,295	9,163,765	0.046301		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	756,017	3,154,961	0.239628		58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000		59.00
60.00	LABORATORY	1,451,331	7,415,436	0.195718		60.00
65.00	RESPIRATORY THERAPY	984,995	1,068,625	0.921741		65.00
66.00	PHYSICAL THERAPY	411,027	974,926	0.421598		66.00
67.00	OCCUPATIONAL THERAPY	212,525	368,564	0.576630		67.00
68.00	SPEECH PATHOLOGY	54,421	36,788	1.479314		68.00
69.00	ELECTROCARDIOLOGY	265,802	1,988,901	0.133643		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	998,925	1,396,342	0.715387		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	201,605	762,580	0.264372		72.00
73.00	DRUGS CHARGED TO PATIENTS	1,255,346	6,181,249	0.203089		73.00
76.97	CARDIAC REHABILITATION	68,161	2,600	26.215769		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	RURAL HEALTH CLINIC	0	0	0.000000		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000		89.00
91.00	EMERGENCY	3,004,297	11,738,583	0.255934		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	519,348	723,822	0.717508		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	CORF	0	0	0.000000		99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00	PANCREAS ACQUISITION	0	0	0.000000		109.00
110.00	INTESTINAL ACQUISITION	0	0	0.000000		110.00
111.00	ISLET ACQUISITION	0	0	0.000000		111.00
200.00	Subtotal (sum of lines 50 thru 199)	16,350,150	0			200.00
201.00	Less Observation Beds	519,348	0			201.00
202.00	Total (line 200 minus line 201)	15,830,802	62,506,567			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150102		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part I Date/Time Prepared: 5/28/2012 8:16 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	115,898	0	115,898	2,559	45.29	30.00
31.00	INTENSIVE CARE UNIT	25,355		25,355	492	51.53	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (Lines 30-199)	141,253		141,253	3,051		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part I Date/Time Prepared: 5/28/2012 8:16 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
	6.00	7.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00 ADULTS & PEDIATRICS	1,516	68,660		30.00
31.00 INTENSIVE CARE UNIT	212	10,924		31.00
41.00 SUBPROVIDER - IRF	0	0		41.00
42.00 SUBPROVIDER	0	0		42.00
45.00 NURSING FACILITY	0	0		45.00
200.00 Total (Lines 30-199)	1,728	79,584		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part II Date/Time Prepared: 5/28/2012 8:16 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	93,064	7,360,922	0.012643	798,023	10,089 50.00
51.00	RECOVERY ROOM	4,374	836,990	0.005226	70,862	370 51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0 52.00
53.00	ANESTHESIOLOGY	416	1,465,344	0.000284	141,417	40 53.00
54.00	RADIOLOGY-DIAGNOSTIC	56,050	7,866,169	0.007125	336,544	2,398 54.00
57.00	CT SCAN	8,166	9,163,765	0.000891	770,659	687 57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	7,385	3,154,961	0.002341	72,760	170 58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0 59.00
60.00	LABORATORY	32,913	7,415,436	0.004438	1,148,213	5,096 60.00
65.00	RESPIRATORY THERAPY	32,740	1,068,625	0.030638	563,613	17,268 65.00
66.00	PHYSICAL THERAPY	22,384	974,926	0.022960	59,622	1,369 66.00
67.00	OCCUPATIONAL THERAPY	3,816	368,564	0.010354	23,911	248 67.00
68.00	SPEECH PATHOLOGY	3,158	36,788	0.085843	6,831	586 68.00
69.00	ELECTROCARDIOLOGY	7,129	1,988,901	0.003584	256,803	920 69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,811	1,396,342	0.014904	545,363	8,128 71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	609	762,580	0.000799	544,728	435 72.00
73.00	DRUGS CHARGED TO PATIENTS	11,965	6,181,249	0.001936	1,683,002	3,258 73.00
76.97	CARDIAC REHABILITATION	11,062	2,600	4.254615	0	0 76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0	0 88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0 89.00
91.00	EMERGENCY	50,553	11,738,583	0.004307	768,517	3,310 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	25,182	723,822	0.034790	42,538	1,480 92.00
200.00	Total (Lines 50-199)	391,777	62,506,567		7,833,406	55,852 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150102		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part III Date/Time Prepared: 5/28/2012 8:16 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
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
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: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part III Date/Time Prepared: 5/28/2012 8:16 pm
---	----------------------	---	---

Cost Center Description	Title XVIII					Hospital	
	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	PPS	
	6.00	7.00	8.00	9.00	11.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	2,559	0.00	1,516	0	0	30.00	
31.00 INTENSIVE CARE UNIT	492	0.00	212	0	0	31.00	
41.00 SUBPROVIDER - IRF	0	0.00	0	0	0	41.00	
42.00 SUBPROVIDER	0	0.00	0	0	0	42.00	
45.00 NURSING FACILITY	0	0.00	0	0	0	45.00	
200.00 Total (Lines 30-199)	3,051		1,728	0	0	200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150102		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part III Date/Time Prepared: 5/28/2012 8:16 pm	
Cost Center Description		PSA Adj . Allied Health Cost	PSA Adj . All Other Medical Education Cost	Title XVIII	Hospital	PPS	
		12.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
41.00	SUBPROVIDER - IRF	0	0				41.00
42.00	SUBPROVIDER	0	0				42.00
45.00	NURSING FACILITY	0	0				45.00
200.00	Total (lines 30-199)	0	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150102

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/28/2012 8:16 pm

Cost Center Description		Title XVIII				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	PPS
		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
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
76.97	CARDIAC REHABILITATION	0	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	0	0	0	0	0	91.00
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: 150102

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/28/2012 8:16 pm

Cost Center Description		Title XVIII			Hospital		PPS
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0	7,360,922	0.000000	0.000000	798,023	50.00
51.00	RECOVERY ROOM	0	836,990	0.000000	0.000000	70,862	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	ANESTHESIOLOGY	0	1,465,344	0.000000	0.000000	141,417	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	7,866,169	0.000000	0.000000	336,544	54.00
57.00	CT SCAN	0	9,163,765	0.000000	0.000000	770,659	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	3,154,961	0.000000	0.000000	72,760	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	LABORATORY	0	7,415,436	0.000000	0.000000	1,148,213	60.00
65.00	RESPIRATORY THERAPY	0	1,068,625	0.000000	0.000000	563,613	65.00
66.00	PHYSICAL THERAPY	0	974,926	0.000000	0.000000	59,622	66.00
67.00	OCCUPATIONAL THERAPY	0	368,564	0.000000	0.000000	23,911	67.00
68.00	SPEECH PATHOLOGY	0	36,788	0.000000	0.000000	6,831	68.00
69.00	ELECTROCARDIOLOGY	0	1,988,901	0.000000	0.000000	256,803	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,396,342	0.000000	0.000000	545,363	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	762,580	0.000000	0.000000	544,728	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	6,181,249	0.000000	0.000000	1,683,002	73.00
76.97	CARDIAC REHABILITATION	0	2,600	0.000000	0.000000	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	EMERGENCY	0	11,738,583	0.000000	0.000000	768,517	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	723,822	0.000000	0.000000	42,538	92.00
200.00	Total (Lines 50-199)	0	62,506,567			7,833,406	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150102

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/28/2012 8:16 pm

Cost Center Description		Title XVIII			Hospital	PPS	
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0	1,839,031	0	0	0	50.00
51.00	RECOVERY ROOM	0	195,985	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	336,695	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	2,013,259	0	0	0	54.00
57.00	CT SCAN	0	2,030,576	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	777,915	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	1,779,592	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	152,619	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	281,635	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	62,165	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	2,599	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	557,310	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	115,837	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	824,621	0	0	0	73.00
76.97	CARDIAC REHABILITATION	0	59	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	0	2,069,191	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (Lines 50-199)	0	13,039,089	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150102

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/28/2012 8:16 pm

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
		23.00	24.00		
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0		50.00
51.00	RECOVERY ROOM	0	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	ANESTHESIOLOGY	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	CT SCAN	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0		59.00
60.00	LABORATORY	0	0		60.00
65.00	RESPIRATORY THERAPY	0	0		65.00
66.00	PHYSICAL THERAPY	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0	0		67.00
68.00	SPEECH PATHOLOGY	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97	CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00	EMERGENCY	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Total (Lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/28/2012 8:16 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	0.374797	1,839,031	0	0	50.00
51.00	RECOVERY ROOM	0.036054	195,985	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	ANESTHESIOLOGY	0.009514	336,695	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.373636	2,013,259	0	0	54.00
57.00	CT SCAN	0.046301	2,030,576	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.239628	777,915	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	LABORATORY	0.195718	1,779,592	0	0	60.00
65.00	RESPIRATORY THERAPY	0.921741	152,619	0	0	65.00
66.00	PHYSICAL THERAPY	0.421598	281,635	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0.576630	62,165	0	0	67.00
68.00	SPEECH PATHOLOGY	1.479314	2,599	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.133643	557,310	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.715387	115,837	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.264372	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.203089	824,621	0	8,447	73.00
76.97	CARDIAC REHABILITATION	26.215769	59	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	RURAL HEALTH CLINIC	0.000000				88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
91.00	EMERGENCY	0.255934	2,069,191	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.717508	0	0	0	92.00
200.00	Subtotal (see instructions)		13,039,089	0	8,447	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		13,039,089	0	8,447	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/28/2012 8:16 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	689,263	0	0		50.00
51.00 RECOVERY ROOM	7,066	0	0		51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00 ANESTHESIOLOGY	3,203	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	752,226	0	0		54.00
57.00 CT SCAN	94,018	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	186,410	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00 LABORATORY	348,298	0	0		60.00
65.00 RESPIRATORY THERAPY	140,675	0	0		65.00
66.00 PHYSICAL THERAPY	118,737	0	0		66.00
67.00 OCCUPATIONAL THERAPY	35,846	0	0		67.00
68.00 SPEECH PATHOLOGY	3,845	0	0		68.00
69.00 ELECTROCARDIOLOGY	74,481	0	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	82,868	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	167,471	0	1,715		73.00
76.97 CARDIAC REHABILITATION	1,547	0	0		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 RURAL HEALTH CLINIC	0	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00 EMERGENCY	529,576	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00 Subtotal (see instructions)	3,235,530	0	1,715		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	3,235,530	0	1,715		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part I Date/Time Prepared: 5/28/2012 8:16 pm
--	--	----------------------	---	---

Cost Center Description	Title XIX			Hospital	PPS	
	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	115,898	0	115,898	2,559	45.29 30.00
31.00	INTENSIVE CARE UNIT	25,355		25,355	492	51.53 31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00 41.00
42.00	SUBPROVIDER	0	0	0	0	0.00 42.00
45.00	NURSING FACILITY	0		0	0	0.00 45.00
200.00	Total (Lines 30-199)	141,253		141,253	3,051	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150102		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part I Date/Time Prepared: 5/28/2012 8:16 pm	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Title XIX Hospital		PPS	
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	169	7,654			30.00	
31.00	INTENSIVE CARE UNIT	0	0			31.00	
41.00	SUBPROVIDER - IRF	0	0			41.00	
42.00	SUBPROVIDER	0	0			42.00	
45.00	NURSING FACILITY	0	0			45.00	
200.00	Total (Lines 30-199)	169	7,654			200.00	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part II Date/Time Prepared: 5/28/2012 8:16 pm
--	--	----------------------	---	--

Cost Center Description		Title XIX			Hospital	PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	93,064	7,360,922	0.012643	113,895	1,440	50.00
51.00	RECOVERY ROOM	4,374	836,990	0.005226	6,166	32	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	416	1,465,344	0.000284	11,944	3	53.00
54.00	RADIOLOGY-DIAGNOSTIC	56,050	7,866,169	0.007125	16,749	119	54.00
57.00	CT SCAN	8,166	9,163,765	0.000891	51,846	46	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	7,385	3,154,961	0.002341	1,694	4	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	LABORATORY	32,913	7,415,436	0.004438	60,099	267	60.00
65.00	RESPIRATORY THERAPY	32,740	1,068,625	0.030638	36,306	1,112	65.00
66.00	PHYSICAL THERAPY	22,384	974,926	0.022960	1,829	42	66.00
67.00	OCCUPATIONAL THERAPY	3,816	368,564	0.010354	1,450	15	67.00
68.00	SPEECH PATHOLOGY	3,158	36,788	0.085843	205	18	68.00
69.00	ELECTROCARDIOLOGY	7,129	1,988,901	0.003584	12,314	44	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,811	1,396,342	0.014904	5,060	75	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	609	762,580	0.000799	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	11,965	6,181,249	0.001936	119,606	232	73.00
76.97	CARDIAC REHABILITATION	11,062	2,600	4.254615	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	EMERGENCY	50,553	11,738,583	0.004307	53,147	229	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	25,182	723,822	0.034790	0	0	92.00
200.00	Total (Lines 50-199)	391,777	62,506,567		492,310	3,678	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150102		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part III Date/Time Prepared: 5/28/2012 8:16 pm	
Cost Center Description		Title XIX		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
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
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: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part III Date/Time Prepared: 5/28/2012 8:16 pm
---	----------------------	---	---

Cost Center Description	Title XIX		Hospital		PPS	
	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
	6.00	7.00	8.00	9.00	11.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	2,559	0.00	169	0	0	0 30.00
31.00 INTENSIVE CARE UNIT	492	0.00	0	0	0	0 31.00
41.00 SUBPROVIDER - IRF	0	0.00	0	0	0	0 41.00
42.00 SUBPROVIDER	0	0.00	0	0	0	0 42.00
45.00 NURSING FACILITY	0	0.00	0	0	0	0 45.00
200.00 Total (Lines 30-199)	3,051		169	0	0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part III Date/Time Prepared: 5/28/2012 8:16 pm
Title XIX		Hospital	PPS

Cost Center Description	PSA Adj . Allied Health Cost	PSA Adj . All Other Medical Education Cost		
	12.00	13.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00 ADULTS & PEDIATRICS	0	0		30.00
31.00 INTENSIVE CARE UNIT	0	0		31.00
41.00 SUBPROVIDER - IRF	0	0		41.00
42.00 SUBPROVIDER	0	0		42.00
45.00 NURSING FACILITY	0	0		45.00
200.00 Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150102

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/28/2012 8:16 pm

Cost Center Description		Title XIX				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	PPS
		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
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
76.97	CARDIAC REHABILITATION	0	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	0	0	0	0	0	91.00
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: 150102

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/28/2012 8:16 pm

Cost Center Description		Title XIX			Hospital		PPS
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0	7,360,922	0.000000	0.000000	113,895	50.00
51.00	RECOVERY ROOM	0	836,990	0.000000	0.000000	6,166	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	ANESTHESIOLOGY	0	1,465,344	0.000000	0.000000	11,944	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	7,866,169	0.000000	0.000000	16,749	54.00
57.00	CT SCAN	0	9,163,765	0.000000	0.000000	51,846	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	3,154,961	0.000000	0.000000	1,694	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	LABORATORY	0	7,415,436	0.000000	0.000000	60,099	60.00
65.00	RESPIRATORY THERAPY	0	1,068,625	0.000000	0.000000	36,306	65.00
66.00	PHYSICAL THERAPY	0	974,926	0.000000	0.000000	1,829	66.00
67.00	OCCUPATIONAL THERAPY	0	368,564	0.000000	0.000000	1,450	67.00
68.00	SPEECH PATHOLOGY	0	36,788	0.000000	0.000000	205	68.00
69.00	ELECTROCARDIOLOGY	0	1,988,901	0.000000	0.000000	12,314	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,396,342	0.000000	0.000000	5,060	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	762,580	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	6,181,249	0.000000	0.000000	119,606	73.00
76.97	CARDIAC REHABILITATION	0	2,600	0.000000	0.000000	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	EMERGENCY	0	11,738,583	0.000000	0.000000	53,147	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	723,822	0.000000	0.000000	0	92.00
200.00	Total (Lines 50-199)	0	62,506,567			492,310	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150102

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/28/2012 8:16 pm

Cost Center Description		Title XIX			Hospital		PPS
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
76.97	CARDIAC REHABILITATION	0	0	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	0	0	0	0	0	91.00
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: 150102

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/28/2012 8:16 pm

Cost Center Description		PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	0	50.00
51.00	RECOVERY ROOM	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	CT SCAN	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.97	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	EMERGENCY	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Total (Lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/28/2012 8:16 pm
	Title XIX	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			PPS	
		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	0.374797	0	0	455,007	50.00
51.00	RECOVERY ROOM	0.036054	0	0	50,716	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	ANESTHESIOLOGY	0.009514	0	0	98,952	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.373636	0	0	610,900	54.00
57.00	CT SCAN	0.046301	0	0	674,491	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.239628	0	0	346,253	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	LABORATORY	0.195718	0	0	581,048	60.00
65.00	RESPIRATORY THERAPY	0.921741	0	0	34,121	65.00
66.00	PHYSICAL THERAPY	0.421598	0	0	50,559	66.00
67.00	OCCUPATIONAL THERAPY	0.576630	0	0	16,056	67.00
68.00	SPEECH PATHOLOGY	1.479314	0	0	3,865	68.00
69.00	ELECTROCARDIOLOGY	0.133643	0	0	123,729	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.715387	0	0	59,475	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.264372	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.203089	0	0	234,828	73.00
76.97	CARDIAC REHABILITATION	26.215769	0	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	RURAL HEALTH CLINIC	0.000000				88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
91.00	EMERGENCY	0.255934	0	0	1,510,082	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.717508	0	0	0	92.00
200.00	Subtotal (see instructions)		0	0	4,850,082	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	4,850,082	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/28/2012 8:16 pm
Title XIX		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	0	0	170,535		50.00
51.00 RECOVERY ROOM	0	0	1,829		51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00 ANESTHESIOLOGY	0	0	941		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	228,254		54.00
57.00 CT SCAN	0	0	31,230		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	82,972		58.00
59.00 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00 LABORATORY	0	0	113,722		60.00
65.00 RESPIRATORY THERAPY	0	0	31,451		65.00
66.00 PHYSICAL THERAPY	0	0	21,316		66.00
67.00 OCCUPATIONAL THERAPY	0	0	9,258		67.00
68.00 SPEECH PATHOLOGY	0	0	5,718		68.00
69.00 ELECTROCARDIOLOGY	0	0	16,536		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	42,548		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	47,691		73.00
76.97 CARDIAC REHABILITATION	0	0	0		76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 RURAL HEALTH CLINIC	0	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00 EMERGENCY	0	0	386,481		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00 Subtotal (see instructions)	0	0	1,190,482		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	1,190,482		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/28/2012 8:16 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)		2,650	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,559	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)		2,559	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		91	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,516	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)		70	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,390,308	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,390,308	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		4,232,182	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		4,232,182	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.564793	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)		1,653.84	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,390,308	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)		934.08	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,416,065	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,416,065	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/28/2012 8:16 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	1,071,049	492	2,176.93	212	461,509
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)					2,492,127
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,369,701
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					79,584
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					55,852
52.00 Total Program excludable cost (sum of lines 50 and 51)					135,436
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,234,265
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					556
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					934.08
89.00 Observation bed cost (line 87 x line 88) (see instructions)					519,348

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150102		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 5/28/2012 8:16 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	115,898	2,390,308	0.048487	519,348	25,182	90.00
91.00	Nursing School cost	0	2,390,308	0.000000	519,348	0	91.00
92.00	Allied health cost	0	2,390,308	0.000000	519,348	0	92.00
93.00	All other Medical Education	0	2,390,308	0.000000	519,348	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/28/2012 8:16 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)		2,650	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,559	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)		2,559	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)		169	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,390,308	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,390,308	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	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)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,390,308	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)		934.08	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		157,860	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)		157,860	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/28/2012 8:16 pm
Cost Center Description			Title XIX	Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	1,071,049	492	2,176.93	0	0
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					
					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				147,884
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				305,744
PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				7,654
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				3,678
52.00	Total Program excludable cost (sum of lines 50 and 51)				11,332
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				294,412
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				0
55.00	Target amount per discharge				0.00
56.00	Target amount (line 54 x line 55)				0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0
58.00	Bonus payment (see instructions)				0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0
62.00	Relief payment (see instructions)				0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)				70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				71.00
72.00	Program routine service cost (line 9 x line 71)				72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				76.00
77.00	Program capital-related costs (line 9 x line 76)				77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				80.00
81.00	Inpatient routine service cost per diem limitation				81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				82.00
83.00	Reasonable inpatient routine service costs (see instructions)				83.00
84.00	Program inpatient ancillary services (see instructions)				84.00
85.00	Utilization review - physician compensation (see instructions)				85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)				556
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				934.08
89.00	Observation bed cost (line 87 x line 88) (see instructions)				519,348

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150102		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 5/28/2012 8:16 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	115,898	2,390,308	0.048487	519,348	25,182	90.00
91.00	Nursing School cost	0	2,390,308	0.000000	519,348	0	91.00
92.00	Allied health cost	0	2,390,308	0.000000	519,348	0	92.00
93.00	All other Medical Education	0	2,390,308	0.000000	519,348	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/28/2012 8:16 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS		1,788,839		30.00
31.00	INTENSIVE CARE UNIT		413,370		31.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.374797	798,023	299,097	50.00
51.00	RECOVERY ROOM	0.036054	70,862	2,555	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	0.009514	141,417	1,345	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.373636	336,544	125,745	54.00
57.00	CT SCAN	0.046301	770,659	35,682	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.239628	72,760	17,435	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.195718	1,148,213	224,726	60.00
65.00	RESPIRATORY THERAPY	0.921741	563,613	519,505	65.00
66.00	PHYSICAL THERAPY	0.421598	59,622	25,137	66.00
67.00	OCCUPATIONAL THERAPY	0.576630	23,911	13,788	67.00
68.00	SPEECH PATHOLOGY	1.479314	6,831	10,105	68.00
69.00	ELECTROCARDIOLOGY	0.133643	256,803	34,320	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.715387	545,363	390,146	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.264372	544,728	144,011	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.203089	1,683,002	341,799	73.00
76.97	CARDIAC REHABILITATION	26.215769	0	0	76.97
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	EMERGENCY	0.359406	768,517	276,210	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.717508	42,538	30,521	92.00
200.00	Total (sum of lines 50-94 and 96-98)		7,833,406	2,492,127	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)		7,833,406		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 150102	Period: From 01/01/2011	Worksheet D-3
	Component CCN: 15U102	To 12/31/2011	

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		39,699		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.374797	9,741	3,651	50.00
51.00	RECOVERY ROOM	0.036054	865	31	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	0.009514	1,726	16	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.373636	4,108	1,535	54.00
57.00	CT SCAN	0.046301	9,407	436	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.239628	888	213	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.195718	14,016	2,743	60.00
65.00	RESPIRATORY THERAPY	0.921741	6,880	6,342	65.00
66.00	PHYSICAL THERAPY	0.421598	728	307	66.00
67.00	OCCUPATIONAL THERAPY	0.576630	292	168	67.00
68.00	SPEECH PATHOLOGY	1.479314	83	123	68.00
69.00	ELECTROCARDIOLOGY	0.133643	3,135	419	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.715387	6,657	4,762	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.264372	6,649	1,758	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.203089	20,544	4,172	73.00
76.97	CARDIAC REHABILITATION	26.215769	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	EMERGENCY	0.255934	9,381	2,401	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.717508	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		95,100	29,077	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		95,100		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/28/2012 8:16 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		168,663		30.00
31.00	INTENSIVE CARE UNIT		37,875		31.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.374797	113,895	42,688	50.00
51.00	RECOVERY ROOM	0.036054	6,166	222	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	0.009514	11,944	114	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.373636	16,749	6,258	54.00
57.00	CT SCAN	0.046301	51,846	2,401	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.239628	1,694	406	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.195718	60,099	11,762	60.00
65.00	RESPIRATORY THERAPY	0.921741	36,306	33,465	65.00
66.00	PHYSICAL THERAPY	0.421598	1,829	771	66.00
67.00	OCCUPATIONAL THERAPY	0.576630	1,450	836	67.00
68.00	SPEECH PATHOLOGY	1.479314	205	303	68.00
69.00	ELECTROCARDIOLOGY	0.133643	12,314	1,646	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.715387	5,060	3,620	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.264372	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.203089	119,606	24,291	73.00
76.97	CARDIAC REHABILITATION	26.215769	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
91.00	EMERGENCY	0.359406	53,147	19,101	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.717508	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		492,310	147,884	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)		492,310		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part A Date/Time Prepared: 5/28/2012 8:16 pm
		Title VIII	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER PPS</b>				
1.00	DRG Amounts Other than Outlier Payments		2,415,875	1.00
2.00	Outlier payments for discharges. (see instructions)		192,938	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)		51.23	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)		8.24	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		12.87	31.00
32.00	Sum of lines 30 and 31		21.11	32.00
33.00	Allowable disproportionate share percentage (see instructions)		6.63	33.00
34.00	Disproportionate share adjustment (see instructions)		160,173	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)		2,768,986	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		2,176,161	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		2,768,986	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		206,670	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: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part A Date/Time Prepared: 5/28/2012 8:16 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)			2,975,656 59.00
60.00	Primary payer payments			0 60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			2,975,656 61.00
62.00	Deductibles billed to program beneficiaries			355,352 62.00
63.00	Coinsurance billed to program beneficiaries			7,924 63.00
64.00	Allowable bad debts (see instructions)			84,199 64.00
65.00	Adjusted reimbursable bad debts (see instructions)			58,939 65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			84,199 66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			2,671,319 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			435,534 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)			3,106,853 71.00
72.00	Interim payments			3,098,236 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)			8,617 74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			827,679 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: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/28/2012 8:16 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		1,715	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		3,235,530	2.00
3.00	PPS payments		1,867,010	3.00
4.00	Outlier payment (see instructions)		72,090	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.872	5.00
6.00	Line 2 times line 5		2,821,382	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		68.73	7.00
8.00	Transitional corridor payment (see instructions)		749,940	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		1,715	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		8,447	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		8,447	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		8,447	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		6,732	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		1,715	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)		2,689,040	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)		477,724	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		2,213,031	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)		2,213,031	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		2,213,031	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)		91,624	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		64,137	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		91,624	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		2,277,168	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		2,277,168	40.00
41.00	Interim payments		2,805,318	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)		-528,150	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/28/2012 8:16 pm
	Title XVIII	Hospital	PPS
WORKSHEET OVERRIDE VALUES			Overrides
			1.00
112.00 Override of Ancillary service charges (line 12)			0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150102

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/28/2012 8:16 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		3,064,537		2,798,854	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	08/29/2011	33,699		6,464	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)		33,699		6,464	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)		3,098,236		2,805,318	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		8,617		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		528,150	6.02	
7.00	Total Medicare program liability (see instructions)		3,106,853		2,277,168	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150102

Period: From 01/01/2011

Worksheet E-1

Component CCN: 15U102

To 12/31/2011

Part I  
Date/Time Prepared:  
5/28/2012 8:16 pm

Title XVIII

Swing Beds - SNF

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		16,631		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		16,631		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		16,631		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 150102

Period:

Worksheet E-2

Component CCN: 15U102

From 01/01/2011  
To 12/31/2011

Date/Time Prepared:  
5/28/2012 8:16 pm

Title XVIII

Swing Beds - SNF

PPS

		Part A	Part B	
		1.00	2.00	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	17,763	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	70	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	17,763	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	17,763	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	17,763	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,132	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	16,631	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	16,631	0	19.00
20.00	Interim payments	16,631	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part VII Date/Time Prepared: 5/28/2012 8:16 pm
		Title XIX	Hospital	PPS
				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		0	1.00
2.00	Medical and other services		1,190,482	2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1,190,482	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)		1,190,482	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable Charges</b>				
8.00	Routine service charges		0	8.00
9.00	Ancillary service charges		5,342,392	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)		5,342,392	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)		5,342,392	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		4,151,910	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)		1,190,482	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.		1,190,482	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)		1,190,482	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)		1,190,482	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		1,190,482	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)		1,190,482	40.00
41.00	Interim payments		0	41.00
42.00	Balance due provider/program (line 40 minus 41)		1,190,482	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: 150102

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

Worksheet G  
Date/Time Prepared:  
5/28/2012 8:16 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	2,669,800	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	12,082,853	0	0	0	4.00
5.00	Other receivable	1,855,580	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-9,261,416	0	0	0	6.00
7.00	Inventory	614,930	0	0	0	7.00
8.00	Prepaid expenses	157,698	0	0	0	8.00
9.00	Other current assets	352,592	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	8,472,037	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	142,789	0	0	0	12.00
13.00	Land improvements	4,448	0	0	0	13.00
14.00	Accumulated depreciation	-794	0	0	0	14.00
15.00	Buildings	1,579,913	0	0	0	15.00
16.00	Accumulated depreciation	-1,079,227	0	0	0	16.00
17.00	Leasehold improvements	4,446,704	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	7,436,104	0	0	0	23.00
24.00	Accumulated depreciation	-2,696,135	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)	9,833,802	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	18,305,839	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	656,318	0	0	0	37.00
38.00	Salaries, wages, and fees payable	783,528	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	40,920	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	398,296	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,879,062	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	174,135	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	174,135	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,053,197	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	16,252,642				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)	16,252,642	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	18,305,839	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150102

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

Worksheet G-1

Date/Time Prepared:  
5/28/2012 8:16 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		12,955,702	
2.00	Net income (loss) (From Wkst. G-3, line 29)		2,260,312			2.00
3.00	Total (sum of line 1 and line 2)		15,216,014		0	3.00
4.00	NET INCREASE IN ASSETS	2,631,989			0	4.00
5.00	NET DECREASE IN LIABILITIES	664,951			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)		3,296,940		0	10.00
11.00	Subtotal (line 3 plus line 10)		18,512,954		0	11.00
12.00	Deductions (debit adjustments) (specify)	2,260,312			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)		2,260,312		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		16,252,642		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150102

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

Worksheet G-1

Date/Time Prepared:  
5/28/2012 8:16 pm

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150102

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

Worksheet G-2 Parts

Date/Time Prepared:  
5/28/2012 8:16 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	4,232,182		4,232,182	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,232,182		4,232,182	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	930,190		930,190	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)	930,190		930,190	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,162,372		5,162,372	17.00
18.00	Ancillary services	11,066,697	38,977,464	50,044,161	18.00
19.00	Outpatient services	1,186,296	10,552,287	11,738,583	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NON REIMBURSABLE REVENUE	989	-2,706	-1,717	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	17,416,354	49,527,045	66,943,399	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		24,219,658		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)		24,219,658		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150102

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

Worksheet G-3

Date/Time Prepared:  
5/28/2012 8:16 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	66,943,399	1.00
2.00	Less contractual allowances and discounts on patients' accounts	42,523,893	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,419,506	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	24,219,658	4.00
5.00	Net income from service to patients (line 3 minus line 4)	199,848	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	2,060,464	24.00
25.00	Total other income (sum of lines 6-24)	2,060,464	25.00
26.00	Total (line 5 plus line 25)	2,260,312	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)	2,260,312	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150102	Period: From 01/01/2011 To 12/31/2011	Worksheet L Parts I-III Date/Time Prepared: 5/28/2012 8:16 pm
		Title XVII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		194,840	1.00
2.00	Capital DRG outlier payments		11,830	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		6.84	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)		206,670	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