

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: 151320	Period: From 10/01/2010 To 09/30/2011	Worksheet S Parts I-III Date/Time Prepared: 3/23/2012 2:39 pm
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**PART I - COST REPORT STATUS**

Provider use only  
 1.  Electronically filed cost report  
 2.  Manually submitted cost report  
 3.  If this is an amended report enter the number of times the provider resubmitted this cost report  
 4.  Medicare Utilization. Enter "F" for full or "L" for low.

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.

Date: 3/23/2012 Time: 2:39 pm

**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 JAY COUNTY HOSPITAL for the cost reporting period beginning 10/01/2010 and ending 09/30/2011 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 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	-312,301	-328,802	0	339,960	1.00
2.00 Subprovider - IPF	0	0	0		-33,403	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	-15,934	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0	0	0		0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0		0	11.00
12.00 CMHC I	0	0	0		0	12.00
200.00 Total	0	-328,235	-328,802	0	306,557	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: 151320		Period: From 10/01/2010 To 09/30/2011		Worksheet S-2 Part I Date/Time Prepared: 3/23/2012 2:38 pm			
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IN		4.00 Zip Code: 47371- County: JAY			
1.00 Street: 500 W. VOTAW		2.00 City: PORTLAND							
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	
3.00 Hospital and Hospital-Based Component Identification:									
3.00 Hospital	JAY COUNTY HOSPITAL	151320	99915	1	01/01/2004	N	O	O	3.00
4.00 Subprovider - IPF	JAY COUNTY HOSPITAL-PSYCH UNIT	15M320	99915	4	10/01/2005	N	P	O	4.00
5.00 Subprovider - IRF									5.00
6.00 Subprovider - (Other)									6.00
7.00 Swing Beds - SNF	JAY COUNTY HOSPITAL	15Z320	99915		01/01/2004	N	O	O	7.00
8.00 Swing Beds - NF						N		N	8.00
9.00 Hospital-Based SNF									9.00
10.00 Hospital-Based NF									10.00
11.00 Hospital-Based OLTC									11.00
12.00 Hospital-Based HHA									12.00
13.00 Separately Certified ASC									13.00
14.00 Hospital-Based Hospice									14.00
15.00 Hospital-Based Health Clinic - RHC						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)					10/01/2010	09/30/2011		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.					N			22.00	
23.00 Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.					3 N			23.00	
		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00 If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	0		0	0	0	0	0		24.00
25.00 If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.	0		0	0	0	0	0		25.00
							1.00		
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 Enter your standard geographic classification (not wage) status at the end of the cost reporting period? Enter (1) for urban or (2) for rural.							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
					Beginning:	Ending:			
					1.00	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

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		Beginning: 1.00	Ending: 2.00			
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		V 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. 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		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

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		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))			
		1.00	2.00	3.00	4.00	5.00			
65.00	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		65.00	
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
				1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010									
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000		66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))			
		1.00	2.00	3.00	4.00	5.00			
67.00	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.					Y			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					N	N	0	71.00
75.00	Inpatient Rehabilitation Facility PPS 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			
80.00	Long Term Care Hospital PPS Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.							N	80.00

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			1.00		
<b>TEFRA Providers</b>					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(i)? Enter "Y" for yes and "N" for no.		N		86.00
			V	XIX	
			1.00	2.00	
<b>Title V or XIX Inpatient Services</b>					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	97.00
<b>Rural Providers</b>					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	N	N	Y
				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	N	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1	118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.		250,000	250,000	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		121.00
<b>Transplant Center Information</b>					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00

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			1.00		2.00			
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.							134.00
All Providers								
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)			Y				140.00
1.00			2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.								
141.00	Name:		Contractor's Name:		Contractor's Number:			141.00
142.00	Street:		PO Box:					142.00
143.00	City:		State:		Zip Code:			143.00
			1.00		2.00			
144.00	Are provider based physicians' costs included in Worksheet A?			Y				144.00
145.00	If costs for renal services are claimed on Worksheet A, 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		2.00			
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	
			0		1.00		2.00	
			Zip Code		CBSA		FTE/Campus	
			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		2.00			
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: 151320	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part II Date/Time Prepared: 3/23/2012 2:38 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A			
		Description	Y/N	Date	
		0	1.00	2.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	02/22/2012		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N			20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet S-2  
Part II  
Date/Time Prepared:  
3/23/2012 2:38 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		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		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		Y		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.		Y		33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		N		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		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?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet S-2  
Part II  
Date/Time Prepared:  
3/23/2012 2:38 pm

		Part B		
		Y/N	Date	
PS&R Data		3.00	4.00	
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	02/22/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet S-3  
Part I  
Date/Time Prepared:  
3/23/2012 2:38 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	25	9,125	64,056.00		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)		25	9,125	64,056.00		7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00					13.00
14.00 Total (see instructions)		25	9,125	64,056.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	40.00	10	3,650			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						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)		35				27.00
28.00 Observation Bed Days						28.00
28.01 SUBPROVIDER - IPF	40.00					28.01
28.02 SUBPROVIDER - IRF	41.00					28.02
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: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet S-3  
Part I  
Date/Time Prepared:  
3/23/2012 2:38 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	1,765	294	2,669		1.00
2.00 HMO		0	0			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	693	0	776		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	10		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,458	294	3,455		7.00
8.00 INTENSIVE CARE UNIT	0	0	0	0		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	0		0	146		13.00
14.00 Total (see instructions)	0	2,458	294	3,601		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF	0	1,971	97	2,673		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						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	12		28.00
28.01 SUBPROVIDER - IPF				0		28.01
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: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet S-3  
Part I  
Date/Time Prepared:  
3/23/2012 2:38 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	435	1.00
2.00 HMO					0	2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	260.55	0.00	0	435	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	15.26	0.00	0	157	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						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	275.81	0.00			27.00
28.00 Observation Bed Days						28.00
28.01 SUBPROVIDER - IPF						28.01
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: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet S-3  
Part I  
Date/Time Prepared:  
3/23/2012 2:38 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)	123	844		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)	123	844		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF	8	225		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
28.01 SUBPROVIDER - IPF				28.01
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



RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet A  
Date/Time Prepared:  
3/23/2012 2:38 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>						
2.00 NEW CAP REL COSTS-MVBLE EQUIP		1,944,156	1,944,156	0	1,944,156	2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP MOB		60,946	60,946	0	60,946	2.01
2.02 NEW CAP REL COSTS-MVBLE EQUIP-POB		111,624	111,624	0	111,624	2.02
2.03 NEW CAP REL COSTS-MVBLE EQUIP- WJ		15,725	15,725	0	15,725	2.03
4.00 EMPLOYEE BENEFITS	0	4,786,557	4,786,557	0	4,786,557	4.00
5.00 ADMINISTRATIVE & GENERAL	1,629,254	1,933,700	3,562,954	0	3,562,954	5.00
7.00 OPERATION OF PLANT	278,074	729,379	1,007,453	-15,587	991,866	7.00
7.01 OPERATION OF PLANT-MOB	0	28,079	28,079	5,856	33,935	7.01
7.02 OPERATION OF PLANT-POB	0	55,979	55,979	8,101	64,080	7.02
7.03 OPERATION OF PLANT-WJ	0	176	176	1,630	1,806	7.03
8.00 LAUNDRY & LINEN SERVICE	40,745	20,700	61,445	0	61,445	8.00
9.00 HOUSEKEEPING	300,954	79,132	380,086	0	380,086	9.00
10.00 DIETARY	326,914	244,047	570,961	-251,645	319,316	10.00
11.00 CAFETERIA	0	0	0	251,645	251,645	11.00
13.00 NURSING ADMINISTRATION	844,457	16,100	860,557	0	860,557	13.00
14.00 CENTRAL SERVICES & SUPPLY	67,353	9,276	76,629	0	76,629	14.00
16.00 MEDICAL RECORDS & LIBRARY	315,639	91,782	407,421	0	407,421	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	1,397,616	163,791	1,561,407	-169,033	1,392,374	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00 SUBPROVIDER - IPF	634,582	425,530	1,060,112	0	1,060,112	40.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	0	0	0	153,085	153,085	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	741,770	846,202	1,587,972	0	1,587,972	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	15,948	15,948	52.00
53.00 ANESTHESIOLOGY	317,971	455,871	773,842	0	773,842	53.00
54.00 RADIOLOGY-DIAGNOSTIC	744,863	726,775	1,471,638	0	1,471,638	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	612,379	1,073,197	1,685,576	0	1,685,576	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	0	352,396	352,396	0	352,396	65.00
66.00 PHYSICAL THERAPY	0	645,361	645,361	0	645,361	66.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	156,703	125,685	282,388	0	282,388	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	371,609	925,298	1,296,907	0	1,296,907	73.00
<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	1,523,946	500,937	2,024,883	0	2,024,883	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
106.00 HEART ACQUISITION	0	0	0	0	0	106.00
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
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	10,304,829	16,368,401	26,673,230	0	26,673,230	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 MOB	0	0	0	0	0	194.00
194.01 POB	0	0	0	0	0	194.01
194.02 WEST JAY CLINIC	249,888	102,308	352,196	0	352,196	194.02
194.03 JAY COMMUNITY HEALTH PARTNERS	577,010	188,767	765,777	0	765,777	194.03
194.04 FAMILY PRACTICE OF JAY COUNTY	1,491,058	315,011	1,806,069	0	1,806,069	194.04
194.05 JAY FAMILY MEDICINE	1,076,834	238,109	1,314,943	0	1,314,943	194.05
194.06 TRI COUNTY	100,957	711,082	812,039	0	812,039	194.06
200.00 TOTAL (SUM OF LINES 118-199)	13,800,576	17,923,678	31,724,254	0	31,724,254	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet A  
Date/Time Prepared:  
3/23/2012 2:38 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-3,996	1,940,160	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	60,946	2.01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	111,624	2.02
2.03	NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	15,725	2.03
4.00	EMPLOYEE BENEFITS	-2,347	4,784,210	4.00
5.00	ADMINISTRATIVE & GENERAL	-261,959	3,300,995	5.00
7.00	OPERATION OF PLANT	0	991,866	7.00
7.01	OPERATION OF PLANT-MOB	0	33,935	7.01
7.02	OPERATION OF PLANT-POB	0	64,080	7.02
7.03	OPERATION OF PLANT-WJ	0	1,806	7.03
8.00	LAUNDRY & LINEN SERVICE	0	61,445	8.00
9.00	HOUSEKEEPING	-35,336	344,750	9.00
10.00	DIETARY	0	319,316	10.00
11.00	CAFETERIA	-100,683	150,962	11.00
13.00	NURSING ADMINISTRATION	-1,188	859,369	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	76,629	14.00
16.00	MEDICAL RECORDS & LIBRARY	-8,686	398,735	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	0	1,392,374	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
40.00	SUBPROVIDER - IPF	0	1,060,112	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	153,085	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	-25,170	1,562,802	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	15,948	52.00
53.00	ANESTHESIOLOGY	-773,842	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	-4,147	1,467,491	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	-70,301	1,615,275	60.00
60.01	BLOOD LABORATORY	0	0	60.01
65.00	RESPIRATORY THERAPY	0	352,396	65.00
66.00	PHYSICAL THERAPY	-25,472	619,889	66.00
68.00	SPEECH PATHOLOGY	0	0	68.00
69.00	ELECTROCARDIOLOGY	-167	282,221	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	-114,975	1,181,932	73.00
<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	-495,369	1,529,514	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	CORF	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
106.00	HEART ACQUISITION	0	0	106.00
109.00	PANCREAS ACQUISITION	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	110.00
111.00	ISLET ACQUISITION	0	0	111.00
113.00	INTEREST EXPENSE	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-1,923,638	24,749,592	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	NONPAID WORKERS	0	0	193.00
194.00	MOB	0	0	194.00
194.01	POB	0	0	194.01
194.02	WEST JAY CLINIC	0	352,196	194.02
194.03	JAY COMMUNITY HEALTH PARTNERS	0	765,777	194.03
194.04	FAMILY PRACTICE OF JAY COUNTY	0	1,806,069	194.04
194.05	JAY FAMILY MEDICINE	0	1,314,943	194.05
194.06	TRI COUNTY	0	812,039	194.06
200.00	TOTAL (SUM OF LINES 118-199)	-1,923,638	29,800,616	200.00

RECLASSIFICATIONS

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet A-6

Date/Time Prepared:  
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		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - NURSERY RECLASS					
1.00	NURSERY	43.00	141,269	11,816	1.00
	TOTALS		141,269	11,816	
B - LABOR & DELIVERY RECLASS					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	15,098	850	1.00
	TOTALS		15,098	850	
C - CAFETERIA					
1.00	CAFETERIA	11.00	144,084	107,561	1.00
	TOTALS		144,084	107,561	
D - MOB, POB, WEST JAY MAINTENANCE					
1.00	OPERATION OF PLANT-MOB	7.01	5,856	0	1.00
2.00	OPERATION OF PLANT-POB	7.02	8,101	0	2.00
3.00	OPERATION OF PLANT-WJ	7.03	1,630	0	3.00
	TOTALS		15,587	0	
500.00	Grand Total: Increases		316,038	120,227	500.00

RECLASSIFICATIONS

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet A-6  
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Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - NURSERY RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	141,269	11,816	0		1.00
	TOTALS		141,269	11,816			
B - LABOR & DELIVERY RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	15,098	850	0		1.00
	TOTALS		15,098	850			
C - CAFETERIA							
1.00	DIETARY	10.00	144,084	107,561	0		1.00
	TOTALS		144,084	107,561			
D - MOB, POB, WEST JAY MAINTENANCE							
1.00	OPERATION OF PLANT	7.00	15,587	0		0	1.00
2.00		0.00	0	0		0	2.00
3.00		0.00	0	0		0	3.00
	TOTALS		15,587	0		0	
500.00	Grand Total: Decreases		316,038	120,227			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
3/23/2012 2:38 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	220,245	0	0	0	1.00
2.00	Land Improvements	854,541	36,948	0	36,948	2.00
3.00	Buildings and Fixtures	21,710,654	1,003,676	0	1,003,676	3.00
4.00	Building Improvements	1,179,003	0	0	0	4.00
5.00	Fixed Equipment	3,082,095	23,638	0	23,638	5.00
6.00	Movable Equipment	6,781,599	2,350,334	0	2,350,334	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	33,828,137	3,414,596	0	3,414,596	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	33,828,137	3,414,596	0	3,414,596	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>						
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,944,156	0	0	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	60,946	0	0	0	2.01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	111,624	0	0	0	2.02
2.03	NEW CAP REL COSTS-MVBLE EQUIP- WJ	15,725	0	0	0	2.03
3.00	Total (sum of lines 1-2)	2,132,451	0	0	0	3.00
<b>COMPUTATION OF RATIOS</b>						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>						
2.00	NEW CAP REL COSTS-MVBLE EQUIP	36,041,810	0	36,041,810	1.000000	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	0	0	0.000000	2.01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	0	0	0.000000	2.02
2.03	NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	0	0	0.000000	2.03
3.00	Total (sum of lines 1-2)	36,041,810	0	36,041,810	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet A-7  
Parts I-III  
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		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	220,245	0		1.00	
2.00	Land Improvements	891,489	0		2.00	
3.00	Buildings and Fixtures	22,714,330	0		3.00	
4.00	Building Improvements	0	0		4.00	
5.00	Fixed Equipment	3,105,733	0		5.00	
6.00	Movable Equipment	9,110,013	0		6.00	
7.00	HIT designated Assets	0	0		7.00	
8.00	Subtotal (sum of lines 1-7)	36,041,810	0		8.00	
9.00	Reconciling Items	0	0		9.00	
10.00	Total (line 8 minus line 9)	36,041,810	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>						
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,944,156		2.00	
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	60,946		2.01	
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	111,624		2.02	
2.03	NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	15,725		2.03	
3.00	Total (sum of lines 1-2)	0	2,132,451		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>						
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,940,160	0
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	0	0	60,946	0
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	0	0	111,624	0
2.03	NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	0	0	15,725	0
3.00	Total (sum of lines 1-2)	0	0	0	2,128,455	0

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet A-7  
Parts I-III  
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Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,940,160	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0	0	0	0	60,946	2.01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	0	0	0	0	111,624	2.02
2.03	NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	0	0	0	15,725	2.03
3.00	Total (sum of lines 1-2)	0	0	0	0	2,128,455	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet A-8

Date/Time Prepared:  
3/23/2012 2:38 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center		Line #
			1.00	2.00	3.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	*** Cost Center Deleted ***		1.00 1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP		2.00 2.00
2.01 Investment income - NEW CAP REL COSTS-MVBLE EQUIP MOB (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP MOB		2.01 2.01
2.02 Investment income - NEW CAP REL COSTS-MVBLE EQUIP-POB (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP-POB		2.02 2.02
2.03 Investment income - NEW CAP REL COSTS-MVBLE EQUIP- WJ (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP- WJ		2.03 2.03
3.00 Investment income - other (chapter 2)		0			0.00 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00 7.00
8.00 Television and radio service (chapter 21)		0			0.00 8.00
9.00 Parking lot (chapter 21)		0			0.00 9.00
10.00 Provider-based physician adjustment	A-8-2	-580,539			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	-25,472			12.00
13.00 Laundry and linen service		0			0.00 13.00
14.00 Cafeteria-employees and guests	B	-102,307	CAFETERIA		11.00 14.00
15.00 Rental of quarters to employee and others		0			0.00 15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00 16.00
17.00 Sale of drugs to other than patients		0			0.00 17.00
18.00 Sale of medical records and abstracts	B	-8,686	MEDICAL RECORDS & LIBRARY		16.00 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00 19.00
20.00 Vending machines		0			0.00 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY		65.00 23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY		66.00 24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***		114.00 25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	*** Cost Center Deleted ***		1.00 26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP		2.00 27.00
27.01 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP MOB		0	NEW CAP REL COSTS-MVBLE EQUIP MOB		2.01 27.01
27.02 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP-POB		0	NEW CAP REL COSTS-MVBLE EQUIP-POB		2.02 27.02
27.03 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP- WJ		0	NEW CAP REL COSTS-MVBLE EQUIP- WJ		2.03 27.03
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***		19.00 28.00
29.00 Physicians' assistant		0			0.00 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***		67.00 30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY		68.00 31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00 32.00
33.00 JEMS RENTAL	B	-6,000	ADMINISTRATIVE & GENERAL		5.00 33.00
33.01 SUPPLY REBATES & DISCOUNTS	B	-781	ADMINISTRATIVE & GENERAL		5.00 33.01
33.02 OTHER REVENUE	B	-7,555	ADMINISTRATIVE & GENERAL		5.00 33.02
33.03 OTHER REVENUE-DIABETIC COUNSELING	B	-1,188	NURSING ADMINISTRATIVE		13.00 33.03
33.04 CRNA OFFSET	A	-773,842	ANESTHESIOLOGY		53.00 33.04
33.05 PHYSICIAN RECRUITMENT	A	-32,198	ADMINISTRATIVE & GENERAL		5.00 33.05
33.06 ADVERTISING EXPENSE	A	-56,460	ADMINISTRATIVE & GENERAL		5.00 33.06
33.07 SENIOR PROGRAM	A	-13,841	ADMINISTRATIVE & GENERAL		5.00 33.07
33.08 SWITCHBOARD SALARY	A	-7,201	ADMINISTRATIVE & GENERAL		5.00 33.08

Provider CCN: 151320  
 Period: From 10/01/2010 To 09/30/2011  
 Worksheet A-8  
 Date/Time Prepared: 3/23/2012 2:38 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #
			Cost Center		
			1.00	2.00	
33.09 SWITCHBOARD EH&W	A	-2,347	EMPLOYEE BENEFITS	4.00	33.09
33.10 PATIENT TELEPHONE EXPENSE	A	-15,598	ADMINISTRATIVE & GENERAL	5.00	33.10
33.11 PATIENT TELEPHONE DEPRECIATION	A	-3,996	NEW CAP REL COSTS-MVBLE EQUIP	2.00	33.11
33.12 HEALTH EDUCATION	B	-47,593	ADMINISTRATIVE & GENERAL	5.00	33.12
33.13 DEFAULT REVENUE	B	-9,027	ADMINISTRATIVE & GENERAL	5.00	33.13
33.14 VENDING MACHINE REVENUE	B	1,624	CAFETERIA	11.00	33.14
33.15 PHARMACY EMPLOYEE SALES	B	-114,975	DRUGS CHARGED TO PATIENTS	73.00	33.15
33.16 MANAGEMENT FEES	B	-15,000	ADMINISTRATIVE & GENERAL	5.00	33.16
33.17		0		0.00	33.17
33.18 HOUSEKEEPING WAGES	A	-35,336	HOUSEKEEPING	9.00	33.18
33.19 ADMINISTRATIVE WAGES	A	-46,408	ADMINISTRATIVE & GENERAL	5.00	33.19
33.20 IHA AND AHA DUES	A	-2,924	ADMINISTRATIVE & GENERAL	5.00	33.20
33.21 OTHER REVENUE RADIOLOGY	B	-4,147	RADIOLOGY-DIAGNOSTIC	54.00	33.21
33.22 LAB OUTREACH HEALTH FAIR	B	-9,125	LABORATORY	60.00	33.22
33.23 LAND RENT	B	-563	ADMINISTRATIVE & GENERAL	5.00	33.23
33.24 CLINIC RENTAL	B	-167	ELECTROCARDIOLOGY	69.00	33.24
33.25 FLU SHOT	B	-330	ADMINISTRATIVE & GENERAL	5.00	33.25
33.26 CONFERENCE ROOM RENTAL	B	-480	ADMINISTRATIVE & GENERAL	5.00	33.26
33.27 OTHER REVENUE LAB	B	-1,176	LABORATORY	60.00	33.27
33.28		0		0.00	33.28
33.29		0		0.00	33.29
33.30		0		0.00	33.30
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,923,638			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet A-8  
Date/Time Prepared:  
3/23/2012 2:38 pm

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
2.01	Investment income - NEW CAP REL COSTS-MVBLE EQUIP MOB (chapter 2)	0	2.01
2.02	Investment income - NEW CAP REL COSTS-MVBLE EQUIP-POB (chapter 2)	0	2.02
2.03	Investment income - NEW CAP REL COSTS-MVBLE EQUIP- WJ (chapter 2)	0	2.03
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0	27.00
27.01	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP MOB	0	27.01
27.02	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP-POB	0	27.02
27.03	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP- WJ	0	27.03
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	JEMS RENTAL	0	33.00
33.01	SUPPLY REBATES & DISCOUNTS	0	33.01
33.02	OTHER REVENUE	0	33.02
33.03	OTHER REVENUE-DIABETIC COUNSELING	0	33.03
33.04	CRNA OFFSET	0	33.04
33.05	PHYSICIAN RECRUITMENT	0	33.05
33.06	ADVERTISING EXPENSE	0	33.06
33.07	SENIOR PROGRAM	0	33.07
33.08	SWITCHBOARD SALARY	0	33.08
33.09	SWITCHBOARD EH&W	0	33.09
33.10	PATIENT TELEPHONE EXPENSE	0	33.10
33.11	PATIENT TELEPHONE DEPRECIATION	9	33.11
33.12	HEALTH EDUCATION	0	33.12
33.13	DEFAULT REVENUE	0	33.13
33.14	VENDING MACHINE REVENUE	0	33.14
33.15	PHARMACY EMPLOYEE SALES	0	33.15

ADJUSTMENTS TO EXPENSES

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet A-8

Date/Time Prepared:  
3/23/2012 2:38 pm

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
33.16	MANAGEMENT FEES	0	33.16
33.17		0	33.17
33.18	HOUSEKEEPING WAGES	0	33.18
33.19	ADMINISTRATIVE WAGES	0	33.19
33.20	IHA AND AHA DUES	0	33.20
33.21	OTHER REVENUE RADIOLOGY	0	33.21
33.22	LAB OUTREACH HEALTH FAIR	0	33.22
33.23	LAND RENT	0	33.23
33.24	CLINIC RENTAL	0	33.24
33.25	FLU SHOT	0	33.25
33.26	CONFERENCE ROOM RENTAL	0	33.26
33.27	OTHER REVENUE LAB	0	33.27
33.28		0	33.28
33.29		0	33.29
33.30		0	33.30
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: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet A-8-1

Date/Time Prepared:  
3/23/2012 2:38 pm

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	66.00	PHYSICAL THERAPY	RENT LEASE EXPENSE	1.00
2.00	0.00			2.00
3.00	0.00			3.00
4.00	0.00			4.00
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. 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	C	JAY CO MED FAC	65.00	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:			100.00

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

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

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

Provider CCN: 151320

Period: From 10/01/2010 To 09/30/2011

Worksheet A-8-1

Date/Time Prepared: 3/23/2012 2:38 pm

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	34,536	60,008	-25,472	10	1.00
2.00	0	0	0	0	2.00
3.00	0	0	0	0	3.00
4.00	0	0	0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				
	34,536	60,008	-25,472		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>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		0.00	6.00
7.00		0.00	7.00
8.00		0.00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:		100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet A-8-2

Date/Time Prepared:  
3/23/2012 2:38 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	60.00	LAB	60,000	60,000	1.00
2.00	50.00	SURGERY	25,170	25,170	2.00
3.00	91.00	DR. BROWN	361,561	123,473	3.00
4.00	91.00	DR. DETAMORE	237,415	68,874	4.00
5.00	91.00	DR. HAGGENJOS	78,735	21,747	5.00
6.00	91.00	DR. HAWROT	391,406	140,123	6.00
7.00	91.00	DR. TOLLIVER	182,418	54,288	7.00
8.00	91.00	DR. MYRON	35,438	10,546	8.00
9.00	91.00	DR. CRANE	38,251	38,251	9.00
10.00	91.00	DR. FOSTER	40,777	30,583	10.00
11.00	91.00	DR. DROEGE	22,454	7,484	11.00
200.00		TOTAL (lines 1.00 through 199.00)	1,473,625	580,539	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet A-8-2

Date/Time Prepared:  
3/23/2012 2:38 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	238,088	0	0	0	0	3.00
4.00	168,541	0	0	0	0	4.00
5.00	56,988	0	0	0	0	5.00
6.00	251,282	0	0	0	0	6.00
7.00	128,130	0	0	0	0	7.00
8.00	24,892	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	10,194	0	0	0	0	10.00
11.00	14,970	0	0	0	0	11.00
200.00	893,085		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet A-8-2

Date/Time Prepared:  
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	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14	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	0	4.00
5.00	0	0	0	0	0	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
11.00	0	0	0	0	0	11.00
200.00	0	0	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet A-8-2

Date/Time Prepared:  
3/23/2012 2:38 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	60,000	1.00
2.00	0	25,170	2.00
3.00	0	123,473	3.00
4.00	0	68,874	4.00
5.00	0	21,747	5.00
6.00	0	140,123	6.00
7.00	0	54,288	7.00
8.00	0	10,546	8.00
9.00	0	38,251	9.00
10.00	0	30,583	10.00
11.00	0	7,484	11.00
200.00	0	580,539	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet B  
Part I  
Date/Time Prepared:  
3/23/2012 2:38 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
		NEW MVBLE EQUIP	NEW MVBLE EQUIP MOB	NEW MVBLE EQUIP-POB	NEW MVBLE EQUIP- WJ	
		2.00	2.01	2.02	2.03	
<b>GENERAL SERVICE COST CENTERS</b>						
2.00 NEW CAP REL COSTS-MVBLE EQUIP	1,940,160	1,940,160				2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP MOB	60,946	0	60,946			2.01
2.02 NEW CAP REL COSTS-MVBLE EQUIP-POB	111,624	0	0	111,624		2.02
2.03 NEW CAP REL COSTS-MVBLE EQUIP- WJ	15,725	0	0	0	15,725	2.03
4.00 EMPLOYEE BENEFITS	4,784,210	0	0	0	0	4.00
5.00 ADMINISTRATIVE & GENERAL	3,300,995	231,586	12,971	3,121	0	5.00
7.00 OPERATION OF PLANT	991,866	120,673	0	0	0	7.00
7.01 OPERATION OF PLANT-MOB	33,935	0	0	0	0	7.01
7.02 OPERATION OF PLANT-POB	64,080	0	0	0	0	7.02
7.03 OPERATION OF PLANT-WJ	1,806	0	0	0	0	7.03
8.00 LAUNDRY & LINEN SERVICE	61,445	13,052	0	0	0	8.00
9.00 HOUSEKEEPING	344,750	10,385	0	0	0	9.00
10.00 DIETARY	319,316	60,720	2,213	0	0	10.00
11.00 CAFETERIA	150,962	58,308	0	0	0	11.00
13.00 NURSING ADMINISTRATION	859,369	41,340	0	0	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	76,629	57,315	0	0	0	14.00
16.00 MEDICAL RECORDS & LIBRARY	398,735	40,149	0	0	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	1,392,374	379,779	0	0	0	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00 SUBPROVIDER - IPF	1,060,112	131,540	0	0	0	40.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	153,085	29,310	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	1,562,802	181,591	0	53,147	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	15,948	3,603	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	1,467,491	177,477	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	1,615,275	68,097	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	352,396	7,945	0	0	0	65.00
66.00 PHYSICAL THERAPY	619,889	0	0	0	0	66.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	282,221	28,374	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 PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	1,181,932	31,495	0	0	0	73.00
<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	1,529,514	131,937	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
106.00 HEART ACQUISITION	0	0	0	0	0	106.00
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
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	24,749,592	1,804,676	15,184	56,268	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,315	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 MOB	0	0	45,762	0	0	194.00
194.01 POB	0	0	0	55,356	0	194.01
194.02 WEST JAY CLINIC	352,196	0	0	0	15,725	194.02
194.03 JAY COMMUNITY HEALTH PARTNERS	765,777	119,169	0	0	0	194.03
194.04 FAMILY PRACTICE OF JAY COUNTY	1,806,069	0	0	0	0	194.04
194.05 JAY FAMILY MEDICINE	1,314,943	0	0	0	0	194.05
194.06 TRI COUNTY	812,039	0	0	0	0	194.06
200.00 Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet B  
Part I  
Date/Time Prepared:  
3/23/2012 2:38 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
		NEW MVBLE EQUIP	NEW MVBLE EQUIP MOB	NEW MVBLE EQUIP-POB	NEW MVBLE EQUIP- WJ	
	0	2.00	2.01	2.02	2.03	
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	29,800,616	1,940,160	60,946	111,624	15,725	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151320

Period: From 10/01/2010 To 09/30/2011

Worksheet B Part I Date/Time Prepared: 3/23/2012 2:38 pm

Cost Center Description		EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT-MOB	
		4.00	4A	5.00	7.00	7.01	
<b>GENERAL SERVICE COST CENTERS</b>							
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB						2.01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB						2.02
2.03	NEW CAP REL COSTS-MVBLE EQUIP- WJ						2.03
4.00	EMPLOYEE BENEFITS	4,784,210					4.00
5.00	ADMINISTRATIVE & GENERAL	578,132	4,126,805	4,126,805			5.00
7.00	OPERATION OF PLANT	93,142	1,205,681	193,801	1,399,482		7.00
7.01	OPERATION OF PLANT-MOB	2,078	36,013	5,789	0	41,802	7.01
7.02	OPERATION OF PLANT-POB	2,875	66,955	10,762	0	0	7.02
7.03	OPERATION OF PLANT-WJ	578	2,384	383	0	0	7.03
8.00	LAUNDRY & LINEN SERVICE	14,458	88,955	14,299	11,503	0	8.00
9.00	HOUSEKEEPING	106,791	461,926	74,250	9,152	0	9.00
10.00	DIETARY	64,876	447,125	71,871	53,515	1,928	10.00
11.00	CAFETERIA	51,127	260,397	41,856	51,389	0	11.00
13.00	NURSING ADMINISTRATION	299,650	1,200,359	192,946	36,435	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	23,900	157,844	25,372	50,514	0	14.00
16.00	MEDICAL RECORDS & LIBRARY	112,002	550,886	88,549	35,385	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	440,449	2,212,602	355,654	334,714	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	SUBPROVIDER - IPF	225,177	1,416,829	227,741	115,932	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	50,128	232,523	37,376	25,832	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	263,212	2,060,752	331,245	160,044	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	5,357	24,908	4,004	3,176	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	264,309	1,909,277	306,897	156,418	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	217,298	1,900,670	305,514	60,016	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	360,341	57,921	7,002	0	65.00
66.00	PHYSICAL THERAPY	0	619,889	99,641	0	0	66.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	55,605	366,200	58,863	25,007	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	131,863	1,345,290	216,242	27,758	0	73.00
<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	540,762	2,202,213	353,984	116,282	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
106.00	HEART ACQUISITION	0	0	0	0	0	106.00
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
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,543,769	23,256,824	3,074,960	1,280,074	1,928	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,315	2,622	14,379	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	MOB	0	45,762	7,356	0	39,874	194.00
194.01	POB	0	55,356	8,898	0	0	194.01
194.02	WEST JAY CLINIC	88,671	456,592	73,393	0	0	194.02
194.03	JAY COMMUNITY HEALTH PARTNERS	204,748	1,089,694	175,157	105,029	0	194.03
194.04	FAMILY PRACTICE OF JAY COUNTY	529,091	2,335,160	375,350	0	0	194.04
194.05	JAY FAMILY MEDICINE	382,107	1,697,050	272,784	0	0	194.05
194.06	TRI COUNTY	35,824	847,863	136,285	0	0	194.06
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	4,784,210	29,800,616	4,126,805	1,399,482	41,802	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet B  
Part I  
Date/Time Prepared:  
3/23/2012 2:38 pm

Cost Center Description	OPERATION OF PLANT-POB	OPERATION OF PLANT-WJ	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	7.02	7.03	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>						
2.00						2.00
2.01						2.01
2.02						2.02
2.03						2.03
4.00						4.00
5.00						5.00
7.00						7.00
7.01						7.01
7.02	77,717					7.02
7.03	0	2,767				7.03
8.00	0	0	114,757			8.00
9.00	0	0	3,269	548,597		9.00
10.00	0	0	2,125	15,585	592,149	10.00
11.00	0	0	0	14,966	0	11.00
13.00	0	0	0	10,611	0	13.00
14.00	0	0	0	14,711	0	14.00
16.00	0	0	0	10,305	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	0	0	64,938	97,478	333,849	30.00
31.00	0	0	0	0	0	31.00
40.00	0	0	13,732	33,763	258,300	40.00
41.00	0	0	0	0	0	41.00
42.00	0	0	0	0	0	42.00
43.00	0	0	2,577	7,523	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	38,068	0	18,636	86,919	0	50.00
52.00	0	0	0	925	0	52.00
53.00	0	0	0	0	0	53.00
54.00	0	0	163	45,553	0	54.00
57.00	0	0	0	0	0	57.00
58.00	0	0	0	0	0	58.00
59.00	0	0	0	0	0	59.00
60.00	0	0	0	17,478	0	60.00
60.01	0	0	0	0	0	60.01
65.00	0	0	0	2,039	0	65.00
66.00	0	0	1,635	0	0	66.00
68.00	0	0	0	0	0	68.00
69.00	0	0	1,798	7,283	0	69.00
71.00	0	0	0	0	0	71.00
72.00	0	0	0	0	0	72.00
73.00	0	0	0	8,084	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	0	0	0	0	0	88.00
89.00	0	0	0	0	0	89.00
91.00	0	0	4,904	33,864	0	91.00
92.00	0	0	0	0	0	92.00
93.00	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
106.00	0	0	0	0	0	106.00
109.00	0	0	0	0	0	109.00
110.00	0	0	0	0	0	110.00
111.00	0	0	0	0	0	111.00
113.00	0	0	0	0	0	113.00
118.00	38,068	0	113,777	407,087	592,149	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	0	0	0	4,188	0	190.00
192.00	0	0	0	0	0	192.00
193.00	0	0	0	0	0	193.00
194.00	0	0	0	64,750	0	194.00
194.01	39,649	0	0	41,985	0	194.01
194.02	0	2,767	490	0	0	194.02
194.03	0	0	490	30,587	0	194.03
194.04	0	0	0	0	0	194.04
194.05	0	0	0	0	0	194.05
194.06	0	0	0	0	0	194.06
200.00	0	0	0	0	0	200.00
201.00	0	0	0	0	0	201.00
202.00	77,717	2,767	114,757	548,597	592,149	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet B  
Part I  
Date/Time Prepared:  
3/23/2012 2:38 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>							
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB						2.01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB						2.02
2.03	NEW CAP REL COSTS-MVBLE EQUIP- WJ						2.03
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
7.01	OPERATION OF PLANT-MOB						7.01
7.02	OPERATION OF PLANT-POB						7.02
7.03	OPERATION OF PLANT-WJ						7.03
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	368,608					11.00
13.00	NURSING ADMINISTRATION	27,621	1,467,972				13.00
14.00	CENTRAL SERVICES & SUPPLY	4,868	0	253,309			14.00
16.00	MEDICAL RECORDS & LIBRARY	20,113	0	869	706,107		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	62,463	563,017	14,557	50,702	4,089,974	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	SUBPROVIDER - IPF	31,479	283,740	3,424	25,596	2,410,536	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	6,828	61,545	0	1,506	375,710	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	26,858	242,090	78,427	105,932	3,148,971	50.00
52.00	DELIVERY ROOM & LABOR ROOM	1,155	10,412	0	2,365	46,945	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	29,973	0	23,344	241,828	2,713,453	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	30,901	0	54,251	143,283	2,512,113	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	0	900	14,099	442,302	65.00
66.00	PHYSICAL THERAPY	0	0	486	17,893	739,544	66.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	8,148	0	2,374	9,513	479,186	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	12,460	0	18,912	40,875	1,669,621	73.00
<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	34,078	307,168	16,819	52,515	3,121,827	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
106.00	HEART ACQUISITION	0	0	0	0	0	106.00
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
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	296,945	1,467,972	214,363	706,107	21,750,182	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	37,504	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	MOB	0	0	0	0	157,742	194.00
194.01	POB	0	0	0	0	145,888	194.01
194.02	WEST JAY CLINIC	0	0	2,993	0	536,235	194.02
194.03	JAY COMMUNITY HEALTH PARTNERS	26,528	0	8,371	0	1,435,856	194.03
194.04	FAMILY PRACTICE OF JAY COUNTY	41,504	0	18,280	0	2,770,294	194.04
194.05	JAY FAMILY MEDICINE	0	0	7,699	0	1,977,533	194.05
194.06	TRI COUNTY	3,631	0	1,603	0	989,382	194.06
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)	368,608	1,467,972	253,309	706,107	29,800,616	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet B  
Part I  
Date/Time Prepared:  
3/23/2012 2:38 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>				
2.00	NEW CAP REL COSTS-MVBLE EQUIP			2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB			2.01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB			2.02
2.03	NEW CAP REL COSTS-MVBLE EQUIP- WJ			2.03
4.00	EMPLOYEE BENEFITS			4.00
5.00	ADMINISTRATIVE & GENERAL			5.00
7.00	OPERATION OF PLANT			7.00
7.01	OPERATION OF PLANT-MOB			7.01
7.02	OPERATION OF PLANT-POB			7.02
7.03	OPERATION OF PLANT-WJ			7.03
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	4,089,974	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
40.00	SUBPROVIDER - 1PF	0	2,410,536	40.00
41.00	SUBPROVIDER - 1RF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	375,710	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	0	3,148,971	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	46,945	52.00
53.00	ANESTHESIOLOGY	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	2,713,453	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	2,512,113	60.00
60.01	BLOOD LABORATORY	0	0	60.01
65.00	RESPIRATORY THERAPY	0	442,302	65.00
66.00	PHYSICAL THERAPY	0	739,544	66.00
68.00	SPEECH PATHOLOGY	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	479,186	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,669,621	73.00
<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	3,121,827	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	CORF	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
106.00	HEART ACQUISITION	0	0	106.00
109.00	PANCREAS ACQUISITION	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	110.00
111.00	ISLET ACQUISITION	0	0	111.00
113.00	INTEREST EXPENSE	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	21,750,182	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	37,504	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	NONPAID WORKERS	0	0	193.00
194.00	MOB	0	157,742	194.00
194.01	POB	0	145,888	194.01
194.02	WEST JAY CLINIC	0	536,235	194.02
194.03	JAY COMMUNITY HEALTH PARTNERS	0	1,435,856	194.03
194.04	FAMILY PRACTICE OF JAY COUNTY	0	2,770,294	194.04
194.05	JAY FAMILY MEDICINE	0	1,977,533	194.05
194.06	TRI COUNTY	0	989,382	194.06
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	29,800,616	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet B  
Part II  
Date/Time Prepared:  
3/23/2012 2:38 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
		NEW MVBLE EQUIP	NEW MVBLE EQUIP MOB	NEW MVBLE EQUIP-POB	NEW MVBLE EQUIP- WJ	
		2.00	2.01	2.02	2.03	
<b>GENERAL SERVICE COST CENTERS</b>						
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB					2.01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB					2.02
2.03	NEW CAP REL COSTS-MVBLE EQUIP- WJ					2.03
4.00	EMPLOYEE BENEFITS	0	0	0	0	4.00
5.00	ADMINISTRATIVE & GENERAL	0	231,586	12,971	3,121	5.00
7.00	OPERATION OF PLANT	0	120,673	0	0	7.00
7.01	OPERATION OF PLANT-MOB	0	0	0	0	7.01
7.02	OPERATION OF PLANT-POB	0	0	0	0	7.02
7.03	OPERATION OF PLANT-WJ	0	0	0	0	7.03
8.00	LAUNDRY & LINEN SERVICE	0	13,052	0	0	8.00
9.00	HOUSEKEEPING	0	10,385	0	0	9.00
10.00	DIETARY	0	60,720	2,213	0	10.00
11.00	CAFETERIA	0	58,308	0	0	11.00
13.00	NURSING ADMINISTRATION	0	41,340	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	57,315	0	0	14.00
16.00	MEDICAL RECORDS & LIBRARY	0	40,149	0	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS	0	379,779	0	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	31.00
40.00	SUBPROVIDER - IPF	0	131,540	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	42.00
43.00	NURSERY	0	29,310	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	0	181,591	0	53,147	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	3,603	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	177,477	0	0	54.00
57.00	CT SCAN	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	LABORATORY	0	68,097	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	7,945	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	66.00
68.00	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	28,374	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	31,495	0	0	73.00
<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	0	131,937	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	CORF	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
106.00	HEART ACQUISITION	0	0	0	0	106.00
109.00	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,804,676	15,184	56,268	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,315	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	193.00
194.00	MOB	0	0	45,762	0	194.00
194.01	POB	0	0	0	55,356	194.01
194.02	WEST JAY CLINIC	0	0	0	0	15,725
194.03	JAY COMMUNITY HEALTH PARTNERS	0	119,169	0	0	194.03
194.04	FAMILY PRACTICE OF JAY COUNTY	0	0	0	0	194.04
194.05	JAY FAMILY MEDICINE	0	0	0	0	194.05
194.06	TRI COUNTY	0	0	0	0	194.06
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151320	Period: From 10/01/2010 To 09/30/2011	Worksheet B Part II Date/Time Prepared: 3/23/2012 2:38 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
		NEW MVBLE EQUIP	NEW MVBLE EQUIP MOB	NEW MVBLE EQUIP-POB	NEW MVBLE EQUIP- WJ	
	0	2.00	2.01	2.02	2.03	
202.00 TOTAL (sum lines 118-201)	0	1,940,160	60,946	111,624	15,725	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet B  
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Cost Center Description	Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT-MOB	
	2A	4.00	5.00	7.00	7.01	
<b>GENERAL SERVICE COST CENTERS</b>						
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP MOB						2.01
2.02 NEW CAP REL COSTS-MVBLE EQUIP-POB						2.02
2.03 NEW CAP REL COSTS-MVBLE EQUIP- WJ						2.03
4.00 EMPLOYEE BENEFITS	0	0				4.00
5.00 ADMINISTRATIVE & GENERAL	247,678	0	247,678			5.00
7.00 OPERATION OF PLANT	120,673	0	11,631	132,304		7.00
7.01 OPERATION OF PLANT-MOB	0	0	347	0	347	7.01
7.02 OPERATION OF PLANT-POB	0	0	646	0	0	7.02
7.03 OPERATION OF PLANT-WJ	0	0	23	0	0	7.03
8.00 LAUNDRY & LINEN SERVICE	13,052	0	858	1,087	0	8.00
9.00 HOUSEKEEPING	10,385	0	4,456	865	0	9.00
10.00 DIETARY	62,933	0	4,313	5,059	16	10.00
11.00 CAFETERIA	58,308	0	2,512	4,858	0	11.00
13.00 NURSING ADMINISTRATION	41,340	0	11,580	3,444	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	57,315	0	1,523	4,775	0	14.00
16.00 MEDICAL RECORDS & LIBRARY	40,149	0	5,314	3,345	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	379,779	0	21,345	31,647	0	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00 SUBPROVIDER - IPF	131,540	0	13,668	10,960	0	40.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	29,310	0	2,243	2,442	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	234,738	0	19,880	15,130	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	3,603	0	240	300	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	177,477	0	18,419	14,787	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	68,097	0	18,336	5,674	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	7,945	0	3,476	662	0	65.00
66.00 PHYSICAL THERAPY	0	0	5,980	0	0	66.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	28,374	0	3,533	2,364	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	31,495	0	12,978	2,624	0	73.00
<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	131,937	0	21,245	10,993	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
106.00 HEART ACQUISITION	0	0	0	0	0	106.00
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
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1,876,128	0	184,546	121,016	16	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,315	0	157	1,359	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 MOB	45,762	0	441	0	331	194.00
194.01 POB	55,356	0	534	0	0	194.01
194.02 WEST JAY CLINIC	15,725	0	4,405	0	0	194.02
194.03 JAY COMMUNITY HEALTH PARTNERS	119,169	0	10,512	9,929	0	194.03
194.04 FAMILY PRACTICE OF JAY COUNTY	0	0	22,533	0	0	194.04
194.05 JAY FAMILY MEDICINE	0	0	16,371	0	0	194.05
194.06 TRI COUNTY	0	0	8,179	0	0	194.06
200.00 Cross Foot Adjustments	0	0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	2,128,455	0	247,678	132,304	347	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet B  
Part II  
Date/Time Prepared:  
3/23/2012 2:38 pm

Cost Center Description		OPERATION OF PLANT-POB	OPERATION OF PLANT-WJ	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		7.02	7.03	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP MOB						2.01
2.02	NEW CAP REL COSTS-MVBLE EQUIP-POB						2.02
2.03	NEW CAP REL COSTS-MVBLE EQUIP- WJ						2.03
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
7.01	OPERATION OF PLANT-MOB						7.01
7.02	OPERATION OF PLANT-POB	646					7.02
7.03	OPERATION OF PLANT-WJ	0	23				7.03
8.00	LAUNDRY & LINEN SERVICE	0	0	14,997			8.00
9.00	HOUSEKEEPING	0	0	427	16,133		9.00
10.00	DIETARY	0	0	278	458	73,057	10.00
11.00	CAFETERIA	0	0	0	440		11.00
13.00	NURSING ADMINISTRATION	0	0	0	312		13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	433		14.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	303		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	0	0	8,486	2,866	41,189	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	SUBPROVIDER - IPF	0	0	1,795	993	31,868	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	0	0	337	221	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	316	0	2,435	2,556	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	27	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	21	1,340	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	514	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	0	0	60	0	65.00
66.00	PHYSICAL THERAPY	0	0	214	0	0	66.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	235	214	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	238	0	73.00
<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	641	996	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
106.00	HEART ACQUISITION	0	0	0	0	0	106.00
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
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	316	0	14,869	11,971	73,057	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	123	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	MOB	0	0	0	1,904	0	194.00
194.01	POB	330	0	0	1,235	0	194.01
194.02	WEST JAY CLINIC	0	23	64	0	0	194.02
194.03	JAY COMMUNITY HEALTH PARTNERS	0	0	64	900	0	194.03
194.04	FAMILY PRACTICE OF JAY COUNTY	0	0	0	0	0	194.04
194.05	JAY FAMILY MEDICINE	0	0	0	0	0	194.05
194.06	TRI COUNTY	0	0	0	0	0	194.06
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)	646	23	14,997	16,133	73,057	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet B  
Part II  
Date/Time Prepared:  
3/23/2012 2:38 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>						
2.00						2.00
2.01						2.01
2.02						2.02
2.03						2.03
4.00						4.00
5.00						5.00
7.00						7.00
7.01						7.01
7.02						7.02
7.03						7.03
8.00						8.00
9.00						9.00
10.00						10.00
11.00	66,118					11.00
13.00	4,955	61,631				13.00
14.00	873	0	64,919			14.00
16.00	3,608	0	223	52,942		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	11,203	23,638	3,731	3,803	527,687	30.00
31.00	0	0	0	0	0	31.00
40.00	5,646	11,912	878	1,920	211,180	40.00
41.00	0	0	0	0	0	41.00
42.00	0	0	0	0	0	42.00
43.00	1,225	2,584	0	113	38,475	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	4,818	10,164	20,100	7,945	318,082	50.00
52.00	207	437	0	177	4,991	52.00
53.00	0	0	0	0	0	53.00
54.00	5,376	0	5,982	18,121	241,523	54.00
57.00	0	0	0	0	0	57.00
58.00	0	0	0	0	0	58.00
59.00	0	0	0	0	0	59.00
60.00	5,543	0	13,903	10,746	122,813	60.00
60.01	0	0	0	0	0	60.01
65.00	0	0	231	1,057	13,431	65.00
66.00	0	0	125	1,342	7,661	66.00
68.00	0	0	0	0	0	68.00
69.00	1,462	0	608	713	37,503	69.00
71.00	0	0	0	0	0	71.00
72.00	0	0	0	0	0	72.00
73.00	2,235	0	4,847	3,066	57,483	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	0	0	0	0	0	88.00
89.00	0	0	0	0	0	89.00
91.00	6,113	12,896	4,310	3,939	193,070	91.00
92.00						92.00
93.00	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
106.00	0	0	0	0	0	106.00
109.00	0	0	0	0	0	109.00
110.00	0	0	0	0	0	110.00
111.00	0	0	0	0	0	111.00
113.00	0	0	0	0	0	113.00
118.00	53,264	61,631	54,938	52,942	1,773,899	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	0	0	0	0	17,954	190.00
192.00	0	0	0	0	0	192.00
193.00	0	0	0	0	0	193.00
194.00	0	0	0	0	48,438	194.00
194.01	0	0	0	0	57,455	194.01
194.02	0	0	767	0	20,984	194.02
194.03	4,758	0	2,145	0	147,477	194.03
194.04	7,445	0	4,685	0	34,663	194.04
194.05	0	0	1,973	0	18,344	194.05
194.06	651	0	411	0	9,241	194.06
200.00					0	200.00
201.00	0	0	0	0	0	201.00
202.00	66,118	61,631	64,919	52,942	2,128,455	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151320	Period: From 10/01/2010 To 09/30/2011	Worksheet B Part II Date/Time Prepared: 3/23/2012 2:38 pm
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Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
2.00 NEW CAP REL COSTS-MVBLE EQUIP			2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP MOB			2.01
2.02 NEW CAP REL COSTS-MVBLE EQUIP-POB			2.02
2.03 NEW CAP REL COSTS-MVBLE EQUIP- WJ			2.03
4.00 EMPLOYEE BENEFITS			4.00
5.00 ADMINISTRATIVE & GENERAL			5.00
7.00 OPERATION OF PLANT			7.00
7.01 OPERATION OF PLANT-MOB			7.01
7.02 OPERATION OF PLANT-POB			7.02
7.03 OPERATION OF PLANT-WJ			7.03
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	527,687	30.00
31.00 INTENSIVE CARE UNIT	0	0	31.00
40.00 SUBPROVIDER - 1PF	0	211,180	40.00
41.00 SUBPROVIDER - 1RF	0	0	41.00
42.00 SUBPROVIDER	0	0	42.00
43.00 NURSERY	0	38,475	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 OPERATING ROOM	0	318,082	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	4,991	52.00
53.00 ANESTHESIOLOGY	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	241,523	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	122,813	60.00
60.01 BLOOD LABORATORY	0	0	60.01
65.00 RESPIRATORY THERAPY	0	13,431	65.00
66.00 PHYSICAL THERAPY	0	7,661	66.00
68.00 SPEECH PATHOLOGY	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	37,503	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	57,483	73.00
<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	193,070	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
99.10 CORF	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>			
106.00 HEART ACQUISITION	0	0	106.00
109.00 PANCREAS ACQUISITION	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	110.00
111.00 ISLET ACQUISITION	0	0	111.00
113.00 INTEREST EXPENSE	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	1,773,899	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,954	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00 NONPAID WORKERS	0	0	193.00
194.00 MOB	0	48,438	194.00
194.01 POB	0	57,455	194.01
194.02 WEST JAY CLINIC	0	20,984	194.02
194.03 JAY COMMUNITY HEALTH PARTNERS	0	147,477	194.03
194.04 FAMILY PRACTICE OF JAY COUNTY	0	34,663	194.04
194.05 JAY FAMILY MEDICINE	0	18,344	194.05
194.06 TRI COUNTY	0	9,241	194.06
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	2,128,455	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet B-1

Date/Time Prepared:  
3/23/2012 2:38 pm

Cost Center Description	CAPITAL RELATED COSTS				EMPLOYEE BENEFITS (GROSS SALARIES)	
	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP MOB (SQUARE FEET)	NEW MVBLE EQUIP-POB (SQUARE FEET)	NEW MVBLE EQUIP- WJ (SQUARE FEET)		
	2.00	2.01	2.02	2.03		
<b>GENERAL SERVICE COST CENTERS</b>						
2.00	68,379					2.00
2.01	0	11,841				2.01
2.02	0	0	11,625			2.02
2.03	0	0	0	3,300		2.03
4.00	0	0	0	0	13,482,605	4.00
5.00	8,162	2,520	325	0	1,629,254	5.00
7.00	4,253	0	0	0	262,487	7.00
7.01	0	0	0	0	5,856	7.01
7.02	0	0	0	0	8,101	7.02
7.03	0	0	0	0	1,630	7.03
8.00	460	0	0	0	40,745	8.00
9.00	366	0	0	0	300,954	9.00
10.00	2,140	430	0	0	182,830	10.00
11.00	2,055	0	0	0	144,084	11.00
13.00	1,457	0	0	0	844,457	13.00
14.00	2,020	0	0	0	67,353	14.00
16.00	1,415	0	0	0	315,639	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	13,385	0	0	0	1,241,249	30.00
31.00	0	0	0	0	0	31.00
40.00	4,636	0	0	0	634,582	40.00
41.00	0	0	0	0	0	41.00
42.00	0	0	0	0	0	42.00
43.00	1,033	0	0	0	141,269	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	6,400	0	5,535	0	741,770	50.00
52.00	127	0	0	0	15,098	52.00
53.00	0	0	0	0	0	53.00
54.00	6,255	0	0	0	744,863	54.00
57.00	0	0	0	0	0	57.00
58.00	0	0	0	0	0	58.00
59.00	0	0	0	0	0	59.00
60.00	2,400	0	0	0	612,379	60.00
60.01	0	0	0	0	0	60.01
65.00	280	0	0	0	0	65.00
66.00	0	0	0	0	0	66.00
68.00	0	0	0	0	0	68.00
69.00	1,000	0	0	0	156,703	69.00
71.00	0	0	0	0	0	71.00
72.00	0	0	0	0	0	72.00
73.00	1,110	0	0	0	371,609	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	0	0	0	0	0	88.00
89.00	0	0	0	0	0	89.00
91.00	4,650	0	0	0	1,523,946	91.00
92.00	0	0	0	0	0	92.00
93.00	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
106.00	0	0	0	0	0	106.00
109.00	0	0	0	0	0	109.00
110.00	0	0	0	0	0	110.00
111.00	0	0	0	0	0	111.00
113.00	0	0	0	0	0	113.00
118.00	63,604	2,950	5,860	0	9,986,858	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	575	0	0	0	0	190.00
192.00	0	0	0	0	0	192.00
193.00	0	0	0	0	0	193.00
194.00	0	8,891	0	0	0	194.00
194.01	0	0	5,765	0	0	194.01
194.02	0	0	0	3,300	249,888	194.02
194.03	4,200	0	0	0	577,010	194.03
194.04	0	0	0	0	1,491,058	194.04
194.05	0	0	0	0	1,076,834	194.05
194.06	0	0	0	0	100,957	194.06
200.00						200.00
201.00						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet B-1

Date/Time Prepared:  
3/23/2012 2:38 pm

Cost Center Description	CAPITAL RELATED COSTS				EMPLOYEE BENEFITS (GROSS SALARIES)	
	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP MOB (SQUARE FEET)	NEW MVBLE EQUIP-POB (SQUARE FEET)	NEW MVBLE EQUIP- WJ (SQUARE FEET)		
	2.00	2.01	2.02	2.03		
202.00 Cost to be allocated (per Wkst. B, Part I)	1,940,160	60,946	111,624	15,725	4,784,210	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	28.373623	5.147032	9.602065	4.765152	0.354843	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)					0	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)					0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet B-1  
Date/Time Prepared:  
3/23/2012 2:38 pm

Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-MOB (SQUARE FEET)	OPERATION OF PLANT-POB (SQUARE FEET)	
	5A	5.00	7.00	7.01	7.02	
<b>GENERAL SERVICE COST CENTERS</b>						
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP MOB						2.01
2.02 NEW CAP REL COSTS-MVBLE EQUIP-POB						2.02
2.03 NEW CAP REL COSTS-MVBLE EQUIP- WJ						2.03
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL	-4,126,805	25,673,811				5.00
7.00 OPERATION OF PLANT	0	1,205,681	55,964			7.00
7.01 OPERATION OF PLANT-MOB	0	36,013	0	9,321		7.01
7.02 OPERATION OF PLANT-POB	0	66,955	0	0	11,300	7.02
7.03 OPERATION OF PLANT-WJ	0	2,384	0	0	0	7.03
8.00 LAUNDRY & LINEN SERVICE	0	88,955	460	0	0	8.00
9.00 HOUSEKEEPING	0	461,926	366	0	0	9.00
10.00 DIETARY	0	447,125	2,140	430	0	10.00
11.00 CAFETERIA	0	260,397	2,055	0	0	11.00
13.00 NURSING ADMINISTRATION	0	1,200,359	1,457	0	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	157,844	2,020	0	0	14.00
16.00 MEDICAL RECORDS & LIBRARY	0	550,886	1,415	0	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	0	2,212,602	13,385	0	0	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00 SUBPROVIDER - 1PF	0	1,416,829	4,636	0	0	40.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	0	232,523	1,033	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	0	2,060,752	6,400	0	5,535	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	24,908	127	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	1,909,277	6,255	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	1,900,670	2,400	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	0	360,341	280	0	0	65.00
66.00 PHYSICAL THERAPY	0	619,889	0	0	0	66.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	366,200	1,000	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	1,345,290	1,110	0	0	73.00
<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	2,202,213	4,650	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
106.00 HEART ACQUISITION	0	0	0	0	0	106.00
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
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-4,126,805	19,130,019	51,189	430	5,535	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,315	575	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 MOB	0	45,762	0	8,891	0	194.00
194.01 POB	0	55,356	0	0	5,765	194.01
194.02 WEST JAY CLINIC	0	456,592	0	0	0	194.02
194.03 JAY COMMUNITY HEALTH PARTNERS	0	1,089,694	4,200	0	0	194.03
194.04 FAMILY PRACTICE OF JAY COUNTY	0	2,335,160	0	0	0	194.04
194.05 JAY FAMILY MEDICINE	0	1,697,050	0	0	0	194.05
194.06 TRI COUNTY	0	847,863	0	0	0	194.06
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)		4,126,805	1,399,482	41,802	77,717	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)		0.160740	25.006826	4.484712	6.877611	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet B-1  
Date/Time Prepared:  
3/23/2012 2:38 pm

Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-MOB (SQUARE FEET)	OPERATION OF PLANT-POB (SQUARE FEET)	
		5A	5.00	7.00	7.01	
204.00 Cost to be allocated (per Wkst. B, Part II)		247,678	132,304	347	646	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)		0.009647	2.364091	0.037228	0.057168	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet B-1

Date/Time Prepared:  
3/23/2012 2:38 pm

Cost Center Description	OPERATION OF PLANT-WJ (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
	7.03	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>						
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP MOB						2.01
2.02 NEW CAP REL COSTS-MVBLE EQUIP-POB						2.02
2.03 NEW CAP REL COSTS-MVBLE EQUIP- WJ						2.03
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT						7.00
7.01 OPERATION OF PLANT-MOB						7.01
7.02 OPERATION OF PLANT-POB						7.02
7.03 OPERATION OF PLANT-WJ	3,300					7.03
8.00 LAUNDRY & LINEN SERVICE	0	42,120				8.00
9.00 HOUSEKEEPING	0	1,200	75,329			9.00
10.00 DIETARY	0	780	2,140	19,438		10.00
11.00 CAFETERIA	0	0	2,055	0	17,869	11.00
13.00 NURSING ADMINISTRATION	0	0	1,457	0	1,339	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	2,020	0	236	14.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	1,415	0	975	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	0	23,834	13,385	10,959	3,028	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00 SUBPROVIDER - 1 PF	0	5,040	4,636	8,479	1,526	40.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	0	946	1,033	0	331	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	0	6,840	11,935	0	1,302	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	127	0	56	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	60	6,255	0	1,453	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	2,400	0	1,498	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	0	0	280	0	0	65.00
66.00 PHYSICAL THERAPY	0	600	0	0	0	66.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	660	1,000	0	395	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	1,110	0	604	73.00
<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	1,800	4,650	0	1,652	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
106.00 HEART ACQUISITION	0	0	0	0	0	106.00
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
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	41,760	55,898	19,438	14,395	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	575	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 MOB	0	0	8,891	0	0	194.00
194.01 POB	0	0	5,765	0	0	194.01
194.02 WEST JAY CLINIC	3,300	180	0	0	0	194.02
194.03 JAY COMMUNITY HEALTH PARTNERS	0	180	4,200	0	1,286	194.03
194.04 FAMILY PRACTICE OF JAY COUNTY	0	0	0	0	2,012	194.04
194.05 JAY FAMILY MEDICINE	0	0	0	0	0	194.05
194.06 TRI COUNTY	0	0	0	0	176	194.06
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	2,767	114,757	548,597	592,149	368,608	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.838485	2.724525	7.282680	30.463474	20.628351	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet B-1

Date/Time Prepared:  
3/23/2012 2:38 pm

Cost Center Description	OPERATION OF PLANT-WJ (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
	7.03	8.00	9.00	10.00	11.00	
204.00 Cost to be allocated (per Wkst. B, Part II)	23	14,997	16,133	73,057	66,118	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.006970	0.356054	0.214167	3.758463	3.700151	205.00

COST ALLOCATION - STATISTICAL BASIS

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Period:  
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To 09/30/2011

Worksheet B-1  
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3/23/2012 2:38 pm

Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY (SUPPLY COST)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
	(DIRECT NRSING FTE)			
	13.00	14.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>				
2.00 NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP MOB				2.01
2.02 NEW CAP REL COSTS-MVBLE EQUIP-POB				2.02
2.03 NEW CAP REL COSTS-MVBLE EQUIP- WJ				2.03
4.00 EMPLOYEE BENEFITS				4.00
5.00 ADMINISTRATIVE & GENERAL				5.00
7.00 OPERATION OF PLANT				7.00
7.01 OPERATION OF PLANT-MOB				7.01
7.02 OPERATION OF PLANT-POB				7.02
7.03 OPERATION OF PLANT-WJ				7.03
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	7,895			13.00
14.00 CENTRAL SERVICES & SUPPLY	0	2,433,388		14.00
16.00 MEDICAL RECORDS & LIBRARY	0	8,349	57,502,725	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00 ADULTS & PEDIATRICS	3,028	139,841	4,128,839	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	31.00
40.00 SUBPROVIDER - IRF	1,526	32,897	2,084,331	40.00
41.00 SUBPROVIDER - IRF	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	42.00
43.00 NURSERY	331	0	122,600	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 OPERATING ROOM	1,302	753,391	8,626,354	50.00
52.00 DELIVERY ROOM & LABOR ROOM	56	0	192,572	52.00
53.00 ANESTHESIOLOGY	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	224,248	19,695,082	54.00
57.00 CT SCAN	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 LABORATORY	0	521,159	11,668,007	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
65.00 RESPIRATORY THERAPY	0	8,647	1,148,100	65.00
66.00 PHYSICAL THERAPY	0	4,667	1,457,094	66.00
68.00 SPEECH PATHOLOGY	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	22,805	774,643	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	181,672	3,328,602	73.00
<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	1,652	161,575	4,276,501	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10 CORF	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
106.00 HEART ACQUISITION	0	0	0	106.00
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
113.00 INTEREST EXPENSE	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	7,895	2,059,251	57,502,725	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	193.00
194.00 MOB	0	0	0	194.00
194.01 POB	0	0	0	194.01
194.02 WEST JAY CLINIC	0	28,749	0	194.02
194.03 JAY COMMUNITY HEALTH PARTNERS	0	80,418	0	194.03
194.04 FAMILY PRACTICE OF JAY COUNTY	0	175,603	0	194.04
194.05 JAY FAMILY MEDICINE	0	73,964	0	194.05
194.06 TRI COUNTY	0	15,403	0	194.06
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)	1,467,972	253,309	706,107	202.00

COST ALLOCATION - STATISTICAL BASIS

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Date/Time Prepared:  
3/23/2012 2:38 pm

Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY (SUPPLY COST)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
	(DIRECT NURSING FTE)			
	13.00	14.00	16.00	
203.00 Unit cost multiplier (Wkst. B, Part I)	185.936922	0.104097	0.012280	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	61,631	64,919	52,942	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	7.806333	0.026678	0.000921	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet C  
Part I  
Date/Time Prepared:  
3/23/2012 2:38 pm

		Title XVIII		Hospital		Cost	
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	4,089,974		4,089,974	0	4,089,974	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0	31.00
40.00	SUBPROVIDER - IPF	2,410,536		2,410,536	0	2,410,536	40.00
41.00	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	SUBPROVIDER	0		0	0	0	42.00
43.00	NURSERY	375,710		375,710	0	375,710	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	3,148,971		3,148,971	0	3,148,971	50.00
52.00	DELIVERY ROOM & LABOR ROOM	46,945		46,945	0	46,945	52.00
53.00	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,713,453		2,713,453	0	2,713,453	54.00
57.00	CT SCAN	0		0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	LABORATORY	2,512,113		2,512,113	0	2,512,113	60.00
60.01	BLOOD LABORATORY	0		0	0	0	60.01
65.00	RESPIRATORY THERAPY	442,302	0	442,302	0	442,302	65.00
66.00	PHYSICAL THERAPY	739,544	0	739,544	0	739,544	66.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	479,186		479,186	0	479,186	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,669,621		1,669,621	0	1,669,621	73.00
<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	3,121,827		3,121,827	0	3,121,827	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	14,192		14,192	0	14,192	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF	0		0		0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
106.00	HEART ACQUISITION	0		0		0	106.00
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
113.00	INTEREST EXPENSE	0		0		0	113.00
200.00	Subtotal (see instructions)	21,764,374	0	21,764,374	0	21,764,374	200.00
201.00	Less Observation Beds	14,192		14,192		14,192	201.00
202.00	Total (see instructions)	21,750,182	0	21,750,182	0	21,750,182	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet C  
Part I  
Date/Time Prepared:  
3/23/2012 2:38 pm

		Title XVIII			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	4,122,505		4,122,505			30.00
31.00	INTENSIVE CARE UNIT	0		0			31.00
40.00	SUBPROVIDER - IPF	2,084,331		2,084,331			40.00
41.00	SUBPROVIDER - IRF	0		0			41.00
42.00	SUBPROVIDER	0		0			42.00
43.00	NURSERY	122,600		122,600			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	2,019,970	6,606,384	8,626,354	0.365041	0.000000	50.00
52.00	DELIVERY ROOM & LABOR ROOM	192,572	0	192,572	0.243779	0.000000	52.00
53.00	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,072,724	18,622,358	19,695,082	0.137773	0.000000	54.00
57.00	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	LABORATORY	1,440,778	10,227,229	11,668,007	0.215299	0.000000	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	RESPIRATORY THERAPY	869,826	278,274	1,148,100	0.385247	0.000000	65.00
66.00	PHYSICAL THERAPY	419,566	1,037,528	1,457,094	0.507547	0.000000	66.00
68.00	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	ELECTROCARDIOLOGY	61,256	713,387	774,643	0.618589	0.000000	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,641,894	1,686,708	3,328,602	0.501598	0.000000	73.00
<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	75,150	4,201,351	4,276,501	0.729996	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	6,334	6,334	2.240606	0.000000	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF	0	0	0			99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
106.00	HEART ACQUISITION	0	0	0			106.00
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
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	14,123,172	43,379,553	57,502,725			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	14,123,172	43,379,553	57,502,725			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151320	Period: From 10/01/2010 To 09/30/2011	Worksheet C Part I Date/Time Prepared: 3/23/2012 2:38 pm
		Title XVIII	Hospital	Cost

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
40.00	SUBPROVIDER - IPF			40.00
41.00	SUBPROVIDER - IRF			41.00
42.00	SUBPROVIDER			42.00
43.00	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	0.365041		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.243779		52.00
53.00	ANESTHESIOLOGY	0.000000		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.137773		54.00
57.00	CT SCAN	0.000000		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	LABORATORY	0.215299		60.00
60.01	BLOOD LABORATORY	0.000000		60.01
65.00	RESPIRATORY THERAPY	0.385247		65.00
66.00	PHYSICAL THERAPY	0.507547		66.00
68.00	SPEECH PATHOLOGY	0.000000		68.00
69.00	ELECTROCARDIOLOGY	0.618589		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.501598		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	RURAL HEALTH CLINIC			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER			89.00
91.00	EMERGENCY	0.729996		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	2.240606		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	CORF			99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
106.00	HEART ACQUISITION			106.00
109.00	PANCREAS ACQUISITION			109.00
110.00	INTESTINAL ACQUISITION			110.00
111.00	ISLET ACQUISITION			111.00
113.00	INTEREST EXPENSE			113.00
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: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet C  
Part I  
Date/Time Prepared:  
3/23/2012 2:38 pm

		Title XIX		Hospital		Cost
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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS		4,089,974		0	30.00
31.00	INTENSIVE CARE UNIT		0		0	31.00
40.00	SUBPROVIDER - 1PF		2,410,536		0	40.00
41.00	SUBPROVIDER - 1RF		0		0	41.00
42.00	SUBPROVIDER		0		0	42.00
43.00	NURSERY		375,710		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM		3,148,971		0	50.00
52.00	DELIVERY ROOM & LABOR ROOM		46,945		0	52.00
53.00	ANESTHESIOLOGY		0		0	53.00
54.00	RADIOLOGY-DIAGNOSTIC		2,713,453		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		2,512,113		0	60.00
60.01	BLOOD LABORATORY		0		0	60.01
65.00	RESPIRATORY THERAPY	0	442,302		0	65.00
66.00	PHYSICAL THERAPY	0	739,544		0	66.00
68.00	SPEECH PATHOLOGY	0	0		0	68.00
69.00	ELECTROCARDIOLOGY		479,186		0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS		0		0	72.00
73.00	DRUGS CHARGED TO PATIENTS		1,669,621		0	73.00
<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		3,121,827		0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		14,192		0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER		0		0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	CORF		0		0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
106.00	HEART ACQUISITION		0		0	106.00
109.00	PANCREAS ACQUISITION		0		0	109.00
110.00	INTESTINAL ACQUISITION		0		0	110.00
111.00	ISLET ACQUISITION		0		0	111.00
113.00	INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		21,764,374	0	0	200.00
201.00	Less Observation Beds		14,192		0	201.00
202.00	Total (see instructions)		21,750,182	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet C  
Part I  
Date/Time Prepared:  
3/23/2012 2:38 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	4,122,505		4,122,505			30.00
31.00	INTENSIVE CARE UNIT	0		0			31.00
40.00	SUBPROVIDER - IPF	2,084,331		2,084,331			40.00
41.00	SUBPROVIDER - IRF	0		0			41.00
42.00	SUBPROVIDER	0		0			42.00
43.00	NURSERY	122,600		122,600			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	2,019,970	6,606,384	8,626,354	0.365041	0.000000	50.00
52.00	DELIVERY ROOM & LABOR ROOM	192,572	0	192,572	0.243779	0.000000	52.00
53.00	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,072,724	18,622,358	19,695,082	0.137773	0.000000	54.00
57.00	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	LABORATORY	1,440,778	10,227,229	11,668,007	0.215299	0.000000	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	RESPIRATORY THERAPY	869,826	278,274	1,148,100	0.385247	0.000000	65.00
66.00	PHYSICAL THERAPY	419,566	1,037,528	1,457,094	0.507547	0.000000	66.00
68.00	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	ELECTROCARDIOLOGY	61,256	713,387	774,643	0.618589	0.000000	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,641,894	1,686,708	3,328,602	0.501598	0.000000	73.00
<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	75,150	4,201,351	4,276,501	0.729996	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	6,334	6,334	2.240606	0.000000	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF	0	0	0			99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
106.00	HEART ACQUISITION	0	0	0			106.00
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
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	14,123,172	43,379,553	57,502,725			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	14,123,172	43,379,553	57,502,725			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151320	Period: From 10/01/2010 To 09/30/2011	Worksheet C Part I Date/Time Prepared: 3/23/2012 2:38 pm
		Title XIX	Hospital	Cost

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
40.00	SUBPROVIDER - IPF			40.00
41.00	SUBPROVIDER - IRF			41.00
42.00	SUBPROVIDER			42.00
43.00	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	0.000000		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	ANESTHESIOLOGY	0.000000		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	CT SCAN	0.000000		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	LABORATORY	0.000000		60.00
60.01	BLOOD LABORATORY	0.000000		60.01
65.00	RESPIRATORY THERAPY	0.000000		65.00
66.00	PHYSICAL THERAPY	0.000000		66.00
68.00	SPEECH PATHOLOGY	0.000000		68.00
69.00	ELECTROCARDIOLOGY	0.000000		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
<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	0.000000		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	CORF			99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
106.00	HEART ACQUISITION			106.00
109.00	PANCREAS ACQUISITION			109.00
110.00	INTESTINAL ACQUISITION			110.00
111.00	ISLET ACQUISITION			111.00
113.00	INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 151320	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part II Date/Time Prepared: 3/23/2012 2:38 pm
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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	318,082	8,626,354	0.036873	684,313	25,233	50.00
52.00	DELIVERY ROOM & LABOR ROOM	4,991	192,572	0.025918	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	241,523	19,695,082	0.012263	476,314	5,841	54.00
57.00	CT SCAN	0	0	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	LABORATORY	122,813	11,668,007	0.010526	646,053	6,800	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	13,431	1,148,100	0.011698	437,478	5,118	65.00
66.00	PHYSICAL THERAPY	7,661	1,457,094	0.005258	111,167	585	66.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	37,503	774,643	0.048413	48,602	2,353	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	57,483	3,328,602	0.017269	372,890	6,439	73.00
<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	193,070	4,276,501	0.045147	12,510	565	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	6,334	0.000000	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
200.00	Total (lines 50-199)	996,557	51,173,289		2,789,327	52,934	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet D  
Part IV  
Date/Time Prepared:  
3/23/2012 2:38 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)	Cost
		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
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
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
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 PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
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
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
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: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet D  
Part IV  
Date/Time Prepared:  
3/23/2012 2:38 pm

Cost Center Description		Title XVIII			Hospital		Inpatient Program Charges	
		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)	Cost		
		6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	OPERATING ROOM	0	8,626,354	0.000000	0.000000	684,313	50.00	
52.00	DELIVERY ROOM & LABOR ROOM	0	192,572	0.000000	0.000000	0	52.00	
53.00	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00	
54.00	RADIOLOGY-DIAGNOSTIC	0	19,695,082	0.000000	0.000000	476,314	54.00	
57.00	CT SCAN	0	0	0.000000	0.000000	0	57.00	
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00	
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00	
60.00	LABORATORY	0	11,668,007	0.000000	0.000000	646,053	60.00	
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01	
65.00	RESPIRATORY THERAPY	0	1,148,100	0.000000	0.000000	437,478	65.00	
66.00	PHYSICAL THERAPY	0	1,457,094	0.000000	0.000000	111,167	66.00	
68.00	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00	
69.00	ELECTROCARDIOLOGY	0	774,643	0.000000	0.000000	48,602	69.00	
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00	
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00	
73.00	DRUGS CHARGED TO PATIENTS	0	3,328,602	0.000000	0.000000	372,890	73.00	
<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	4,276,501	0.000000	0.000000	12,510	91.00	
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	6,334	0.000000	0.000000	0	92.00	
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00	
200.00	Total (lines 50-199)	0	51,173,289			2,789,327	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet D  
Part IV  
Date/Time Prepared:  
3/23/2012 2:38 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	Cost
		11.00	12.00	13.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	0	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	ANESTHESIOLOGY	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	CT SCAN	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	LABORATORY	0	0	0		60.00
60.01	BLOOD LABORATORY	0	0	0		60.01
65.00	RESPIRATORY THERAPY	0	0	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
68.00	SPEECH PATHOLOGY	0	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
<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	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151320	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 3/23/2012 2:38 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see instructions)	Cost	Cost		
			Reimbursed Services Subject To Ded. & Coins. (see instructions)	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	0.365041	0	1,653,740	0		50.00
52.00 DELIVERY ROOM & LABOR ROOM	0.243779	0	0	0		52.00
53.00 ANESTHESIOLOGY	0.000000	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.137773	0	4,299,937	55		54.00
57.00 CT SCAN	0.000000	0	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0.000000	0	0	0		59.00
60.00 LABORATORY	0.215299	0	3,359,390	0		60.00
60.01 BLOOD LABORATORY	0.000000	0	0	0		60.01
65.00 RESPIRATORY THERAPY	0.385247	0	106,858	0		65.00
66.00 PHYSICAL THERAPY	0.507547	0	324,207	0		66.00
68.00 SPEECH PATHOLOGY	0.000000	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	0.618589	0	176,675	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.501598	0	501,375	245		73.00
<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	0.729996	0	658,132	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	2.240606	0	106,581	0		92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0		93.00
200.00 Subtotal (see instructions)		0	11,186,895	300		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	11,186,895	300		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151320	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 3/23/2012 2:38 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 OPERATING ROOM	0	603,683	0		50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00 ANESTHESIOLOGY	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	592,415	8		54.00
57.00 CT SCAN	0	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00 LABORATORY	0	723,273	0		60.00
60.01 BLOOD LABORATORY	0	0	0		60.01
65.00 RESPIRATORY THERAPY	0	41,167	0		65.00
66.00 PHYSICAL THERAPY	0	164,550	0		66.00
68.00 SPEECH PATHOLOGY	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	0	109,289	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	251,489	123		73.00
<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	480,434	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	238,806	0		92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
200.00 Subtotal (see instructions)	0	3,205,106	131		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	3,205,106	131		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151320	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part II Date/Time Prepared: 3/23/2012 2:38 pm
		Component CCN: 15M320	Title XVIII	Subprovider - IPF
		PPS		

Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	318,082	8,626,354	0.036873	0	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	4,991	192,572	0.025918	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	241,523	19,695,082	0.012263	59,121	725	54.00
57.00 CT SCAN	0	0	0.000000	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00 LABORATORY	122,813	11,668,007	0.010526	166,646	1,754	60.00
60.01 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00 RESPIRATORY THERAPY	13,431	1,148,100	0.011698	84,725	991	65.00
66.00 PHYSICAL THERAPY	7,661	1,457,094	0.005258	21,470	113	66.00
68.00 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00 ELECTROCARDIOLOGY	37,503	774,643	0.048413	42	2	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	57,483	3,328,602	0.017269	112,373	1,941	73.00
<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	193,070	4,276,501	0.045147	56,830	2,566	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	6,334	0.000000	0	0	92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
200.00 Total (Lines 50-199)	996,557	51,173,289		501,207	8,092	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151320 Component CCN: 15M320	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part IV Date/Time Prepared: 3/23/2012 2:38 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
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
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
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 PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
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
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
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: 151320 Component CCN: 15M320	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part IV Date/Time Prepared: 3/23/2012 2:38 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	0	8,626,354	0.000000	0.000000	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	192,572	0.000000	0.000000	0	52.00
53.00 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	19,695,082	0.000000	0.000000	59,121	54.00
57.00 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00 LABORATORY	0	11,668,007	0.000000	0.000000	166,646	60.00
60.01 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00 RESPIRATORY THERAPY	0	1,148,100	0.000000	0.000000	84,725	65.00
66.00 PHYSICAL THERAPY	0	1,457,094	0.000000	0.000000	21,470	66.00
68.00 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00 ELECTROCARDIOLOGY	0	774,643	0.000000	0.000000	42	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	3,328,602	0.000000	0.000000	112,373	73.00
<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	4,276,501	0.000000	0.000000	56,830	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	6,334	0.000000	0.000000	0	92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
200.00 Total (Lines 50-199)	0	51,173,289			501,207	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151320 Component CCN: 15M320	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part IV Date/Time Prepared: 3/23/2012 2:38 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 OPERATING ROOM	0	0	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
57.00 CT SCAN	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 LABORATORY	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
65.00 RESPIRATORY THERAPY	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	66.00
68.00 SPEECH PATHOLOGY	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
<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	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	93.00
200.00 Total (Lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151320 Component CCN: 15Z320	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 3/23/2012 2:38 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	
	1.00	2.00	3.00	4.00	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 OPERATING ROOM	0.365041	0	0	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0.243779	0	0	0	52.00
53.00 ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.137773	0	0	0	54.00
57.00 CT SCAN	0.000000	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00 LABORATORY	0.215299	0	0	0	60.00
60.01 BLOOD LABORATORY	0.000000	0	0	0	60.01
65.00 RESPIRATORY THERAPY	0.385247	0	0	0	65.00
66.00 PHYSICAL THERAPY	0.507547	0	0	0	66.00
68.00 SPEECH PATHOLOGY	0.000000	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0.618589	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.501598	0	0	0	73.00
<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	0.729996	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	2.240606	0	0	0	92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	93.00
200.00 Subtotal (see instructions)		0	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)			0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151320 Component CCN: 15Z320	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 3/23/2012 2:38 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 OPERATING ROOM	0	0	0		50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00 ANESTHESIOLOGY	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00 CT SCAN	0	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00 LABORATORY	0	0	0		60.00
60.01 BLOOD LABORATORY	0	0	0		60.01
65.00 RESPIRATORY THERAPY	0	0	0		65.00
66.00 PHYSICAL THERAPY	0	0	0		66.00
68.00 SPEECH PATHOLOGY	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	0	0	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
<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	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
200.00 Subtotal (see instructions)	0	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151320	Period: From 10/01/2010 To 09/30/2011	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 3/23/2012 2:38 pm
Cost Center Description		Cost		
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,467	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,681	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)		2,681	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)		776	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)		10	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,765	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)		693	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		146.75	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		146.75	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,089,974	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)		1,468	25.00
26.00	Total swing-bed cost (see instructions)		919,220	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,170,754	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		4,128,839	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		4,128,839	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.767953	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)		1,540.04	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,170,754	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,182.67	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,087,413	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,087,413	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151320		Period: From 10/01/2010 To 09/30/2011		Worksheet D-1	
Title XVIII		Hospital		Cost		Date/Time Prepared: 3/23/2012 2:38 pm	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					905,717	0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,993,130	0	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge					0.00	0	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	0	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	0	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					819,590	0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					819,590	0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						12	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,182.68	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						14,192	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151320		Period: From 10/01/2010 To 09/30/2011		Worksheet D-1 Date/Time Prepared: 3/23/2012 2:38 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151320	Period: From 10/01/2010 To 09/30/2011	Worksheet D-1
		Component CCN: 15M320		Date/Time Prepared: 3/23/2012 2:38 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,673	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,673	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)		2,673	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,971	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)		2,410,536	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)		2,410,536	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)		2,410,536	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)		901.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,777,468	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)		1,777,468	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151320		Period: From 10/01/2010 To 09/30/2011		Worksheet D-1	
		Component CCN: 15M320				Date/Time Prepared: 3/23/2012 2:38 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					185,439		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,962,907		49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					8,092		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					8,092		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					1,954,815		53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151320 Component CCN: 15M320		Period: From 10/01/2010 To 09/30/2011		Worksheet D-1 Date/Time Prepared: 3/23/2012 2:38 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	2,410,536	0.000000	0	0	90.00
91.00	Nursing School cost	0	2,410,536	0.000000	0	0	91.00
92.00	Allied health cost	0	2,410,536	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,410,536	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151320	Period: From 10/01/2010 To 09/30/2011	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 3/23/2012 2:38 pm
Cost Center Description				Cost
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,467	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,681	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)		2,681	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)		776	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)		10	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		294	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)		146	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,089,974	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)		918,086	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,171,888	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		4,128,839	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		4,128,839	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.768228	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)		1,540.04	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,171,888	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,183.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		347,831	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)		347,831	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151320	Period: From 10/01/2010 To 09/30/2011	Worksheet D-1 Date/Time Prepared: 3/23/2012 2:38 pm	
Cost Center Description			Title XIX	Hospital	Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	375,710	146	2,573.36	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				184,547	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				532,378	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0 54.00
55.00	Target amount per discharge				0.00	55.00
56.00	Target amount (line 54 x line 55)					0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00	Bonus payment (see instructions)					0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00	Relief payment (see instructions)					0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)				12	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,183.10	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				14,197	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151320		Period: From 10/01/2010 To 09/30/2011		Worksheet D-1 Date/Time Prepared: 3/23/2012 2:38 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151320	Period: From 10/01/2010 To 09/30/2011	Worksheet D-3 Date/Time Prepared: 3/23/2012 2:38 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		2,040,643		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
40.00	SUBPROVIDER - IPF		0		40.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.365041	684,313	249,802	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.243779	0	0	52.00
53.00	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.137773	476,314	65,623	54.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.215299	646,053	139,095	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0.385247	437,478	168,537	65.00
66.00	PHYSICAL THERAPY	0.507547	111,167	56,422	66.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.618589	48,602	30,065	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.501598	372,890	187,041	73.00
<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	0.729996	12,510	9,132	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	2.240606	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		2,789,327	905,717	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)		2,789,327		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151320 Component CCN: 15M320	Period: From 10/01/2010 To 09/30/2011	Worksheet D-3 Date/Time Prepared: 3/23/2012 2:38 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
40.00	SUBPROVIDER - IPF		1,427,000		40.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.365041	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.243779	0	0	52.00
53.00	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.137773	59,121	8,145	54.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.215299	166,646	35,879	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0.385247	84,725	32,640	65.00
66.00	PHYSICAL THERAPY	0.507547	21,470	10,897	66.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.618589	42	26	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.501598	112,373	56,366	73.00
<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	0.729996	56,830	41,486	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	2.240606	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		501,207	185,439	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)		501,207		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151320	Period: From 10/01/2010 To 09/30/2011	Worksheet D-3	
		Component CCN: 15Z320		Date/Time Prepared: 3/23/2012 2:38 pm	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
40.00	SUBPROVIDER - IPF		0		40.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY		0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.365041	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.243779	0	0	52.00
53.00	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.137773	21,483	2,960	54.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.215299	44,887	9,664	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0.385247	110,637	42,623	65.00
66.00	PHYSICAL THERAPY	0.507547	231,709	117,603	66.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.618589	8,315	5,144	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.501598	63,729	31,966	73.00
<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	0.729996	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	2.240606	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		480,760	209,960	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)		480,760		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151320	Period: From 10/01/2010 To 09/30/2011	Worksheet D-3 Date/Time Prepared: 3/23/2012 2:38 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		332,444		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
40.00	SUBPROVIDER - IPF		0		40.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY		0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.365041	287,373	104,903	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.243779	0	0	52.00
53.00	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.137773	49,157	6,773	54.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.215299	93,149	20,055	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0.385247	39,866	15,358	65.00
66.00	PHYSICAL THERAPY	0.507547	0	0	66.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.618589	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.501598	66,223	33,217	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
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	0.729996	5,810	4,241	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	2.240606	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		541,578	184,547	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)		541,578		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151320	Period: From 10/01/2010 To 09/30/2011	Worksheet D-3	
		Component CCN: 15M320		Date/Time Prepared: 3/23/2012 2:38 pm	
		Title XIX	Subprovider - IPF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
40.00	SUBPROVIDER - IPF		90,440		40.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY		0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.365041	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.243779	0	0	52.00
53.00	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.137773	1,228	169	54.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.215299	8,333	1,794	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0.385247	7,853	3,025	65.00
66.00	PHYSICAL THERAPY	0.507547	250	127	66.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.618589	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.501598	21,970	11,020	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
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	0.729996	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	2.240606	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		39,634	16,135	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)		39,634		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151320	Period: From 10/01/2010 To 09/30/2011	Worksheet D-3	
		Component CCN: 15Z320		Date/Time Prepared: 3/23/2012 2:38 pm	
		Title XIX	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
40.00	SUBPROVIDER - IPF		0		40.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY		0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.365041	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.243779	0	0	52.00
53.00	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.137773	0	0	54.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.215299	0	0	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0.385247	0	0	65.00
66.00	PHYSICAL THERAPY	0.507547	0	0	66.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.618589	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.501598	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
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	0.729996	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	2.240606	0	0	92.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		0	0	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)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151320	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 3/23/2012 2:38 pm
		Title XVIII	Hospital	Cost
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			3,205,237 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			3,205,237 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			3,237,289 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)			18,348 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,615,530 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)			1,603,411 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)			1,603,411 30.00
31.00	Primary payer payments			323 31.00
32.00	Subtotal (line 30 minus line 31)			1,603,088 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			0 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			0 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			1,603,088 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)			1,603,088 40.00
41.00	Interim payments			1,931,890 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)			-328,802 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: 151320	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 3/23/2012 2:38 pm
		Component CCN: 15M320	Title XVIII	Subprovider - IPF
		PPS		
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	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)		0	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		0	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		0	40.00
41.00	Interim payments		0	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet E-1  
Part I  
Date/Time Prepared:  
3/23/2012 2:38 pm

		Title XVIII		Hospital		Cost	
		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		2,420,540		2,043,899	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	10/01/2010	48,177	10/01/2010	129,413	3.01	
3.02		05/05/2011	15,981	05/05/2011	66,959	3.02	
3.03		05/05/2011	139,647		0	3.03	
3.04		09/13/2011	371,934		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0	05/05/2011	132,569	3.50	
3.51			0	09/13/2011	175,812	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)		575,739		-112,009	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)		2,996,279		1,931,890	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		312,301		328,802	6.02	
7.00	Total Medicare program liability (see instructions)		2,683,978		1,603,088	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: 151320

Period: From 10/01/2010

Worksheet E-1

Component CCN: 15M320

To 09/30/2011

Part I  
Date/Time Prepared:  
3/23/2012 2:38 pm

Title XVIII

Subprovider -  
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,608,909		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,608,909		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,608,909		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151320

Period:

Worksheet E-1

Component CCN: 152320

From 10/01/2010

Part I

To 09/30/2011

Date/Time Prepared: 3/23/2012 2:38 pm

Title XVIII

Swing Beds - SNF

Cost

		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		875,005		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	05/05/2011	80,340		0	3.01
3.02		09/13/2011	93,512		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)		173,852		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,048,857		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		15,934		0	6.02
7.00	Total Medicare program liability (see instructions)		1,032,923		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: 151320	Period: From 10/01/2010 To 09/30/2011	Worksheet E-2
		Component CCN: 15Z320		Date/Time Prepared: 3/23/2012 2:38 pm
		Title XVIII	Swing Beds - SNF	Cost
		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)	827,786	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)	212,060	0	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	693	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)	1,039,846	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,039,846	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)	1,039,846	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	6,923	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)	1,032,923	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)	1,032,923	0	19.00
20.00	Interim payments	1,048,857	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)	-15,934	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 - SWING BEDS		Provider CCN: 151320	Period:	Worksheet E-2
		Component CCN: 15Z320	From 10/01/2010 To 09/30/2011	Date/Time Prepared: 3/23/2012 2:38 pm
		Title XIX	Swing Beds - SNF	Cost
			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)		0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		0	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)		0	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		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)		0	8.00
9.00	Primary payer payments (see instructions)		0	9.00
10.00	Subtotal (line 8 minus line 9)		0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	11.00
12.00	Subtotal (line 10 minus line 11)		0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)		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)		0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	16.00
17.00	Reimbursable bad debts (see instructions)		0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)		0	19.00
20.00	Interim payments		0	20.00
21.00	Tentative settlement (for contractor use only)		0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)		0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151320	Period: From 10/01/2010 To 09/30/2011	Worksheet E-3 Part V Date/Time Prepared: 3/23/2012 2:38 pm
		Title XVIII	Hospital	Cost
		1.00		
<b>PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)</b>				
1.00	Inpatient services		2,993,130	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 thru 3)		2,993,130	4.00
5.00	Primary payer payments		3,813	5.00
6.00	Total cost (line 4 less line 5) . For CAH (see instructions)		3,019,248	6.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
<b>Customary charges</b>				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	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	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	17.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		3,019,248	19.00
20.00	Deductibles (exclude professional component)		326,852	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		2,692,396	22.00
23.00	Coinsurance		8,418	23.00
24.00	Subtotal (line 22 minus line 23)		2,683,978	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		0	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26)		2,683,978	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		2,683,978	30.00
31.00	Interim payments		2,996,279	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)		-312,301	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151320	Period: From 10/01/2010 To 09/30/2011	Worksheet E-3 Part II Date/Time Prepared: 3/23/2012 2:38 pm
		Component CCN: 15M320	Title XVII	Subprovider - IPF
		PPS		
		1.00		
<b>PART II - MEDICARE PART A SERVICES - IPF PPS</b>				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		1,717,139	1.00
2.00	Net IPF PPS Outlier Payments		5,574	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		7.323288	9.00
10.00	Medical Education Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$ .		0.000000	10.00
11.00	Medical Education Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		1,722,713	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition		0	14.00
15.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	15.00
16.00	Subtotal (see instructions)		1,722,713	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		1,722,713	18.00
19.00	Deductibles		90,080	19.00
20.00	Subtotal (line 18 minus line 19)		1,632,633	20.00
21.00	Coinurance		23,724	21.00
22.00	Subtotal (line 20 minus line 21)		1,608,909	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	25.00
26.00	Subtotal (sum of lines 22 and 24)		1,608,909	26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.99	Recovery of Accelerated Depreciation		0	30.99
31.00	Total amount payable to the provider (see instructions)		1,608,909	31.00
32.00	Interim payments		1,608,909	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus the sum lines 32 and 33)		0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	35.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151320	Period: From 10/01/2010 To 09/30/2011	Worksheet E-3 Part VII Date/Time Prepared: 3/23/2012 2:38 pm
		Title XIX	Hospital	Cost
				1.00
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>				
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient hospital/SNF/NF services		532,378	1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		532,378	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)		532,378	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable Charges</b>				
8.00	Routine service charges		332,444	8.00
9.00	Ancillary service charges		541,578	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)		874,022	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)		874,022	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		341,644	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)		532,378	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.		532,378	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)		532,378	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)		532,378	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		532,378	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)		532,378	40.00
41.00	Interim payments		192,418	41.00
42.00	Balance due provider/program (line 40 minus 41)		339,960	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151320	Period: From 10/01/2010 To 09/30/2011	Worksheet E-3 Part VII Date/Time Prepared: 3/23/2012 2:38 pm
		Title XIX	Subprovider - IPF	Cost
				1.00
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>				
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient hospital/SNF/NF services		0	1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	4.00
5.00	Inpatient primary payer payments		0	5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable Charges</b>				
8.00	Routine service charges		90,440	8.00
9.00	Ancillary service charges		39,634	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)		130,074	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)		130,074	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		130,074	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)		0	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.		0	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)		0	31.00
32.00	Deductibles		0	32.00
33.00	Coinurance		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Utilization review		0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	40.00
41.00	Interim payments		33,403	41.00
42.00	Balance due provider/program (line 40 minus 41)		-33,403	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: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet G

Date/Time Prepared:  
3/23/2012 2:38 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	3,778,586	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	9,104,914	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,212,333	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)	14,095,833	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	242,163	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	15,390,910	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	15,633,073	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	12,775,278	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	12,775,278	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	42,504,184	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	626,404	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,156,284	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	266,780	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)	2,049,468	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,049,468	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	40,454,716				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)	40,454,716	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	42,504,184	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet G-1

Date/Time Prepared:  
3/23/2012 2:38 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		39,105,870	
2.00	Net income (loss) (From Wkst. G-3, line 29)		1,348,846			2.00
3.00	Total (sum of line 1 and line 2)		40,454,716		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		40,454,716		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		40,454,716		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet G-1

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet G-2 Parts

Date/Time Prepared:  
3/23/2012 2:38 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	3,910,761		3,910,761	1.00
2.00	SUBPROVIDER - IPF	2,084,331		2,084,331	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	533,250		533,250	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,528,342		6,528,342	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,528,342		6,528,342	17.00
18.00	Ancillary services	8,154,954	45,521,531	53,676,485	18.00
19.00	Outpatient services	0	7,106,143	7,106,143	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	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	14,683,296	52,627,674	67,310,970	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		31,724,254		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)		31,724,254		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151320

Period:  
From 10/01/2010  
To 09/30/2011

Worksheet G-3

Date/Time Prepared:  
3/23/2012 2:38 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	67,310,970	1.00
2.00	Less contractual allowances and discounts on patients' accounts	35,008,487	2.00
3.00	Net patient revenues (line 1 minus line 2)	32,302,483	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	31,724,254	4.00
5.00	Net income from service to patients (line 3 minus line 4)	578,229	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) OTHER/NONOP/GRANTS	770,617	24.00
25.00	Total other income (sum of lines 6-24)	770,617	25.00
26.00	Total (line 5 plus line 25)	1,348,846	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)	1,348,846	29.00