

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: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet S Parts I-III Date/Time Prepared: 1/23/2012 9:19 am
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 1/23/2012	Time: 9:19 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MORGAN COUNTY HOSPITAL for the cost reporting period beginning 01/01/2011 and ending 06/30/2011 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 XVIII		HIT	Title XIX	
	Title V	Part A			
	1.00	2.00	3.00	4.00	5.00
PART III - SETTLEMENT SUMMARY					
1.00 Hospital	0	-14,837	3,611	0	2,316,722
2.00 Subprovider - IPF	0	747	0	0	0
3.00 Subprovider - IRF	0	0	0	0	0
4.00 SUBPROVIDER I	0	0	0	0	0
5.00 Swing bed - SNF	0	0	0	0	0
6.00 Swing bed - NF	0	0	0	0	0
7.00 Skilled Nursing Facility	0	0	0	0	0
8.00 Nursing Facility	0	0	0	0	0
9.00 HOME HEALTH AGENCY I	0	0	0	0	0
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0
12.00 CMHC I	0	0	0	0	0
200.00 Total	0	-14,090	3,611	0	2,316,722

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: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/23/2012 9:16 am
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1.00	2.00	3.00	4.00	1.00
Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2209 JOHN R WOODEN DRIVE		PO Box:	1.00
2.00	City: MARTINSVILLE		State: IN Zip Code: 46151- County: MORGAN	2.00

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	MORGAN COUNTY HOSPITAL	150038	26900	1	01/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	MORGAN COUNTY PSYCH UNIT	15S038	26900	4	01/01/2004	N	P	N	4.00
5.00	Subprovider - IRF	MORGAN COUNTY REHAB UNIT	15T038	26900	5	01/01/2004	N	P	N	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF						N	N	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									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									17.10
18.00	Renal Dialysis						N	N	N	18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2011	06/30/2011	20.00
21.00	Type of Control (see instructions)	6		21.00

Inpatient PPS Information										
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.					3	N			23.00

	In-State Medicaid paid days	In-State Medicaid eligible 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	224	155	0	0	187	0	24.00
25.00	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.		1 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.		1 27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.		0 35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/23/2012 9:16 am		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00	61.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. 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		0	71.00
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				Y			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				N	N	0	76.00
						1.00		
Long Term Care Hospital PPS								
80.00	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		
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(i)? Enter "Y" for yes and "N" for no.		N		86.00
			V	XIX	
			1.00	2.00	
Title V or XIX Inpatient Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	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
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
				1.00	2.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.		N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			0	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.			0	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00

1/23/2012 9:16 am J:\60567000 Morgan Hospital and Medical Center\2011\Hfs\MorganHosp2011.mcrx

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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)			N				140.00	
			1.00	2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:		Contractor's Name:		Contractor's Number:			141.00	
142.00	Street:		PO Box:					142.00	
143.00	City:		State:		Zip Code:			143.00	
							1.00		
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 - Other			N		N		158.00	
159.00	SNF			N		N		159.00	
160.00	HHA			N		N		160.00	
161.00	CMHC					N		161.00	
							1.00		
Multi campus									
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N		165.00	
			Name	County	State	Zip Code	CBSA	FTE/Campus	
			0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5							0.00	166.00
							1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					N		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 1/23/2012 9:16 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		N		3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N		5.00
			Y/N	Type	Date
			1.00	2.00	3.00
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.		N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
			Y/N	Legal Oper.	
			1.00	2.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
			Part A		
			Description	Y/N	Date
			0	1.00	2.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	11/18/2011	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: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 1/23/2012 9:16 am
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		Part A				
		Description	Y/N	Date		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	1.00 N	2.00		21.00
					1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)						
Capital Related Cost						
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions					22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					27.00
Interest Expense						
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
Purchased Services						
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
Provider-Based Physicians						
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.					35.00
					Y/N	Date
					1.00	2.00
Home Office Costs						
36.00	Were home office costs claimed on the cost report?		N			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					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: 150038

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

Worksheet S-2
Part II
Date/Time Prepared:
1/23/2012 9:16 am

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/18/2011	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: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet S-3 Part I Date/Time Prepared: 1/23/2012 9:16 am
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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	47	8,507	0.00	1.00
2.00 HMO					2.00
3.00 HMO IPF					3.00
4.00 HMO IRF					4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					5.00
6.00 Hospital Adults & Peds. Swing Bed NF					6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		47	8,507	0.00	7.00
8.00 INTENSIVE CARE UNIT	31.00	14	2,534	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)		61	11,041	0.00	14.00
15.00 CAH visits					15.00
16.00 SUBPROVIDER - IPF	40.00	10	1,810		16.00
17.00 SUBPROVIDER - IRF	41.00	5	905		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)		76			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: 150038

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

Worksheet S-3
Part I
Date/Time Prepared:
1/23/2012 9:16 am

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	1,122	306	1,746		1.00
2.00 HMO		83	31			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,122	306	1,746		7.00
8.00 INTENSIVE CARE UNIT	0	489	128	855		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		88	185		13.00
14.00 Total (see instructions)	0	1,611	522	2,786		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF	0	1,146	52	1,462		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		179	566		28.00
28.01 SUBPROVIDER - IPF	0	0	0	0		28.01
28.02 SUBPROVIDER - IRF	0	0	0	0		28.02
28.03 SUBPROVIDER	0	0	0	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)			13	16		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150038

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

Worksheet S-3
Part I
Date/Time Prepared:
1/23/2012 9:16 am

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	433	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	297.07	0.00	0	433	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	14.21	0.00	0	91	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	311.28	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: 150038

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

Worksheet S-3
Part I
Date/Time Prepared:
1/23/2012 9:16 am

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)	159	592		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)	159	592		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF	4	117		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

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 150038		Period: From 01/01/2011 To 06/30/2011		Worksheet S-3 Part II Date/Time Prepared: 1/23/2012 9:16 am	
	Worksheet A Line Number	Amount Reported	Salary Adjustments for Vacation, Holiday, Sick, Other Paid Time Off, Severance, and Bonus, Paid to Employees and Not Reflected in Column 2	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)		
	1.00	2.00	2.50	3.00	4.00		

PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	7,713,283	0	0	7,713,283	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0	2.00
3.00	Non-physician anesthetist Part B		342,220	0	0	342,220	3.00
4.00	Physician-Part A		28,210	0	0	28,210	4.00
4.01	Physicians - Part A - direct teaching		0	0	0	0	4.01
5.00	Physician-Part B		0	0	0	0	5.00
6.00	Non-physician-Part B		82,683	0	0	82,683	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0	7.00
7.01	Contracted interns and residents (in approved programs)		0	0	0	0	7.01
8.00	Home office personnel		0	0	0	0	8.00
9.00	SNF	44.00	0	0	0	0	9.00
10.00	Excluded area salaries (see instructions)		340,970	0	0	340,970	10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		3,605	0	0	3,605	11.00
12.00	Management and administrative services		0	0	0	0	12.00
13.00	Contract labor: physician-Part A		0	0	0	0	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0	14.00
15.00	Home office: physician Part A		0	0	0	0	15.00
16.00	Teaching physician salaries (see instructions)		0	0	0	0	16.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24		1,529,891	0	0	1,529,891	17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV Line 25		0	0	0	0	18.00
19.00	Excluded areas		71,560	0	0	71,560	19.00
20.00	Non-physician anesthetist Part A		0	0	0	0	20.00
21.00	Non-physician anesthetist Part B		0	0	0	0	21.00
22.00	Physician Part A		5,920	0	0	5,920	22.00
23.00	Physician Part B		17,353	0	0	17,353	23.00
24.00	Wage-related costs (RHC/FOHC)		0	0	0	0	24.00
25.00	Interns & residents (in an approved program)		0	0	0	0	25.00
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits	4.00	154,761	0	0	154,761	26.00
27.00	Administrative & General	5.00	1,410,269	0	0	1,410,269	27.00
28.00	Administrative & General under contract (see inst.)		384,878	0	0	384,878	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0	29.00
30.00	Operation of Plant	7.00	160,773	0	0	160,773	30.00
31.00	Laundry & Linen Service	8.00	4,172	0	0	4,172	31.00
32.00	Housekeeping	9.00	200,678	0	0	200,678	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0	33.00
34.00	Dietary	10.00	187,378	0	-112,613	74,765	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0	35.00
36.00	Cafeteria	11.00	0	0	112,613	112,613	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0	37.00
38.00	Nursing Administration	13.00	166,006	0	0	166,006	38.00
39.00	Central Services and Supply	14.00	19,080	0	0	19,080	39.00
40.00	Pharmacy	15.00	240,975	0	0	240,975	40.00
41.00	Medical Records & Medical Records Library	16.00	234,381	0	0	234,381	41.00
42.00	Social Service	17.00	0	0	0	0	42.00
43.00	Other General Service	18.00	0	0	0	0	43.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet S-3 Part II Date/Time Prepared: 1/23/2012 9:16 am
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		Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		5.00	6.00	
PART II - WAGE DATA				
SALARIES				
1.00	Total salaries (see instructions)	323,224.20	23.86	1.00
2.00	Non-physician anesthetist Part A	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B	6,720.00	50.93	3.00
4.00	Physician-Part A	265.00	106.45	4.00
4.01	Physicians - Part A - direct teaching	0.00	0.00	4.01
5.00	Physician-Part B	0.00	0.00	5.00
6.00	Non-physician-Part B	775.00	106.69	6.00
7.00	Interns & residents (in an approved program)	0.00	0.00	7.00
7.01	Contracted interns and residents (in approved programs)	0.00	0.00	7.01
8.00	Home office personnel	0.00	0.00	8.00
9.00	SNF	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)	16,176.00	21.08	10.00
OTHER WAGES & RELATED COSTS				
11.00	Contract labor (see instructions)	73.00	49.38	11.00
12.00	Management and administrative services	0.00	0.00	12.00
13.00	Contract labor: physician-Part A	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs	0.00	0.00	14.00
15.00	Home office: physician Part A	0.00	0.00	15.00
16.00	Teaching physician salaries (see instructions)	0.00	0.00	16.00
WAGE-RELATED COSTS				
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24			17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV Line 25			18.00
19.00	Excluded areas			19.00
20.00	Non-physician anesthetist Part A			20.00
21.00	Non-physician anesthetist Part B			21.00
22.00	Physician Part A			22.00
23.00	Physician Part B			23.00
24.00	Wage-related costs (RHC/FQHC)			24.00
25.00	Interns & residents (in an approved program)			25.00
OVERHEAD COSTS - DIRECT SALARIES				
26.00	Employee Benefits	4,325.00	35.78	26.00
27.00	Administrative & General	64,669.80	21.81	27.00
28.00	Administrative & General under contract (see inst.)	1,349.06	285.29	28.00
29.00	Maintenance & Repairs	0.00	0.00	29.00
30.00	Operation of Plant	8,919.00	18.03	30.00
31.00	Laundry & Linen Service	508.50	8.20	31.00
32.00	Housekeeping	19,687.00	10.19	32.00
33.00	Housekeeping under contract (see instructions)	0.00	0.00	33.00
34.00	Dietary	5,852.00	12.78	34.00
35.00	Dietary under contract (see instructions)	0.00	0.00	35.00
36.00	Cafeteria	8,815.00	12.78	36.00
37.00	Maintenance of Personnel	0.00	0.00	37.00
38.00	Nursing Administration	5,783.00	28.71	38.00
39.00	Central Services and Supply	1,365.00	13.98	39.00
40.00	Pharmacy	6,418.00	37.55	40.00
41.00	Medical Records & Medical Records Library	11,037.00	21.24	41.00
42.00	Social Service	0.00	0.00	42.00
43.00	Other General Service	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150038

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

Worksheet S-3
Part III
Date/Time Prepared:
1/23/2012 9:16 am

	Worksheet A Line Number	Amount Reported	Salary Adjustments for Vacation, Holiday, Sick, Other Paid Time Off, Severance, and Bonus, Paid to Employees and Not Reflected in Column 2	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adj usted Sal aries (col . 2 ± col . 3)	
	1.00	2.00	2.50	3.00	4.00	
PART III - HOSPITAL WAGE INDEX SUMMARY						
1.00	Net salaries (see instructions)	7,645,048	0	0	7,645,048	1.00
2.00	Excluded area salaries (see instructions)	340,970	0	0	340,970	2.00
3.00	Subtotal salaries (line 1 minus line 2)	7,304,078	0	0	7,304,078	3.00
4.00	Subtotal other wages & related costs (see inst.)	3,605	0	0	3,605	4.00
5.00	Subtotal wage-related costs (see inst.)	1,535,811	0	0	1,535,811	5.00
6.00	Total (sum of lines 3 thru 5)	8,843,494	0	0	8,843,494	6.00
7.00	Total overhead cost (see instructions)	3,163,351	0	0	3,163,351	7.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150038

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

Worksheet S-3
Part III
Date/Time Prepared:
1/23/2012 9:16 am

		Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY				
1.00	Net salaries (see instructions)	317,078.26	24.11	1.00
2.00	Excluded area salaries (see instructions)	16,176.00	21.08	2.00
3.00	Subtotal salaries (line 1 minus line 2)	300,902.26	24.27	3.00
4.00	Subtotal other wages & related costs (see inst.)	73.00	49.38	4.00
5.00	Subtotal wage-related costs (see inst.)	0.00	21.03	5.00
6.00	Total (sum of lines 3 thru 5)	300,975.26	29.38	6.00
7.00	Total overhead cost (see instructions)	138,728.36	22.80	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet S-3 Part IV Date/Time Prepared: 1/23/2012 9:16 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	194,673	3.00
4.00	Prior Year Pension Service Cost	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	547,063	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	24,312	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	57,177	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	24,267	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	131,493	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	538,306	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	12,600	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,529,891	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet S-3 Part V Date/Time Prepared: 1/23/2012 9:16 am
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Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital -Based SNF			8.00
9.00	Hospital -Based NF			9.00
10.00	Hospital -Based OLTC			10.00
11.00	Hospital -Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital -Based Hospice			13.00
14.00	Hospital -Based Health Clinic RHC	0	0	14.00
15.00	Hospital -Based Health Clinic FQHC	0	0	15.00
16.00	Hospital -Based-CMHC			16.00
16.10	Hospital -Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis			17.00
18.00		0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet S-10 Date/Time Prepared: 1/23/2012 9:16 am
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)		0.245742	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		4,696,150	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		Y	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		14,349,075	6.00	
7.00	Medicaid cost (line 1 times line 6)		3,526,170	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		3,596	9.00	
10.00	Stand-alone SCHIP charges		6,528	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		1,604	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00	
			Uninsured patients	Insured patients	
			1.00	2.00	
			Total (col. 1 + col. 2)	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	999,847	918,927	1,918,774	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	245,704	225,819	471,523	21.00
22.00	Partial payment by patients approved for charity care	2,117	3,676	5,793	22.00
23.00	Cost of charity care (line 21 minus line 22)	243,587	222,143	465,730	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		4,205,858	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		16,042	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		4,189,816	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		1,029,614	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		1,495,344	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,495,344	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet A	
					Date/Time Prepared: 1/23/2012 9:16 am	
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT		1,089,410	1,089,410	467,971	1,557,381	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		0	0	311,600	311,600	2.00
4.00 EMPLOYEE BENEFITS	154,761	1,722,712	1,877,473	0	1,877,473	4.00
5.00 ADMINISTRATIVE & GENERAL	1,410,269	1,651,644	3,061,913	-89,701	2,972,212	5.00
7.00 OPERATION OF PLANT	160,773	634,504	795,277	-3,005	792,272	7.00
8.00 LAUNDRY & LINEN SERVICE	4,172	46,964	51,136	0	51,136	8.00
9.00 HOUSEKEEPING	200,678	42,320	242,998	0	242,998	9.00
10.00 DIETARY	187,378	94,884	282,262	-169,638	112,624	10.00
11.00 CAFETERIA	0	0	0	169,638	169,638	11.00
13.00 NURSING ADMINISTRATION	166,006	47,758	213,764	-709	213,055	13.00
14.00 CENTRAL SERVICES & SUPPLY	19,080	17,303	36,383	0	36,383	14.00
15.00 PHARMACY	240,975	665,848	906,823	-83,626	823,197	15.00
16.00 MEDICAL RECORDS & LIBRARY	234,381	64,963	299,344	0	299,344	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	799,890	160,379	960,269	-54,728	905,541	30.00
31.00 INTENSIVE CARE UNIT	582,339	85,164	667,503	-4,002	663,501	31.00
40.00 SUBPROVIDER - IPF	327,386	204,083	531,469	-2,076	529,393	40.00
41.00 SUBPROVIDER - IRF	0	2,455	2,455	0	2,455	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	799	233	1,032	44,783	45,815	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	351,130	1,097,322	1,448,452	-423,256	1,025,196	50.00
54.00 RADIOLOGY-DIAGNOSTIC	975,650	2,082,703	3,058,353	-51,495	3,006,858	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	524,339	766,014	1,290,353	-660	1,289,693	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	343,965	103,222	447,187	-35,893	411,294	65.00
66.00 PHYSICAL THERAPY	223,425	8,975	232,400	252	232,652	66.00
67.00 OCCUPATIONAL THERAPY	88,780	4,263	93,043	0	93,043	67.00
68.00 SPEECH PATHOLOGY	20,863	4,289	25,152	0	25,152	68.00
69.00 ELECTROCARDIOLOGY	73,739	49,172	122,911	0	122,911	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	109,590	109,590	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	254,967	254,967	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 DIABETES SERVICES	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
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	608,921	223,195	832,116	-15,683	816,433	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
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		424,329	424,329	-424,329	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	7,699,699	11,294,108	18,993,807	0	18,993,807	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,256	0	3,256	0	3,256	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	10,328	10,017	20,345	0	20,345	192.00
200.00 TOTAL (SUM OF LINES 118-199)	7,713,283	11,304,125	19,017,408	0	19,017,408	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150038

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

Worksheet A
Date/Time Prepared:
1/23/2012 9:16 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	-215,262	1,342,119	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	311,600	2.00
4.00	EMPLOYEE BENEFITS	-24,424	1,853,049	4.00
5.00	ADMINISTRATIVE & GENERAL	-358,214	2,613,998	5.00
7.00	OPERATION OF PLANT	-5,375	786,897	7.00
8.00	LAUNDRY & LINEN SERVICE	0	51,136	8.00
9.00	HOUSEKEEPING	-10,805	232,193	9.00
10.00	DIETARY	-6,970	105,654	10.00
11.00	CAFETERIA	-54,887	114,751	11.00
13.00	NURSING ADMINISTRATION	-3,873	209,182	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	36,383	14.00
15.00	PHARMACY	-8,288	814,909	15.00
16.00	MEDICAL RECORDS & LIBRARY	-440	298,904	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	905,541	30.00
31.00	INTENSIVE CARE UNIT	0	663,501	31.00
40.00	SUBPROVIDER - IPF	-1,310	528,083	40.00
41.00	SUBPROVIDER - IRF	0	2,455	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	45,815	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	-431,066	594,130	50.00
54.00	RADIOLOGY-DIAGNOSTIC	-2,892	3,003,966	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	-160,109	1,129,584	60.00
60.01	BLOOD LABORATORY	0	0	60.01
65.00	RESPIRATORY THERAPY	0	411,294	65.00
66.00	PHYSICAL THERAPY	0	232,652	66.00
67.00	OCCUPATIONAL THERAPY	0	93,043	67.00
68.00	SPEECH PATHOLOGY	0	25,152	68.00
69.00	ELECTROCARDIOLOGY	-32,653	90,258	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	109,590	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	254,967	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	DIABETES SERVICES	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	EMERGENCY	-125,923	690,510	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS				
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)	-1,442,491	17,551,316	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,256	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	20,345	192.00
200.00	TOTAL (SUM OF LINES 118-199)	-1,442,491	17,574,917	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - NEW CAPITAL					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	311,600	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
TOTALS			0	311,600	
B - MED SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	364,557	1.00
2.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	254,967	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
TOTALS			0	619,524	
C - CAFETERIA					
1.00	CAFETERIA	11.00	112,613	57,025	1.00
TOTALS			112,613	57,025	
D - NEW CAP COSTS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	43,642	1.00
TOTALS			0	43,642	
E - NURSERY					
1.00	NURSERY	43.00	44,783	0	1.00
TOTALS			44,783	0	
F - INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	424,329	1.00
TOTALS			0	424,329	
500.00	Grand Total: Increases		157,396	1,456,120	500.00

RECLASSIFICATIONS

Provider CCN: 150038

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

Worksheet A-6

Date/Time Prepared:
1/23/2012 9:16 am

Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - NEW CAPITAL							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	46,059	10		1.00
2.00	OPERATION OF PLANT	7.00	0	3,005	0		2.00
3.00	NURSING ADMINISTRATION	13.00	0	330	0		3.00
4.00	PHARMACY	15.00	0	83,626	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	1,151	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	901	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	330	0		7.00
8.00	OPERATING ROOM	50.00	0	160,928	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	330	0		9.00
10.00	LABORATORY	60.00	0	660	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	13,379	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	330	0		12.00
13.00	EMERGENCY	91.00	0	571	0		13.00
	TOTALS		0	311,600			
B - MED SUPPLIES							
1.00	NURSING ADMINISTRATION	13.00	0	49	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	8,794	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	3,101	0		3.00
4.00	SUBPROVIDER - IPF	40.00	0	2,076	0		4.00
5.00	OPERATING ROOM	50.00	0	262,328	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	51,165	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	22,514	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	-582	0		8.00
9.00	EMERGENCY	91.00	0	15,112	0		9.00
10.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	254,967	0		10.00
	TOTALS		0	619,524			
C - CAFETERIA							
1.00	DIETARY	10.00	112,613	57,025	0		1.00
	TOTALS		112,613	57,025			
D - NEW CAP COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	43,642	12		1.00
	TOTALS		0	43,642			
E - NURSERY							
1.00	ADULTS & PEDIATRICS	30.00	44,783	0	0		1.00
	TOTALS		44,783	0			
F - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	424,329	11		1.00
	TOTALS		0	424,329			
500.00	Grand Total: Decreases		157,396	1,456,120			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150038

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/23/2012 9:16 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,913,186	0	0	0	1.00
2.00	Land Improvements	555,386	0	0	0	2.00
3.00	Buildings and Fixtures	22,070,318	0	0	0	3.00
4.00	Building Improvements	1,144,601	157,390	0	157,390	4.00
5.00	Fixed Equipment	5,606,368	0	0	0	5.00
6.00	Movable Equipment	32,802,357	1,509,151	0	1,509,151	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	64,092,216	1,666,541	0	1,666,541	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	64,092,216	1,666,541	0	1,666,541	10.00
SUMMARY OF CAPITAL						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,089,410	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,089,410	0	0	0	3.00
COMPUTATION OF RATIOS						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150038

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/23/2012 9:16 am

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,913,186	0			1.00	
2.00	Land Improvements	555,386	0			2.00	
3.00	Buildings and Fixtures	22,070,318	0			3.00	
4.00	Building Improvements	639,769	0			4.00	
5.00	Fixed Equipment	5,606,368	0			5.00	
6.00	Movable Equipment	34,257,326	0			6.00	
7.00	HIT designated Assets	0	0			7.00	
8.00	Subtotal (sum of lines 1-7)	65,042,353	0			8.00	
9.00	Reconciling Items	0	0			9.00	
10.00	Total (line 8 minus line 9)	65,042,353	0			10.00	
SUMMARY OF CAPITAL							
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,089,410			1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0			2.00	
3.00	Total (sum of lines 1-2)	0	1,089,410			3.00	
ALLOCATION OF OTHER CAPITAL							
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,087,144	-173,762	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	311,600	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,087,144	137,838	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150038

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
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Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	385,095	43,642	0	0	1,342,119	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	311,600	2.00
3.00	Total (sum of lines 1-2)	385,095	43,642	0	0	1,653,719	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150038

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

Worksheet A-8

Date/Time Prepared:
1/23/2012 9:16 am

		Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
		Basis/Code (2)	Amount	Cost Center	Line #
		1.00	2.00	3.00	4.00
1.00	Investment income - buildings and fixtures (chapter 2)			NEW CAP REL COSTS-BLDG & FIXT	1.00
2.00	Investment income - movable equipment (chapter 2)			NEW CAP REL COSTS-MVBLE EQUIP	2.00
3.00	Investment income - other (chapter 2)	A	-30,683	NEW CAP REL COSTS-BLDG & FIXT	1.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00
5.00	Refunds and rebates of expenses (chapter 8)	A	-46,858	ADMINISTRATIVE & GENERAL	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-61,891	ADMINISTRATIVE & GENERAL	5.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-4,474	ADMINISTRATIVE & GENERAL	5.00
8.00	Television and radio service (chapter 21)		0		0.00
9.00	Parking lot (chapter 21)		0		0.00
10.00	Provider-based physician adjustment	A-8-2	-687,585		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	A	-2,892	RADIOLOGY-DIAGNOSTIC	54.00
12.00	Related organization transactions (chapter 10)	A-8-1	0		12.00
13.00	Laundry and linen service		0		0.00
14.00	Cafeteria-employees and guests	B	-54,887	CAFETERIA	11.00
15.00	Rental of quarters to employee and others		0		0.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00
17.00	Sale of drugs to other than patients		0		0.00
18.00	Sale of medical records and abstracts		0		0.00
19.00	Nursing school (tuition, fees, books, etc.)	B	-3,873	NURSING ADMINISTRATION	13.00
20.00	Vending machines	B	-941	DIETARY	10.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		RESPIRATORY THERAPY	65.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00
25.00	Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***	114.00
26.00	Depreciation - buildings and fixtures			NEW CAP REL COSTS-BLDG & FIXT	1.00
27.00	Depreciation - movable equipment			NEW CAP REL COSTS-MVBLE EQUIP	2.00
28.00	Non-physician Anesthetist			*** Cost Center Deleted ***	19.00
29.00	Physicians' assistant				0.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		SPEECH PATHOLOGY	68.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00
33.00	MEALS ON WHEELS	A	-6,029	DIETARY	10.00
34.00	PUBLIC RELATIONS	A	-90,089	ADMINISTRATIVE & GENERAL	5.00
35.00	HOSP RELATIONS	A	-15,716	ADMINISTRATIVE & GENERAL	5.00
36.00	HOSP RELATIONS	A	-1,310	SUBPROVIDER - I PF	40.00
37.00			0		0.00
38.00			0		0.00
39.00			0		0.00
40.00	HOSP RELATIONS	A	-691	EMPLOYEE BENEFITS	4.00
41.00	IHA DUES	A	-1,153	ADMINISTRATIVE & GENERAL	5.00
42.00	AHA DUES	A	-4,191	ADMINISTRATIVE & GENERAL	5.00
43.00			0		0.00
44.00	BOND ISSUANCE AMORTIZATION	A	-8,551	NEW CAP REL COSTS-BLDG & FIXT	1.00
45.00	TELEPHONE FRINGES	A	-456	EMPLOYEE BENEFITS	4.00
45.01	TELEPHONE DEPR	A	-2,266	NEW CAP REL COSTS-BLDG & FIXT	1.00
45.02	MORGAN HEALTH SERV RENT INC	B	-116,264	NEW CAP REL COSTS-BLDG & FIXT	1.00
45.03	MORGAN HEALTH SERV TELEPHONE	B	-4,786	ADMINISTRATIVE & GENERAL	5.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150038

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

Worksheet A-8

Date/Time Prepared:
1/23/2012 9:16 am

		Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
		Basiss/Code (2)	Amount	Cost Center	Line #
		1.00	2.00	3.00	4.00
45.04	MORGAN HEALTH SERV UTILITIES	B	-5,375	OPERATION OF PLANT	7.00 45.04
45.05	MORGAN HEALTH SERV ACCT FEES	B	-16,800	ADMINISTRATIVE & GENERAL	5.00 45.05
45.06	MORGAN HEALTH SERV HOUSEKEEP	B	-10,805	HOUSEKEEPING	9.00 45.06
45.07	RENTAL INCOME	B	-57,498	NEW CAP REL COSTS-BLDG & FIXT	1.00 45.07
45.08			0		0.00 45.08
45.09	MED RECORDS	B	-440	MEDICAL RECORDS & LIBRARY	16.00 45.09
45.10	MISC INCOME	B	-95,693	ADMINISTRATIVE & GENERAL	5.00 45.10
45.11	PHYSICIAN RECRUITMENT	A	-23,277	EMPLOYEE BENEFITS	4.00 45.11
45.12	CREDITENALING MISC INCOME	B	-4,900	ADMINISTRATIVE & GENERAL	5.00 45.12
45.13	EMPLOYEE RX SALES	B	-8,288	PHARMACY	15.00 45.13
45.14	ADJUSTMENT TO AJE # 8	A	-62,166	LABORATORY	60.00 45.14
45.15	AJE # 11	A	-11,663	ADMINISTRATIVE & GENERAL	5.00 45.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,442,491		50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150038

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

Worksheet A-8

Date/Time Prepared:
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		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - buildings and fixtures (chapter 2)	0	1.00
2.00	Investment income - movable equipment (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	11	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 - buildings and fixtures	0	26.00
27.00	Depreciation - movable equipment	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	MEALS ON WHEELS	0	33.00
34.00	PUBLIC RELATIONS	0	34.00
35.00	HOSP RELATIONS	0	35.00
36.00	HOSP RELATIONS	0	36.00
37.00		0	37.00
38.00		0	38.00
39.00		0	39.00
40.00	HOSP RELATIONS	0	40.00
41.00	IHA DUES	0	41.00
42.00	AHA DUES	0	42.00
43.00		0	43.00
44.00	BOND ISSUANCE AMORTIZATION	11	44.00
45.00	TELEPHONE FRINGES	0	45.00
45.01	TELEPHONE DEPR	9	45.01
45.02	MORGAN HEALTH SERV RENT INC	10	45.02
45.03	MORGAN HEALTH SERV TELEPHONE	0	45.03
45.04	MORGAN HEALTH SERV UTILITIES	0	45.04
45.05	MORGAN HEALTH SERV ACCT FEES	0	45.05
45.06	MORGAN HEALTH SERV HOUSEKEEP	0	45.06
45.07	RENTAL INCOME	10	45.07
45.08		0	45.08
45.09	MED RECORDS	0	45.09
45.10	MISC INCOME	0	45.10
45.11	PHYSICIAN RECRUITMENT	0	45.11
45.12	CREDITENALING MISC INCOME	0	45.12
45.13	EMPLOYEE RX SALES	0	45.13
45.14	ADJUSTMENT TO AJE # 8	0	45.14
45.15	AJE # 11	0	45.15

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ADJUSTMENTS TO EXPENSES		Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet A-8 Date/Time Prepared: 1/23/2012 9:16 am
		Wkst. A-7 Ref.		
		5.00		
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150038

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

Worksheet A-8-2

Date/Time Prepared:
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	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	50.00	ANESTHESIA AND PAIN MANAGEMENT	431,066	431,066	1.00
2.00	60.00	PATHOLOGY	14,531	14,531	2.00
3.00	60.00	PATHOLOGY	110,893	82,683	3.00
4.00	69.00	EKG	32,653	32,653	4.00
5.00	91.00	EMERGENCY	125,923	125,923	5.00
6.00	0.00		0	0	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00		TOTAL (lines 1.00 through 199.00)	715,066	686,856	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150038

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

Worksheet A-8-2

Date/Time Prepared:
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	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	215,700	0	0	0	2.00
3.00	28,210	215,700	265	27,481	1,374	3.00
4.00	0	177,200	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
200.00	28,210		265	27,481	1,374	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150038

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

Worksheet A-8-2

Date/Time Prepared:
1/23/2012 9:16 am

	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	27,481	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
200.00	0	0	0	0	27,481	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150038

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

Worksheet A-8-2

Date/Time Prepared:
1/23/2012 9:16 am

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	431,066	1.00
2.00	0	14,531	2.00
3.00	729	83,412	3.00
4.00	0	32,653	4.00
5.00	0	125,923	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	729	687,585	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150038

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

Worksheet B Part I Date/Time Prepared: 1/23/2012 9:16 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT	1,342,119	1,342,119				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	311,600		311,600			2.00
4.00 EMPLOYEE BENEFITS	1,853,049	4,819	1,119	1,858,987		4.00
5.00 ADMINISTRATIVE & GENERAL	2,613,998	104,899	24,354	346,848	3,090,099	5.00
7.00 OPERATION OF PLANT	786,897	192,392	44,670	39,541	1,063,500	7.00
8.00 LAUNDRY & LINEN SERVICE	51,136	4,030	936	1,026	57,128	8.00
9.00 HOUSEKEEPING	232,193	35,036	8,134	49,356	324,719	9.00
10.00 DIETARY	105,654	48,255	11,203	18,388	183,500	10.00
11.00 CAFETERIA	114,751	23,131	5,370	27,697	170,949	11.00
13.00 NURSING ADMINISTRATION	209,182	3,702	859	40,829	254,572	13.00
14.00 CENTRAL SERVICES & SUPPLY	36,383	14,128	3,280	4,693	58,484	14.00
15.00 PHARMACY	814,909	10,755	2,497	59,267	887,428	15.00
16.00 MEDICAL RECORDS & LIBRARY	298,904	37,281	8,655	57,645	402,485	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	905,541	184,914	42,932	185,716	1,319,103	30.00
31.00 INTENSIVE CARE UNIT	663,501	74,222	17,232	143,224	898,179	31.00
40.00 SUBPROVIDER - I PF	528,083	39,756	9,230	80,519	657,588	40.00
41.00 SUBPROVIDER - I RF	2,455	0	0	0	2,455	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	45,815	73,379	17,036	11,211	147,441	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	594,130	104,702	24,309	86,359	809,500	50.00
54.00 RADIOLOGY-DIAGNOSTIC	3,003,966	176,394	40,953	239,957	3,461,270	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	1,129,584	47,335	10,990	128,959	1,316,868	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	411,294	13,066	3,033	84,597	511,990	65.00
66.00 PHYSICAL THERAPY	232,652	35,430	8,226	54,950	331,258	66.00
67.00 OCCUPATIONAL THERAPY	93,043	12,814	2,975	21,835	130,667	67.00
68.00 SPEECH PATHOLOGY	25,152	5,805	1,348	5,131	37,436	68.00
69.00 ELECTROCARDIOLOGY	90,258	37,456	8,696	18,136	154,546	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	109,590	0	0	0	109,590	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	254,967	0	0	0	254,967	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 DIABETES SERVICES	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
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	690,510	54,037	12,546	149,762	906,855	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
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)	17,551,316	1,337,738	310,583	1,855,646	17,542,577	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,256	4,381	1,017	801	9,455	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	20,345	0	0	2,540	22,885	192.00
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	17,574,917	1,342,119	311,600	1,858,987	17,574,917	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150038

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

Worksheet B Part I Date/Time Prepared: 1/23/2012 9:16 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	3,090,099					5.00
7.00	OPERATION OF PLANT	226,881	1,290,381				7.00
8.00	LAUNDRY & LINEN SERVICE	12,187	5,001	74,316			8.00
9.00	HOUSEKEEPING	69,274	43,470	0	437,463		9.00
10.00	DIETARY	39,147	59,872	0	21,090	303,609	10.00
11.00	CAFETERIA	36,469	28,699	0	10,109	0	11.00
13.00	NURSING ADMINISTRATION	54,309	4,593	0	1,618	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	12,477	17,529	0	6,175	0	14.00
15.00	PHARMACY	189,319	13,344	0	4,700	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	85,864	46,256	0	16,294	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	281,410	229,433	18,149	80,818	132,948	30.00
31.00	INTENSIVE CARE UNIT	191,612	92,090	12,638	32,439	62,976	31.00
40.00	SUBPROVIDER - IPF	140,286	49,327	8,478	17,375	107,685	40.00
41.00	SUBPROVIDER - IRF	524	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	31,454	91,044	556	32,070	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	172,694	129,908	9,997	45,760	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC	738,399	218,859	7,701	77,093	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	280,933	58,730	0	20,688	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	109,225	16,211	618	5,710	0	65.00
66.00	PHYSICAL THERAPY	70,669	43,959	3,431	15,485	0	66.00
67.00	OCCUPATIONAL THERAPY	27,876	15,899	144	5,600	0	67.00
68.00	SPEECH PATHOLOGY	7,986	7,202	0	2,537	0	68.00
69.00	ELECTROCARDIOLOGY	32,970	46,473	0	16,370	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,379	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	54,393	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	DIABETES SERVICES	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
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	193,463	67,047	12,604	23,617	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
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)	3,083,200	1,284,946	74,316	435,548	303,609	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,017	5,435	0	1,915	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	4,882	0	0	0	0	192.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	3,090,099	1,290,381	74,316	437,463	303,609	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150038

Period:
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Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA	246,226					11.00
13.00 NURSING ADMINISTRATION	6,818	321,910				13.00
14.00 CENTRAL SERVICES & SUPPLY	1,609	0	96,274			14.00
15.00 PHARMACY	7,566	0	0	1,102,357		15.00
16.00 MEDICAL RECORDS & LIBRARY	13,012	0	16	0	563,927	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	35,815	96,759	7,977	0	28,751	30.00
31.00 INTENSIVE CARE UNIT	22,136	59,804	3,678	0	23,171	31.00
40.00 SUBPROVIDER - IPF	17,425	47,077	887	0	17,041	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	1,777	4,800	24	0	2,560	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	15,929	43,035	12,422	0	74,553	50.00
54.00 RADIOLOGY-DIAGNOSTIC	42,462	0	6,822	0	159,932	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	23,571	0	4,060	0	95,347	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	14,473	0	2,612	0	14,174	65.00
66.00 PHYSICAL THERAPY	7,251	0	826	0	10,996	66.00
67.00 OCCUPATIONAL THERAPY	4,444	0	122	0	2,084	67.00
68.00 SPEECH PATHOLOGY	645	0	163	0	516	68.00
69.00 ELECTROCARDIOLOGY	3,577	0	248	0	19,481	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	15,323	0	6,043	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	33,368	0	3,136	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	1,102,357	28,998	73.00
76.00 DIABETES SERVICES	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
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	26,072	70,435	7,722	0	77,144	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
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)	244,582	321,910	96,270	1,102,357	563,927	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	431	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	1,213	0	4	0	0	192.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	246,226	321,910	96,274	1,102,357	563,927	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150038

Period:
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To 06/30/2011

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Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00 EMPLOYEE BENEFITS				4.00
5.00 ADMINISTRATIVE & GENERAL				5.00
7.00 OPERATION OF PLANT				7.00
8.00 LAUNDRY & LINEN SERVICE				8.00
9.00 HOUSEKEEPING				9.00
10.00 DIETARY				10.00
11.00 CAFETERIA				11.00
13.00 NURSING ADMINISTRATION				13.00
14.00 CENTRAL SERVICES & SUPPLY				14.00
15.00 PHARMACY				15.00
16.00 MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS	2,231,163	0	2,231,163	30.00
31.00 INTENSIVE CARE UNIT	1,398,723	0	1,398,723	31.00
40.00 SUBPROVIDER - IPF	1,063,169	0	1,063,169	40.00
41.00 SUBPROVIDER - IRF	2,979	0	2,979	41.00
42.00 SUBPROVIDER	0	0	0	42.00
43.00 NURSERY	311,726	0	311,726	43.00
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	1,313,798	0	1,313,798	50.00
54.00 RADIOLOGY-DIAGNOSTIC	4,712,538	0	4,712,538	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	1,800,197	0	1,800,197	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
65.00 RESPIRATORY THERAPY	675,013	0	675,013	65.00
66.00 PHYSICAL THERAPY	483,875	0	483,875	66.00
67.00 OCCUPATIONAL THERAPY	186,836	0	186,836	67.00
68.00 SPEECH PATHOLOGY	56,485	0	56,485	68.00
69.00 ELECTROCARDIOLOGY	273,665	0	273,665	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	154,335	0	154,335	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	345,864	0	345,864	72.00
73.00 DRUGS CHARGED TO PATIENTS	1,131,355	0	1,131,355	73.00
76.00 DIABETES SERVICES	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00 EMERGENCY	1,384,959	0	1,384,959	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
99.10 CORF	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS				
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)	17,526,680	0	17,526,680	118.00
NONREIMBURSABLE COST CENTERS				
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,253	0	19,253	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	28,984	0	28,984	192.00
200.00 Cross Foot Adjustments	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	17,574,917	0	17,574,917	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150038

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

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	0	4,819	1,119	5,938	4.00
5.00	ADMINISTRATIVE & GENERAL	0	104,899	24,354	129,253	5.00
7.00	OPERATION OF PLANT	0	192,392	44,670	237,062	7.00
8.00	LAUNDRY & LINEN SERVICE	0	4,030	936	4,966	8.00
9.00	HOUSEKEEPING	0	35,036	8,134	43,170	9.00
10.00	DIETARY	0	48,255	11,203	59,458	10.00
11.00	CAFETERIA	0	23,131	5,370	28,501	11.00
13.00	NURSING ADMINISTRATION	0	3,702	859	4,561	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	14,128	3,280	17,408	14.00
15.00	PHARMACY	0	10,755	2,497	13,252	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	37,281	8,655	45,936	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	184,914	42,932	227,846	30.00
31.00	INTENSIVE CARE UNIT	0	74,222	17,232	91,454	31.00
40.00	SUBPROVIDER - IPF	0	39,756	9,230	48,986	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	73,379	17,036	90,415	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	104,702	24,309	129,011	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	176,394	40,953	217,347	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	47,335	10,990	58,325	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	13,066	3,033	16,099	65.00
66.00	PHYSICAL THERAPY	0	35,430	8,226	43,656	66.00
67.00	OCCUPATIONAL THERAPY	0	12,814	2,975	15,789	67.00
68.00	SPEECH PATHOLOGY	0	5,805	1,348	7,153	68.00
69.00	ELECTROCARDIOLOGY	0	37,456	8,696	46,152	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	DIABETES SERVICES	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
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	54,037	12,546	66,583	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
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	1,337,738	310,583	1,648,321	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,381	1,017	5,398	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,342,119	311,600	1,653,719	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150038		Period: From 01/01/2011 To 06/30/2011		Worksheet B Part II Date/Time Prepared: 1/23/2012 9:16 am	
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	130,358					5.00
7.00	OPERATION OF PLANT	9,572	246,760				7.00
8.00	LAUNDRY & LINEN SERVICE	514	956	6,439			8.00
9.00	HOUSEKEEPING	2,922	8,313	0	54,563		9.00
10.00	DIETARY	1,652	11,449	0	2,630	75,248	10.00
11.00	CAFETERIA	1,539	5,488	0	1,261	0	11.00
13.00	NURSING ADMINISTRATION	2,291	878	0	202	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	526	3,352	0	770	0	14.00
15.00	PHARMACY	7,987	2,552	0	586	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	3,622	8,846	0	2,032	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	11,872	43,877	1,573	10,081	32,951	30.00
31.00	INTENSIVE CARE UNIT	8,084	17,610	1,095	4,046	15,608	31.00
40.00	SUBPROVIDER - IPF	5,918	9,433	735	2,167	26,689	40.00
41.00	SUBPROVIDER - IRF	22	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	1,327	17,410	48	4,000	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	7,286	24,842	866	5,707	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC	31,145	41,853	667	9,616	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	11,852	11,231	0	2,580	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	4,608	3,100	54	712	0	65.00
66.00	PHYSICAL THERAPY	2,981	8,406	297	1,931	0	66.00
67.00	OCCUPATIONAL THERAPY	1,176	3,040	12	699	0	67.00
68.00	SPEECH PATHOLOGY	337	1,377	0	316	0	68.00
69.00	ELECTROCARDIOLOGY	1,391	8,887	0	2,042	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	986	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	2,295	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	DIABETES SERVICES	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
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	8,162	12,821	1,092	2,946	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
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)	130,067	245,721	6,439	54,324	75,248	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	85	1,039	0	239	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	206	0	0	0	0	192.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	130,358	246,760	6,439	54,563	75,248	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150038

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

Worksheet B
Part II
Date/Time Prepared:
1/23/2012 9:16 am

Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA	36,878					11.00
13.00 NURSING ADMINISTRATION	1,021	9,083				13.00
14.00 CENTRAL SERVICES & SUPPLY	241	0	22,312			14.00
15.00 PHARMACY	1,133	0	0	25,699		15.00
16.00 MEDICAL RECORDS & LIBRARY	1,949	0	4	0	62,573	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	5,364	2,732	1,849	0	3,189	30.00
31.00 INTENSIVE CARE UNIT	3,315	1,687	852	0	2,570	31.00
40.00 SUBPROVIDER - IPF	2,610	1,328	206	0	1,890	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	266	135	5	0	284	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	2,386	1,214	2,879	0	8,269	50.00
54.00 RADIOLOGY-DIAGNOSTIC	6,358	0	1,581	0	17,765	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	3,530	0	941	0	10,575	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	2,168	0	605	0	1,572	65.00
66.00 PHYSICAL THERAPY	1,086	0	191	0	1,220	66.00
67.00 OCCUPATIONAL THERAPY	666	0	28	0	231	67.00
68.00 SPEECH PATHOLOGY	97	0	38	0	57	68.00
69.00 ELECTROCARDIOLOGY	536	0	57	0	2,161	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3,551	0	670	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	7,734	0	348	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	25,699	3,216	73.00
76.00 DIABETES SERVICES	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 EMERGENCY	3,905	1,987	1,790	0	8,556	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
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)	36,631	9,083	22,311	25,699	62,573	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	65	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	182	0	1	0	0	192.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	36,878	9,083	22,312	25,699	62,573	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150038

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

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Part II
Date/Time Prepared:
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Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00 EMPLOYEE BENEFITS				4.00
5.00 ADMINISTRATIVE & GENERAL				5.00
7.00 OPERATION OF PLANT				7.00
8.00 LAUNDRY & LINEN SERVICE				8.00
9.00 HOUSEKEEPING				9.00
10.00 DIETARY				10.00
11.00 CAFETERIA				11.00
13.00 NURSING ADMINISTRATION				13.00
14.00 CENTRAL SERVICES & SUPPLY				14.00
15.00 PHARMACY				15.00
16.00 MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS	341,928	0	341,928	30.00
31.00 INTENSIVE CARE UNIT	146,779	0	146,779	31.00
40.00 SUBPROVIDER - IPF	100,219	0	100,219	40.00
41.00 SUBPROVIDER - IRF	22	0	22	41.00
42.00 SUBPROVIDER	0	0	0	42.00
43.00 NURSERY	113,926	0	113,926	43.00
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	182,736	0	182,736	50.00
54.00 RADIOLOGY-DIAGNOSTIC	327,099	0	327,099	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	99,446	0	99,446	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
65.00 RESPIRATORY THERAPY	29,188	0	29,188	65.00
66.00 PHYSICAL THERAPY	59,944	0	59,944	66.00
67.00 OCCUPATIONAL THERAPY	21,711	0	21,711	67.00
68.00 SPEECH PATHOLOGY	9,391	0	9,391	68.00
69.00 ELECTROCARDIOLOGY	61,284	0	61,284	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	5,207	0	5,207	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	10,377	0	10,377	72.00
73.00 DRUGS CHARGED TO PATIENTS	28,915	0	28,915	73.00
76.00 DIABETES SERVICES	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00 EMERGENCY	108,321	0	108,321	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
99.10 CORF	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS				
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)	1,646,493	0	1,646,493	118.00
NONREIMBURSABLE COST CENTERS				
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,829	0	6,829	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	397	0	397	192.00
200.00 Cross Foot Adjustments	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	1,653,719	0	1,653,719	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150038

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	122,545					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		122,545				2.00
4.00	EMPLOYEE BENEFITS	440	440	7,558,522			4.00
5.00	ADMINISTRATIVE & GENERAL	9,578	9,578	1,410,269	-3,090,099	14,484,818	5.00
7.00	OPERATION OF PLANT	17,567	17,567	160,773	0	1,063,500	7.00
8.00	LAUNDRY & LINEN SERVICE	368	368	4,172	0	57,128	8.00
9.00	HOUSEKEEPING	3,199	3,199	200,678	0	324,719	9.00
10.00	DIETARY	4,406	4,406	74,765	0	183,500	10.00
11.00	CAFETERIA	2,112	2,112	112,613	0	170,949	11.00
13.00	NURSING ADMINISTRATION	338	338	166,006	0	254,572	13.00
14.00	CENTRAL SERVICES & SUPPLY	1,290	1,290	19,080	0	58,484	14.00
15.00	PHARMACY	982	982	240,975	0	887,428	15.00
16.00	MEDICAL RECORDS & LIBRARY	3,404	3,404	234,381	0	402,485	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	16,884	16,884	755,107	0	1,319,103	30.00
31.00	INTENSIVE CARE UNIT	6,777	6,777	582,339	0	898,179	31.00
40.00	SUBPROVIDER - IPF	3,630	3,630	327,386	0	657,588	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	2,455	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	6,700	6,700	45,582	0	147,441	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	9,560	9,560	351,130	0	809,500	50.00
54.00	RADIOLOGY-DIAGNOSTIC	16,106	16,106	975,650	0	3,461,270	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	4,322	4,322	524,339	0	1,316,868	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	1,193	1,193	343,965	0	511,990	65.00
66.00	PHYSICAL THERAPY	3,235	3,235	223,425	0	331,258	66.00
67.00	OCCUPATIONAL THERAPY	1,170	1,170	88,780	0	130,667	67.00
68.00	SPEECH PATHOLOGY	530	530	20,863	0	37,436	68.00
69.00	ELECTROCARDIOLOGY	3,420	3,420	73,739	0	154,546	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	109,590	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	254,967	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	DIABETES SERVICES	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	4,934	4,934	608,921	0	906,855	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
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)	122,145	122,145	7,544,938	-3,090,099	14,452,478	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	400	400	3,256	0	9,455	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	10,328	0	22,885	192.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,342,119	311,600	1,858,987		3,090,099	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	10.952050	2.542739	0.245946		0.213334	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			5,938		130,358	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000786		0.009000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150038

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (PAID HOURS)	
	7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT	94,960					7.00
8.00 LAUNDRY & LINEN SERVICE	368	15,507				8.00
9.00 HOUSEKEEPING	3,199	0	91,393			9.00
10.00 DIETARY	4,406	0	4,406	4,122		10.00
11.00 CAFETERIA	2,112	0	2,112	0	208,859	11.00
13.00 NURSING ADMINISTRATION	338	0	338	0	5,783	13.00
14.00 CENTRAL SERVICES & SUPPLY	1,290	0	1,290	0	1,365	14.00
15.00 PHARMACY	982	0	982	0	6,418	15.00
16.00 MEDICAL RECORDS & LIBRARY	3,404	0	3,404	0	11,037	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	16,884	3,787	16,884	1,805	30,380	30.00
31.00 INTENSIVE CARE UNIT	6,777	2,637	6,777	855	18,777	31.00
40.00 SUBPROVIDER - IPF	3,630	1,769	3,630	1,462	14,781	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	6,700	116	6,700	0	1,507	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	9,560	2,086	9,560	0	13,512	50.00
54.00 RADIOLOGY-DIAGNOSTIC	16,106	1,607	16,106	0	36,016	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	4,322	0	4,322	0	19,994	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	1,193	129	1,193	0	12,277	65.00
66.00 PHYSICAL THERAPY	3,235	716	3,235	0	6,151	66.00
67.00 OCCUPATIONAL THERAPY	1,170	30	1,170	0	3,770	67.00
68.00 SPEECH PATHOLOGY	530	0	530	0	547	68.00
69.00 ELECTROCARDIOLOGY	3,420	0	3,420	0	3,034	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 DIABETES SERVICES	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 EMERGENCY	4,934	2,630	4,934	0	22,115	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
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)	94,560	15,507	90,993	4,122	207,464	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	400	0	400	0	366	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	1,029	192.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	1,290,381	74,316	437,463	303,609	246,226	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	13.588679	4.792416	4.786614	73.655750	1.178910	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	246,760	6,439	54,563	75,248	36,878	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	2.598568	0.415232	0.597015	18.255216	0.176569	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150038

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	NURSING ADMINISTRATION (NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 EMPLOYEE BENEFITS					4.00
5.00 ADMINISTRATIVE & GENERAL					5.00
7.00 OPERATION OF PLANT					7.00
8.00 LAUNDRY & LINEN SERVICE					8.00
9.00 HOUSEKEEPING					9.00
10.00 DIETARY					10.00
11.00 CAFETERIA					11.00
13.00 NURSING ADMINISTRATION	101,072				13.00
14.00 CENTRAL SERVICES & SUPPLY	0	735,647			14.00
15.00 PHARMACY	0	0	100		15.00
16.00 MEDICAL RECORDS & LIBRARY	0	119	0	72,645,994	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS	30,380	60,956	0	3,703,583	30.00
31.00 INTENSIVE CARE UNIT	18,777	28,105	0	2,984,792	31.00
40.00 SUBPROVIDER - IPF	14,781	6,781	0	2,195,129	40.00
41.00 SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	42.00
43.00 NURSERY	1,507	181	0	329,778	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	13,512	94,920	0	9,603,585	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	52,129	0	20,604,988	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	31,026	0	12,282,209	60.00
60.01 BLOOD LABORATORY	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	0	19,959	0	1,825,858	65.00
66.00 PHYSICAL THERAPY	0	6,308	0	1,416,466	66.00
67.00 OCCUPATIONAL THERAPY	0	929	0	268,451	67.00
68.00 SPEECH PATHOLOGY	0	1,248	0	66,436	68.00
69.00 ELECTROCARDIOLOGY	0	1,892	0	2,509,516	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	117,087	0	778,447	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	254,967	0	403,935	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	100	3,735,464	73.00
76.00 DIABETES SERVICES	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
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	22,115	59,006	0	9,937,357	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
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)	101,072	735,613	100	72,645,994	118.00
NONREIMBURSABLE COST CENTERS					
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	34	0	0	192.00
200.00 Cross Foot Adjustments					200.00
201.00 Negative Cost Centers					201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	321,910	96,274	1,102,357	563,927	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	3.184957	0.130870	11.023.570000	0.007763	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	9,083	22,312	25,699	62,573	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.089867	0.030330	256.990000	0.000861	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150038

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

Worksheet C
Part I
Date/Time Prepared:
1/23/2012 9:16 am

		Title XVIII		Hospital		PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS		2,231,163	0	2,231,163	30.00
31.00	INTENSIVE CARE UNIT		1,398,723	0	1,398,723	31.00
40.00	SUBPROVIDER - IPF		1,063,169	0	1,063,169	40.00
41.00	SUBPROVIDER - IRF		2,979	0	2,979	41.00
42.00	SUBPROVIDER		0	0	0	42.00
43.00	NURSERY		311,726	0	311,726	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM		1,313,798	0	1,313,798	50.00
54.00	RADIOLOGY-DIAGNOSTIC		4,712,538	0	4,712,538	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		1,800,197	729	1,800,926	60.00
60.01	BLOOD LABORATORY		0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	675,013	0	675,013	65.00
66.00	PHYSICAL THERAPY	0	483,875	0	483,875	66.00
67.00	OCCUPATIONAL THERAPY	0	186,836	0	186,836	67.00
68.00	SPEECH PATHOLOGY	0	56,485	0	56,485	68.00
69.00	ELECTROCARDIOLOGY		273,665	0	273,665	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		154,335	0	154,335	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT		345,864	0	345,864	72.00
73.00	DRUGS CHARGED TO PATIENTS		1,131,355	0	1,131,355	73.00
76.00	DIABETES SERVICES		0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC		0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
91.00	EMERGENCY		1,384,959	0	1,384,959	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		546,213		546,213	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF		0		0	99.10
SPECIAL PURPOSE COST CENTERS						
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)		18,072,893	729	18,073,622	200.00
201.00	Less Observation Beds		546,213		546,213	201.00
202.00	Total (see instructions)		17,526,680	729	17,527,409	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 1/23/2012 9:16 am
		Title XVIIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	3,449,235		3,449,235			30.00
31.00 INTENSIVE CARE UNIT	2,297,918		2,297,918			31.00
40.00 SUBPROVIDER - IPF	2,195,129		2,195,129			40.00
41.00 SUBPROVIDER - IRF	0		0			41.00
42.00 SUBPROVIDER	0		0			42.00
43.00 NURSERY	314,984		314,984			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	1,585,633	8,017,952	9,603,585	0.136803	0.000000	50.00
54.00 RADIOLOGY-DIAGNOSTIC	1,706,997	18,897,991	20,604,988	0.228709	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	2,998,207	9,284,002	12,282,209	0.146569	0.000000	60.00
60.01 BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00 RESPIRATORY THERAPY	1,151,866	673,992	1,825,858	0.369696	0.000000	65.00
66.00 PHYSICAL THERAPY	246,794	1,169,672	1,416,466	0.341607	0.000000	66.00
67.00 OCCUPATIONAL THERAPY	8,268	260,183	268,451	0.695978	0.000000	67.00
68.00 SPEECH PATHOLOGY	10,068	56,368	66,436	0.850217	0.000000	68.00
69.00 ELECTROCARDIOLOGY	611,572	1,897,944	2,509,516	0.109051	0.000000	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	349,282	429,165	778,447	0.198260	0.000000	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	173,813	230,122	403,935	0.856237	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	2,451,043	1,284,421	3,735,464	0.302869	0.000000	73.00
76.00 DIABETES SERVICES	0	0	0	0.000000	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0			88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
91.00 EMERGENCY	1,482,863	8,454,494	9,937,357	0.139369	0.000000	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,854,179	1,854,179	0.294585	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0			99.10
SPECIAL PURPOSE COST CENTERS						
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)	21,033,672	52,510,485	73,544,157			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	21,033,672	52,510,485	73,544,157			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 1/23/2012 9:16 am
		Title XVIII	Hospital	PPS

Cost Center Description	PPS Inpatient Ratio		
INPATIENT ROUTINE SERVICE COST CENTERS			
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
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	0.136803		50.00
54.00 RADIOLOGY-DIAGNOSTIC	0.228709		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	0.146629		60.00
60.01 BLOOD LABORATORY	0.000000		60.01
65.00 RESPIRATORY THERAPY	0.369696		65.00
66.00 PHYSICAL THERAPY	0.341607		66.00
67.00 OCCUPATIONAL THERAPY	0.695978		67.00
68.00 SPEECH PATHOLOGY	0.850217		68.00
69.00 ELECTROCARDIOLOGY	0.109051		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.198260		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.856237		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.302869		73.00
76.00 DIABETES SERVICES	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS			
88.00 RURAL HEALTH CLINIC			88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER			89.00
91.00 EMERGENCY	0.139369		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.294585		92.00
OTHER REIMBURSABLE COST CENTERS			
99.10 CORF			99.10
SPECIAL PURPOSE COST CENTERS			
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: 150038

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

Worksheet C
Part I
Date/Time Prepared:
1/23/2012 9:16 am

		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	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS		2,231,163	0	0	30.00
31.00	INTENSIVE CARE UNIT		1,398,723	0	0	31.00
40.00	SUBPROVIDER - IPF		1,063,169	0	0	40.00
41.00	SUBPROVIDER - IRF		2,979	0	0	41.00
42.00	SUBPROVIDER		0	0	0	42.00
43.00	NURSERY		311,726	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM		1,313,798	0	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC		4,712,538	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		1,800,197	0	0	60.00
60.01	BLOOD LABORATORY		0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	675,013	0	0	65.00
66.00	PHYSICAL THERAPY	0	483,875	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	186,836	0	0	67.00
68.00	SPEECH PATHOLOGY	0	56,485	0	0	68.00
69.00	ELECTROCARDIOLOGY		273,665	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		154,335	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT		345,864	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS		1,131,355	0	0	73.00
76.00	DIABETES SERVICES		0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC		0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
91.00	EMERGENCY		1,384,959	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		546,213	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF		0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
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)		18,072,893	0	0	200.00
201.00	Less Observation Beds		546,213	0	0	201.00
202.00	Total (see instructions)		17,526,680	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 1/23/2012 9:16 am
		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			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	3,449,235		3,449,235			30.00
31.00 INTENSIVE CARE UNIT	2,297,918		2,297,918			31.00
40.00 SUBPROVIDER - IPF	2,195,129		2,195,129			40.00
41.00 SUBPROVIDER - IRF	0		0			41.00
42.00 SUBPROVIDER	0		0			42.00
43.00 NURSERY	314,984		314,984			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	1,585,633	8,017,952	9,603,585	0.136803	0.000000	50.00
54.00 RADIOLOGY-DIAGNOSTIC	1,706,997	18,897,991	20,604,988	0.228709	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	2,998,207	9,284,002	12,282,209	0.146569	0.000000	60.00
60.01 BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00 RESPIRATORY THERAPY	1,151,866	673,992	1,825,858	0.369696	0.000000	65.00
66.00 PHYSICAL THERAPY	246,794	1,169,672	1,416,466	0.341607	0.000000	66.00
67.00 OCCUPATIONAL THERAPY	8,268	260,183	268,451	0.695978	0.000000	67.00
68.00 SPEECH PATHOLOGY	10,068	56,368	66,436	0.850217	0.000000	68.00
69.00 ELECTROCARDIOLOGY	611,572	1,897,944	2,509,516	0.109051	0.000000	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	349,282	429,165	778,447	0.198260	0.000000	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	173,813	230,122	403,935	0.856237	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	2,451,043	1,284,421	3,735,464	0.302869	0.000000	73.00
76.00 DIABETES SERVICES	0	0	0	0.000000	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
91.00 EMERGENCY	1,482,863	8,454,494	9,937,357	0.139369	0.000000	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,854,179	1,854,179	0.294585	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0			99.10
SPECIAL PURPOSE COST CENTERS						
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)	21,033,672	52,510,485	73,544,157			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	21,033,672	52,510,485	73,544,157			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 1/23/2012 9:16 am
	Title XIX	Hospital	Cost

Cost Center Description	PPS Inpatient Ratio		
INPATIENT ROUTINE SERVICE COST CENTERS			
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
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	0.000000		50.00
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
67.00 OCCUPATIONAL THERAPY	0.000000		67.00
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 PATIENT	0.000000		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00 DIABETES SERVICES	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS			
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
OTHER REIMBURSABLE COST CENTERS			
99.10 CORF			99.10
SPECIAL PURPOSE COST CENTERS			
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

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet C Part II Date/Time Prepared: 1/23/2012 9:16 am
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Cost Center Description		Title XIX			Hospital		Cost
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	1,313,798	182,736	1,131,062	0	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC	4,712,538	327,099	4,385,439	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	1,800,197	99,446	1,700,751	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	675,013	29,188	645,825	0	0	65.00
66.00	PHYSICAL THERAPY	483,875	59,944	423,931	0	0	66.00
67.00	OCCUPATIONAL THERAPY	186,836	21,711	165,125	0	0	67.00
68.00	SPEECH PATHOLOGY	56,485	9,391	47,094	0	0	68.00
69.00	ELECTROCARDIOLOGY	273,665	61,284	212,381	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	154,335	5,207	149,128	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	345,864	10,377	335,487	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,131,355	28,915	1,102,440	0	0	73.00
76.00	DIABETES SERVICES	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
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	1,384,959	108,321	1,276,638	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	546,213	0	546,213	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
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						113.00
200.00	Subtotal (sum of lines 50 thru 199)	13,065,133	943,619	12,121,514	0	0	200.00
201.00	Less Observation Beds	546,213	0	546,213	0	0	201.00
202.00	Total (line 200 minus line 201)	12,518,920	397,406	11,575,301	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY	Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet C Part II Date/Time Prepared: 1/23/2012 9:16 am
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Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Cost
		6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	1,313,798	9,603,585	0.136803	50.00
54.00	RADIOLOGY-DIAGNOSTIC	4,712,538	20,604,988	0.228709	54.00
57.00	CT SCAN	0	0	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	59.00
60.00	LABORATORY	1,800,197	12,282,209	0.146569	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	60.01
65.00	RESPIRATORY THERAPY	675,013	1,825,858	0.369696	65.00
66.00	PHYSICAL THERAPY	483,875	1,416,466	0.341607	66.00
67.00	OCCUPATIONAL THERAPY	186,836	268,451	0.695978	67.00
68.00	SPEECH PATHOLOGY	56,485	66,436	0.850217	68.00
69.00	ELECTROCARDIOLOGY	273,665	2,509,516	0.109051	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	154,335	778,447	0.198260	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	345,864	403,935	0.856237	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,131,355	3,735,464	0.302869	73.00
76.00	DIABETES SERVICES	0	0	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0.000000	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	89.00
91.00	EMERGENCY	1,384,959	9,937,357	0.139369	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	546,213	1,854,179	0.294585	92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	CORF	0	0	0.000000	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	PANCREAS ACQUISITION	0	0	0.000000	109.00
110.00	INTESTINAL ACQUISITION	0	0	0.000000	110.00
111.00	ISLET ACQUISITION	0	0	0.000000	111.00
113.00	INTEREST EXPENSE				113.00
200.00	Subtotal (sum of lines 50 thru 199)	13,065,133	0		200.00
201.00	Less Observation Beds	546,213	0		201.00
202.00	Total (line 200 minus line 201)	12,518,920	138,831,048		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part I Date/Time Prepared: 1/23/2012 9:16 am
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Cost Center Description	Title XVIII			Hospital	PPS	
	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	341,928	0	341,928	2,312	147.89	30.00
31.00 INTENSIVE CARE UNIT	146,779	0	146,779	855	171.67	31.00
40.00 SUBPROVIDER - IPF	100,219	0	100,219	1,462	68.55	40.00
41.00 SUBPROVIDER - IRF	22	0	22	0	0.00	41.00
42.00 SUBPROVIDER	0	0	0	0	0.00	42.00
43.00 NURSERY	113,926		113,926	185	615.82	43.00
200.00 Total (lines 30-199)	702,874		702,874	4,814		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part I Date/Time Prepared: 1/23/2012 9:16 am
		Title XVIII	Hospital	PPS

Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
	6.00	7.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS	1,122	165,933		30.00
31.00 INTENSIVE CARE UNIT	489	83,947		31.00
40.00 SUBPROVIDER - IPF	1,146	78,558		40.00
41.00 SUBPROVIDER - IRF	0	0		41.00
42.00 SUBPROVIDER	0	0		42.00
43.00 NURSERY	0	0		43.00
200.00 Total (lines 30-199)	2,757	328,438		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part II Date/Time Prepared: 1/23/2012 9:16 am
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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	
Title XVIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	182,736	9,603,585	0.019028	810,035	15,413	50.00
54.00	RADIOLOGY-DIAGNOSTIC	327,099	20,604,988	0.015875	965,870	15,333	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	99,446	12,282,209	0.008097	1,760,934	14,258	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	29,188	1,825,858	0.015986	496,599	7,939	65.00
66.00	PHYSICAL THERAPY	59,944	1,416,466	0.042319	147,530	6,243	66.00
67.00	OCCUPATIONAL THERAPY	21,711	268,451	0.080875	5,764	466	67.00
68.00	SPEECH PATHOLOGY	9,391	66,436	0.141354	4,065	575	68.00
69.00	ELECTROCARDIOLOGY	61,284	2,509,516	0.024421	414,762	10,129	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,207	778,447	0.006689	306,995	2,053	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	10,377	403,935	0.025690	108,857	2,797	72.00
73.00	DRUGS CHARGED TO PATIENTS	28,915	3,735,464	0.007741	1,395,193	10,800	73.00
76.00	DIABETES SERVICES	0	0	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
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	108,321	9,937,357	0.010900	846,832	9,230	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	83,708	1,854,179	0.045146	0	0	92.00
200.00	Total (lines 50-199)	1,027,327	65,286,891		7,263,436	95,236	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150038		Period: From 01/01/2011 To 06/30/2011		Worksheet D Part III Date/Time Prepared: 1/23/2012 9:16 am	
Cost Center Description		Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	PPS Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	SUBPROVIDER - IPF	0	0	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	0	0	0	0	0	43.00
200.00	Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part III Date/Time Prepared: 1/23/2012 9:16 am
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Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	Title XVIII Hospital PPS	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,312	0.00	1,122	0		30.00
31.00 INTENSIVE CARE UNIT	855	0.00	489	0		31.00
40.00 SUBPROVIDER - IPF	1,462	0.00	1,146	0		40.00
41.00 SUBPROVIDER - IRF	0	0.00	0	0		41.00
42.00 SUBPROVIDER	0	0.00	0	0		42.00
43.00 NURSERY	185	0.00	0	0		43.00
200.00 Total (lines 30-199)	4,814		2,757	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/23/2012 9:16 am
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Cost Center Description	Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS								
50.00 OPERATING ROOM	0	0	0	0	0	0	0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	0	54.00
57.00 CT SCAN	0	0	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	0	0	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	0	73.00
76.00 DIABETES SERVICES	0	0	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	0	89.00
91.00 EMERGENCY	0	0	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/23/2012 9:16 am
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Cost Center Description		Title XVIII			Hospital		PPS
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	9,603,585	0.000000	0.000000	810,035	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	20,604,988	0.000000	0.000000	965,870	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	12,282,209	0.000000	0.000000	1,760,934	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	RESPIRATORY THERAPY	0	1,825,858	0.000000	0.000000	496,599	65.00
66.00	PHYSICAL THERAPY	0	1,416,466	0.000000	0.000000	147,530	66.00
67.00	OCCUPATIONAL THERAPY	0	268,451	0.000000	0.000000	5,764	67.00
68.00	SPEECH PATHOLOGY	0	66,436	0.000000	0.000000	4,065	68.00
69.00	ELECTROCARDIOLOGY	0	2,509,516	0.000000	0.000000	414,762	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	778,447	0.000000	0.000000	306,995	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	403,935	0.000000	0.000000	108,857	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	3,735,464	0.000000	0.000000	1,395,193	73.00
76.00	DIABETES SERVICES	0	0	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS							
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	9,937,357	0.000000	0.000000	846,832	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,854,179	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	65,286,891			7,263,436	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/23/2012 9:16 am
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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	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	2,088,201	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	7,063,581	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	249,935	0	60.00
60.01	BLOOD LABORATORY	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	30,047	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	894,287	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	203,463	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	47,716	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	452,093	0	73.00
76.00	DIABETES SERVICES	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
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	1,542,582	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	455,744	0	92.00
200.00	Total (Lines 50-199)	0	13,027,649	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/23/2012 9:16 am
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services		Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	
			Subject To Ded. & Coins. (see instructions)	Subject To Ded. & Coins. (see instructions)		
	1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0.136803	2,088,201	0	1		50.00
54.00 RADIOLOGY-DIAGNOSTIC	0.228709	7,063,581	0	239		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	0.146569	249,935	0	1		60.00
60.01 BLOOD LABORATORY	0.000000	0	0	0		60.01
65.00 RESPIRATORY THERAPY	0.369696	30,047	0	0		65.00
66.00 PHYSICAL THERAPY	0.341607	0	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0.695978	0	0	0		67.00
68.00 SPEECH PATHOLOGY	0.850217	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	0.109051	894,287	-1,212	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.198260	203,463	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.856237	47,716	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.302869	452,093	0	0		73.00
76.00 DIABETES SERVICES	0.000000	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0.000000					88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
91.00 EMERGENCY	0.139369	1,542,582	0	3		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.294585	455,744	0	0		92.00
200.00 Subtotal (see instructions)		13,027,649	-1,212	244		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00 Net Charges (line 200 +/- line 201)		13,027,649	-1,212	244		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/23/2012 9:16 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	285,672	0	0		50.00
54.00 RADIOLOGY-DIAGNOSTIC	1,615,505	0	55		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	36,633	0	0		60.00
60.01 BLOOD LABORATORY	0	0	0		60.01
65.00 RESPIRATORY THERAPY	11,108	0	0		65.00
66.00 PHYSICAL THERAPY	0	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	97,523	-132	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	40,339	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	40,856	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	136,925	0	0		73.00
76.00 DIABETES SERVICES	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00 EMERGENCY	214,988	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	134,255	0	0		92.00
200.00 Subtotal (see instructions)	2,613,804	-132	55		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	2,613,804	-132	55		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 150038 Component CCN: 15S038	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part II Date/Time Prepared: 1/23/2012 9:16 am
	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	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	182,736	9,603,585	0.019028	0	0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	327,099	20,604,988	0.015875	27,456	436	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	99,446	12,282,209	0.008097	269,718	2,184	60.00
60.01 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00 RESPIRATORY THERAPY	29,188	1,825,858	0.015986	51,402	822	65.00
66.00 PHYSICAL THERAPY	59,944	1,416,466	0.042319	33,915	1,435	66.00
67.00 OCCUPATIONAL THERAPY	21,711	268,451	0.080875	0	0	67.00
68.00 SPEECH PATHOLOGY	9,391	66,436	0.141354	0	0	68.00
69.00 ELECTROCARDIOLOGY	61,284	2,509,516	0.024421	2,424	59	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	5,207	778,447	0.006689	10,702	72	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	10,377	403,935	0.025690	118	3	72.00
73.00 DRUGS CHARGED TO PATIENTS	28,915	3,735,464	0.007741	380,869	2,948	73.00
76.00 DIABETES SERVICES	0	0	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
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	108,321	9,937,357	0.010900	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	83,708	1,854,179	0.045146	0	0	92.00
200.00 Total (Lines 50-199)	1,027,327	65,286,891		776,604	7,959	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150038 Component CCN: 15S038	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/23/2012 9:16 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	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	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	DIABETES SERVICES	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
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	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150038 Component CCN: 15S038	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/23/2012 9:16 am
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	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	9,603,585	0.000000	0.000000	0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	20,604,988	0.000000	0.000000	27,456	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	12,282,209	0.000000	0.000000	269,718	60.00
60.01 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00 RESPIRATORY THERAPY	0	1,825,858	0.000000	0.000000	51,402	65.00
66.00 PHYSICAL THERAPY	0	1,416,466	0.000000	0.000000	33,915	66.00
67.00 OCCUPATIONAL THERAPY	0	268,451	0.000000	0.000000	0	67.00
68.00 SPEECH PATHOLOGY	0	66,436	0.000000	0.000000	0	68.00
69.00 ELECTROCARDIOLOGY	0	2,509,516	0.000000	0.000000	2,424	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	778,447	0.000000	0.000000	10,702	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	403,935	0.000000	0.000000	118	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	3,735,464	0.000000	0.000000	380,869	73.00
76.00 DIABETES SERVICES	0	0	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS						
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	9,937,357	0.000000	0.000000	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,854,179	0.000000	0.000000	0	92.00
200.00 Total (Lines 50-199)	0	65,286,891			776,604	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150038	Period: From 01/01/2011	Worksheet D Part IV Date/Time Prepared: 1/23/2012 9:16 am
	Component CCN: 15S038	To 06/30/2011	
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	
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	0	0	50.00
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
67.00 OCCUPATIONAL THERAPY	0	0	0	67.00
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 PATIENT	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00 DIABETES SERVICES	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
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
200.00 Total (Lines 50-199)	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 150038 Component CCN: 15T038	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part II Date/Time Prepared: 1/23/2012 9:16 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	182,736	9,603,585	0.019028	0	0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	327,099	20,604,988	0.015875	0	0	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	99,446	12,282,209	0.008097	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00 RESPIRATORY THERAPY	29,188	1,825,858	0.015986	0	0	65.00
66.00 PHYSICAL THERAPY	59,944	1,416,466	0.042319	0	0	66.00
67.00 OCCUPATIONAL THERAPY	21,711	268,451	0.080875	0	0	67.00
68.00 SPEECH PATHOLOGY	9,391	66,436	0.141354	0	0	68.00
69.00 ELECTROCARDIOLOGY	61,284	2,509,516	0.024421	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	5,207	778,447	0.006689	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	10,377	403,935	0.025690	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	28,915	3,735,464	0.007741	0	0	73.00
76.00 DIABETES SERVICES	0	0	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
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	108,321	9,937,357	0.010900	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	83,708	1,854,179	0.045146	0	0	92.00
200.00 Total (lines 50-199)	1,027,327	65,286,891		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150038 Component CCN: 15T038	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/23/2012 9:16 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	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	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	DIABETES SERVICES	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
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	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150038 Component CCN: 15T038	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/23/2012 9:16 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	9,603,585	0.000000	0.000000		0 50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	20,604,988	0.000000	0.000000		0 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	12,282,209	0.000000	0.000000		0 60.00
60.01 BLOOD LABORATORY	0	0	0.000000	0.000000		0 60.01
65.00 RESPIRATORY THERAPY	0	1,825,858	0.000000	0.000000		0 65.00
66.00 PHYSICAL THERAPY	0	1,416,466	0.000000	0.000000		0 66.00
67.00 OCCUPATIONAL THERAPY	0	268,451	0.000000	0.000000		0 67.00
68.00 SPEECH PATHOLOGY	0	66,436	0.000000	0.000000		0 68.00
69.00 ELECTROCARDIOLOGY	0	2,509,516	0.000000	0.000000		0 69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	778,447	0.000000	0.000000		0 71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	403,935	0.000000	0.000000		0 72.00
73.00 DRUGS CHARGED TO PATIENTS	0	3,735,464	0.000000	0.000000		0 73.00
76.00 DIABETES SERVICES	0	0	0.000000	0.000000		0 76.00
OUTPATIENT SERVICE COST CENTERS						
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	9,937,357	0.000000	0.000000		0 91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,854,179	0.000000	0.000000		0 92.00
200.00 Total (Lines 50-199)	0	65,286,891				0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150038 Component CCN: 15T038	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/23/2012 9:16 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	0	0	50.00
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
67.00 OCCUPATIONAL THERAPY	0	0	0	67.00
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 PATIENT	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00 DIABETES SERVICES	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
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
200.00 Total (Lines 50-199)	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part I Date/Time Prepared: 1/23/2012 9:16 am
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Cost Center Description	Title XIX			Hospital	Cost	
	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	341,928	0	341,928	2,312	147.89	30.00
31.00 INTENSIVE CARE UNIT	146,779	0	146,779	855	171.67	31.00
40.00 SUBPROVIDER - IPF	100,219	0	100,219	1,462	68.55	40.00
41.00 SUBPROVIDER - IRF	22	0	22	0	0.00	41.00
42.00 SUBPROVIDER	0	0	0	0	0.00	42.00
43.00 NURSERY	113,926		113,926	185	615.82	43.00
200.00 Total (lines 30-199)	702,874		702,874	4,814		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part I Date/Time Prepared: 1/23/2012 9:16 am
		Title XIX	Hospital	Cost

Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
	6.00	7.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS	306	45,254		30.00
31.00 INTENSIVE CARE UNIT	128	21,974		31.00
40.00 SUBPROVIDER - IPF	52	3,565		40.00
41.00 SUBPROVIDER - IRF	0	0		41.00
42.00 SUBPROVIDER	0	0		42.00
43.00 NURSERY	88	54,192		43.00
200.00 Total (lines 30-199)	574	124,985		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part II Date/Time Prepared: 1/23/2012 9:16 am
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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	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	182,736	9,603,585	0.019028	259,721	4,942	50.00
54.00	RADIOLOGY-DIAGNOSTIC	327,099	20,604,988	0.015875	246,661	3,916	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	99,446	12,282,209	0.008097	371,824	3,011	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	29,188	1,825,858	0.015986	102,486	1,638	65.00
66.00	PHYSICAL THERAPY	59,944	1,416,466	0.042319	23,274	985	66.00
67.00	OCCUPATIONAL THERAPY	21,711	268,451	0.080875	1,721	139	67.00
68.00	SPEECH PATHOLOGY	9,391	66,436	0.141354	3,975	562	68.00
69.00	ELECTROCARDIOLOGY	61,284	2,509,516	0.024421	67,833	1,657	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,207	778,447	0.006689	31,585	211	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	10,377	403,935	0.025690	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	28,915	3,735,464	0.007741	344,271	2,665	73.00
76.00	DIABETES SERVICES	0	0	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
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	108,321	9,937,357	0.010900	190,772	2,079	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,854,179	0.000000	-7,335	0	92.00
200.00	Total (lines 50-199)	943,619	65,286,891		1,636,788	21,805	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150038		Period: From 01/01/2011 To 06/30/2011		Worksheet D Part III Date/Time Prepared: 1/23/2012 9:16 am	
Cost Center Description		Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	Cost Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	SUBPROVIDER - IPF	0	0	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	0	0	0	0	0	43.00
200.00	Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part III Date/Time Prepared: 1/23/2012 9:16 am
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Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	Cost	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,312	0.00	306	0		30.00
31.00 INTENSIVE CARE UNIT	855	0.00	128	0		31.00
40.00 SUBPROVIDER - IPF	1,462	0.00	52	0		40.00
41.00 SUBPROVIDER - IRF	0	0.00	0	0		41.00
42.00 SUBPROVIDER	0	0.00	0	0		42.00
43.00 NURSERY	185	0.00	88	0		43.00
200.00 Total (lines 30-199)	4,814		574	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/23/2012 9:16 am
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Cost Center Description	Title XIX				Hospital	Cost	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0	0	0	0	0	0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
57.00 CT SCAN	0	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00 DIABETES SERVICES	0	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
91.00 EMERGENCY	0	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150038

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

Worksheet D
Part IV
Date/Time Prepared:
1/23/2012 9:16 am

Cost Center Description		Title XIX			Hospital		Cost
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	9,603,585	0.000000	0.000000	259,721	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	20,604,988	0.000000	0.000000	246,661	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	12,282,209	0.000000	0.000000	371,824	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	RESPIRATORY THERAPY	0	1,825,858	0.000000	0.000000	102,486	65.00
66.00	PHYSICAL THERAPY	0	1,416,466	0.000000	0.000000	23,274	66.00
67.00	OCCUPATIONAL THERAPY	0	268,451	0.000000	0.000000	1,721	67.00
68.00	SPEECH PATHOLOGY	0	66,436	0.000000	0.000000	3,975	68.00
69.00	ELECTROCARDIOLOGY	0	2,509,516	0.000000	0.000000	67,833	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	778,447	0.000000	0.000000	31,585	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	403,935	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	3,735,464	0.000000	0.000000	344,271	73.00
76.00	DIABETES SERVICES	0	0	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS							
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	9,937,357	0.000000	0.000000	190,772	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,854,179	0.000000	0.000000	-7,335	92.00
200.00	Total (lines 50-199)	0	65,286,891			1,636,788	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150038

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

Worksheet D
Part IV
Date/Time Prepared:
1/23/2012 9:16 am

Cost Center Description		Title XIX			Hospital	Cost
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0		50.00
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
67.00	OCCUPATIONAL THERAPY	0	0	0		67.00
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 PATIENT	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	DIABETES SERVICES	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS						
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
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/23/2012 9:16 am
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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	
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.136803	0	0	1,439,232	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0.228709	0	0	2,645,280	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	0.146569	0	0	1,251,424	60.00
60.01 BLOOD LABORATORY	0.000000	0	0	0	60.01
65.00 RESPIRATORY THERAPY	0.369696	0	0	139,272	65.00
66.00 PHYSICAL THERAPY	0.341607	0	0	140,152	66.00
67.00 OCCUPATIONAL THERAPY	0.695978	0	0	13,011	67.00
68.00 SPEECH PATHOLOGY	0.850217	0	0	34,527	68.00
69.00 ELECTROCARDIOLOGY	0.109051	0	0	189,694	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.198260	0	0	112,128	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.856237	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.302869	0	0	164,152	73.00
76.00 DIABETES SERVICES	0.000000	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0.000000				88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
91.00 EMERGENCY	0.139369	0	0	194,480	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.294585	0	0	277,347	92.00
200.00 Subtotal (see instructions)		0	0	6,600,699	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	6,600,699	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/23/2012 9:16 am
	Title XIX	Hospital	Cost

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	0	196,891		50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	604,999		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	183,420		60.00
60.01 BLOOD LABORATORY	0	0	0		60.01
65.00 RESPIRATORY THERAPY	0	0	51,488		65.00
66.00 PHYSICAL THERAPY	0	0	47,877		66.00
67.00 OCCUPATIONAL THERAPY	0	0	9,055		67.00
68.00 SPEECH PATHOLOGY	0	0	29,355		68.00
69.00 ELECTROCARDIOLOGY	0	0	20,686		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	22,230		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	49,717		73.00
76.00 DIABETES SERVICES	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS					
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	27,104		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	81,702		92.00
200.00 Subtotal (see instructions)	0	0	1,324,524		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges					201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	1,324,524		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 1/23/2012 9:16 am
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,312	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,312	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)		2,312	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)		1,122	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,231,163	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)		2,231,163	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		3,449,235	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		3,449,235	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.646857	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)		1,491.88	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)		2,231,163	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		965.04	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,082,775	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)		1,082,775	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/23/2012 9:16 am		
Cost Center Description			Title XVIII		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	1,398,723	855	1,635.93	489	799,970	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,571,263	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,454,008	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)					249,880	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					95,236	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					345,116	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,108,892	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)					566	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					965.04	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					546,213	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150038		Period: From 01/01/2011 To 06/30/2011		Worksheet D-1 Date/Time Prepared: 1/23/2012 9:16 am	
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	341,928	2,231,163	0.153251	546,213	83,708	90.00
91.00	Nursing School cost	0	2,231,163	0.000000	546,213	0	91.00
92.00	Allied health cost	0	2,231,163	0.000000	546,213	0	92.00
93.00	All other Medical Education	0	2,231,163	0.000000	546,213	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet D-1
		Component CCN: 15S038		Date/Time Prepared: 1/23/2012 9:16 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,462	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,462	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)		1,462	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)		1,146	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,063,169	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,063,169	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,195,129	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,195,129	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.484331	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)		1,501.46	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,063,169	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		727.20	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		833,371	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)		833,371	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150038		Period: From 01/01/2011 To 06/30/2011		Worksheet D-1	
		Component CCN: 15S038				Date/Time Prepared: 1/23/2012 9:16 am	
		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	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)					194,256		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,027,627		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)					78,558		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					7,959		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					86,517		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					941,110		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet D-1
		Component CCN: 15S038		Date/Time Prepared: 1/23/2012 9:16 am
		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	100,219	1,063,169	0.094264	0	0	90.00
91.00 Nursing School cost	0	1,063,169	0.000000	0	0	91.00
92.00 Allied health cost	0	1,063,169	0.000000	0	0	92.00
93.00 All other Medical Education	0	1,063,169	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet D-1
		Component CCN: 15T038		Date/Time Prepared: 1/23/2012 9:16 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			0 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			0 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)			0 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			0 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)		2,979	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)		2,979	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
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)		2,979	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		0.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	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)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST					Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet D-1
					Component CCN: 15T038		Date/Time Prepared: 1/23/2012 9:16 am
					Title XVIII	Subprovider - IRF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
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)						0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						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	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150038 Component CCN: 15T038		Period: From 01/01/2011 To 06/30/2011		Worksheet D-1 Date/Time Prepared: 1/23/2012 9:16 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	22	2,979	0.007385	0	0	90.00
91.00	Nursing School cost	0	2,979	0.000000	0	0	91.00
92.00	Allied health cost	0	2,979	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,979	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 1/23/2012 9:16 am
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,312	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,312	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)		2,312	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)		306	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)		185	15.00
16.00	Nursery days (title V or XIX only)		88	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,231,163	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)		2,231,163	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		3,449,235	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		3,449,235	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.646857	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)		1,491.88	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)		2,231,163	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		965.04	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		295,302	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)		295,302	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/23/2012 9:16 am		
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)	311,726	185	1,685.01	88	148,281	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	1,398,723	855	1,635.93	128	209,399	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)					339,216	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					992,198	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)					566	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					965.04	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					546,213	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150038		Period: From 01/01/2011 To 06/30/2011		Worksheet D-1 Date/Time Prepared: 1/23/2012 9:16 am	
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: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet D-3 Date/Time Prepared: 1/23/2012 9:16 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		1,580,259		30.00
31.00	INTENSIVE CARE UNIT		1,229,944		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
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.136803	810,035	110,815	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0.228709	965,870	220,903	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	0.146629	1,760,934	258,204	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0.369696	496,599	183,591	65.00
66.00	PHYSICAL THERAPY	0.341607	147,530	50,397	66.00
67.00	OCCUPATIONAL THERAPY	0.695978	5,764	4,012	67.00
68.00	SPEECH PATHOLOGY	0.850217	4,065	3,456	68.00
69.00	ELECTROCARDIOLOGY	0.109051	414,762	45,230	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.198260	306,995	60,865	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.856237	108,857	93,207	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.302869	1,395,193	422,561	73.00
76.00	DIABETES SERVICES	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	EMERGENCY	0.139369	846,832	118,022	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.294585	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		7,263,436	1,571,263	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		7,263,436		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150038 Component CCN: 15S038	Period: From 01/01/2011 To 06/30/2011	Worksheet D-3 Date/Time Prepared: 1/23/2012 9:16 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		0	30.00
31.00	INTENSIVE CARE UNIT		0	31.00
40.00	SUBPROVIDER - IPF		1,722,833	40.00
41.00	SUBPROVIDER - IRF		0	41.00
42.00	SUBPROVIDER		0	42.00
43.00	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.136803	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0.228709	27,456	54.00
57.00	CT SCAN	0.000000	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	LABORATORY	0.146629	269,718	60.00
60.01	BLOOD LABORATORY	0.000000	0	60.01
65.00	RESPIRATORY THERAPY	0.369696	51,402	65.00
66.00	PHYSICAL THERAPY	0.341607	33,915	66.00
67.00	OCCUPATIONAL THERAPY	0.695978	0	67.00
68.00	SPEECH PATHOLOGY	0.850217	0	68.00
69.00	ELECTROCARDIOLOGY	0.109051	2,424	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.198260	10,702	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.856237	118	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.302869	380,869	73.00
76.00	DIABETES SERVICES	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
91.00	EMERGENCY	0.139369	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.294585	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		776,604	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net Charges (line 200 minus line 201)		776,604	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet D-3
		Component CCN: 15T038	Date/Time Prepared: 1/23/2012 9:16 am	
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	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			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.136803	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0.228709	0	54.00
57.00	CT SCAN	0.000000	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	LABORATORY	0.146629	0	60.00
60.01	BLOOD LABORATORY	0.000000	0	60.01
65.00	RESPIRATORY THERAPY	0.369696	0	65.00
66.00	PHYSICAL THERAPY	0.341607	0	66.00
67.00	OCCUPATIONAL THERAPY	0.695978	0	67.00
68.00	SPEECH PATHOLOGY	0.850217	0	68.00
69.00	ELECTROCARDIOLOGY	0.109051	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.198260	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.856237	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.302869	0	73.00
76.00	DIABETES SERVICES	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
91.00	EMERGENCY	0.139369	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.294585	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net Charges (line 200 minus line 201)		0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet D-3 Date/Time Prepared: 1/23/2012 9:16 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		781,602		30.00
31.00	INTENSIVE CARE UNIT		261,655		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		198,285		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.136803	259,721	35,531	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0.228709	246,661	56,414	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	0.146569	371,824	54,498	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0.369696	102,486	37,889	65.00
66.00	PHYSICAL THERAPY	0.341607	23,274	7,951	66.00
67.00	OCCUPATIONAL THERAPY	0.695978	1,721	1,198	67.00
68.00	SPEECH PATHOLOGY	0.850217	3,975	3,380	68.00
69.00	ELECTROCARDIOLOGY	0.109051	67,833	7,397	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.198260	31,585	6,262	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.856237	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.302869	344,271	104,269	73.00
76.00	DIABETES SERVICES	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
91.00	EMERGENCY	0.139369	190,772	26,588	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.294585	-7,335	-2,161	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,636,788	339,216	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)		1,636,788		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet D-3
		Component CCN: 15S038	Date/Time Prepared: 1/23/2012 9:16 am	
		Title XIX	Subprovider - IPF	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		0	30.00
31.00	INTENSIVE CARE UNIT		0	31.00
40.00	SUBPROVIDER - IPF		73,422	40.00
41.00	SUBPROVIDER - IRF		0	41.00
42.00	SUBPROVIDER		0	42.00
43.00	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.000000	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000	2,043	54.00
57.00	CT SCAN	0.000000	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	LABORATORY	0.000000	11,384	60.00
60.01	BLOOD LABORATORY	0.000000	0	60.01
65.00	RESPIRATORY THERAPY	0.000000	1,769	65.00
66.00	PHYSICAL THERAPY	0.000000	4,734	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	ELECTROCARDIOLOGY	0.000000	3,006	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000	18,866	73.00
76.00	DIABETES SERVICES	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
91.00	EMERGENCY	0.000000	2,755	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		44,557	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net Charges (line 200 minus line 201)		44,557	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet E Part A Date/Time Prepared: 1/23/2012 9:16 am
		Title XVIIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		2,315,963	1.00
2.00	Outlier payments for discharges. (see instructions)		32,784	2.00
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		57.87	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.79	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		20.20	31.00
32.00	Sum of lines 30 and 31		25.99	32.00
33.00	Allowable disproportionate share percentage (see instructions)		10.75	33.00
34.00	Disproportionate share adjustment (see instructions)		248,966	34.00
Additional payment for high percentage of ESRD beneficiary discharges				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0	46.00
47.00	Subtotal (see instructions)		2,597,713	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		2,597,713	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		193,183	50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0	56.00
57.00	Routine service other pass through costs		0	57.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet E Part A Date/Time Prepared: 1/23/2012 9:16 am
		Title XVIII	Hospital	PPS
				1.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)			0 58.00
59.00	Total (sum of amounts on lines 49 through 58)			2,790,896 59.00
60.00	Primary payer payments			3,221 60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			2,787,675 61.00
62.00	Deductibles billed to program beneficiaries			313,468 62.00
63.00	Coinsurance billed to program beneficiaries			566 63.00
64.00	Allowable bad debts (see instructions)			15,216 64.00
65.00	Adjusted reimbursable bad debts (see instructions)			10,651 65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			2,484,292 67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)			0 68.00
69.00	Outlier payments reconciliation			0 69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 70.00
70.95	Recovery of Accelerated Depreciation			0 70.95
70.96	Low Volume Payment-1			0 70.96
70.97	Low Volume Payment-2			0 70.97
70.98	Low Volume Payment-3			0 70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			2,484,292 71.00
72.00	Interim payments			2,499,129 72.00
73.00	Tentative settlement (for contractor use only)			0 73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)			-14,837 74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 75.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Operating outlier amount from Worksheet E, Part A line 2			0 90.00
91.00	Capital outlier from Worksheet L, Part I, line 2			0 91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0 92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0 93.00
94.00	The rate used to calculate the Time Value of Money			0.00 94.00
95.00	Time Value of Money for operating expenses(see instructions)			0 95.00
96.00	Time Value of Money for capital related expenses (see instructions)			0 96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/23/2012 9:16 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		-77	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		2,613,804	2.00
3.00	PPS payments		1,977,372	3.00
4.00	Outlier payment (see instructions)		17,744	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)		-77	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		-968	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)		-968	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		-968	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)		891	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		-968	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)		1,995,116	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		468,032	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)		1,526,116	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)		1,526,116	30.00
31.00	Primary payer payments		2,400	31.00
32.00	Subtotal (line 30 minus line 31)		1,523,716	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		6,633	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		4,643	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)		1,528,359	37.00
38.00	MSP-LCC reconciliation amount from PS&R		88	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)		1,528,271	40.00
41.00	Interim payments		1,524,660	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)		3,611	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150038 Component CCN: 15S038	Period: From 01/01/2011 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/23/2012 9:16 am
		Title XVIIII	Subprovider - IPF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		0	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		0	40.00
41.00	Interim payments		0	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 150038		Period: From 01/01/2011 To 06/30/2011		Worksheet E-1 Part I Date/Time Prepared: 1/23/2012 9:16 am	
		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		2,488,926		1,524,660	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	08/25/2011	10,203		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)		10,203		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)		2,499,129		1,524,660	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		3,611	6.01	
6.02	SETTLEMENT TO PROGRAM		14,837		0	6.02	
7.00	Total Medicare program liability (see instructions)		2,484,292		1,528,271	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: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet E-1 Part I Date/Time Prepared: 1/23/2012 9:16 am	
		Title XVIII		Subprovider - IPF	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider		887,621		0
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
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)				
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
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)		887,621		0
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)				
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		747		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		888,368		0
				Contractor Number	Date (Mo/Day/Yr)
		0		1.00	2.00
8.00	Name of Contractor				

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet E-1 Part II Date/Time Prepared: 1/23/2012 9:16 am
		Title XVIII	Hospital	PPS
				1.00
DATA COLLECTION NEEDED FOR THE HIT CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			592 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			1,611 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2			83 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			2,601 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			73,544,157 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			0 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			0 8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial /interim HIT payment(s)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 minus line 30, plus or minus line 31)			0 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150038 Component CCN: 15S038	Period: From 01/01/2011 To 06/30/2011	Worksheet E-3 Part II Date/Time Prepared: 1/23/2012 9:16 am
		Title XVII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			933,517 1.00
2.00	Net IPF PPS Outlier Payments			18,655 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)			8.077348 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)			952,172 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)			952,172 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			952,172 18.00
19.00	Deductibles			61,156 19.00
20.00	Subtotal (line 18 minus line 19)			891,016 20.00
21.00	Coinurance			3,396 21.00
22.00	Subtotal (line 20 minus line 21)			887,620 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			1,068 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			748 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)			888,368 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)			888,368 31.00
32.00	Interim payments			887,621 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)			747 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150038 Component CCN: 15T038	Period: From 01/01/2011 To 06/30/2011	Worksheet E-3 Part III Date/Time Prepared: 1/23/2012 9:16 am
		Title XVIIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			0 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0000 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			0 3.00
4.00	Outlier Payments			0 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			0.000000 10.00
11.00	Medical Education Adjustment Factor $\{((1 + (\text{line } 9/\text{line } 10)) \text{ raised to the power of } .6876 - 1)\}$.			0.000000 11.00
12.00	Medical Education Adjustment (line 1 multiplied by line 11).			0 12.00
13.00	Total PPS Payment (sum of lines 1, 3, 4 and 12)			0 13.00
14.00	Nursing and Allied Health Managed Care payment (see instruction)			0 14.00
15.00	Organ acquisition			0 15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 16.00
17.00	Subtotal (see instructions)			0 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			0 19.00
20.00	Deductibles			0 20.00
21.00	Subtotal (line 19 minus line 20)			0 21.00
22.00	Coinsurance			0 22.00
23.00	Subtotal (line 21 minus line 22)			0 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			0 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			0 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			0 32.00
33.00	Interim payments			0 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus the sum lines 33 and 34)			0 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet E-3 Part VII Date/Time Prepared: 1/23/2012 9:16 am
		Title XIX	Hospital	Cost
				1.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		992,198	1.00
2.00	Medical and other services		1,324,524	2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		2,316,722	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)		2,316,722	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		0	8.00
9.00	Ancillary service charges		8,237,487	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)		8,237,487	12.00
CUSTOMARY CHRGES				
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)		8,237,487	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 7) (see instructions)		5,920,765	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 7 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 (line 7)		2,316,722	21.00
PROSPECTIVE PAYMENT AMOUNT				
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, plus line 3 minus lines 5 and 6)		0	27.00
28.00	Customary charges (title XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX (see instructions)		2,316,722	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus line 29 minus line 30)		2,316,722	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)		2,316,722	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		2,316,722	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)		2,316,722	40.00
41.00	Interim payments		0	41.00
42.00	Balance due provider/program (line 40 minus 41)		2,316,722	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: 150038 Period: From 01/01/2011 To 06/30/2011 Worksheet G
 Date/Time Prepared: 1/23/2012 9:16 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	4,367,189	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	3,820,701	0	0	0	4.00
5.00	Other receivable	11,803	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	925,812	0	0	0	7.00
8.00	Prepaid expenses	654,424	0	0	0	8.00
9.00	Other current assets	1,863,636	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)	11,643,565	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,913,186	0	0	0	12.00
13.00	Land improvements	555,386	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	22,710,087	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	5,606,368	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	34,257,326	0	0	0	23.00
24.00	Accumulated depreciation	-46,347,795	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)	18,694,558	0	0	0	30.00
OTHER ASSETS						
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	3,659,995	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,659,995	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	33,998,118	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,785,393	0	0	0	37.00
38.00	Salaries, wages, and fees payable	325,946	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	700,142	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,098,424	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,909,905	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	767,767	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,028,500	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,796,267	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,706,172	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	28,291,946				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)	28,291,946	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	33,998,118	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150038

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

Worksheet G-1

Date/Time Prepared:
1/23/2012 9:16 am

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		28,613,890	
2.00	Net income (loss) (From Wkst. G-3, line 29)		1,696,426			2.00
3.00	Total (sum of line 1 and line 2)		30,310,316		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)		30,310,316		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)		30,310,316		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150038

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

Worksheet G-1

Date/Time Prepared:
1/23/2012 9:16 am

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150038

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

Worksheet G-2 Parts
Date/Time Prepared:
1/23/2012 9:16 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,764,219		3,764,219	1.00
2.00	SUBPROVIDER - IPF	2,195,129		2,195,129	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,959,348		5,959,348	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	2,297,918		2,297,918	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)	2,297,918		2,297,918	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,257,266		8,257,266	17.00
18.00	Ancillary services	11,138,316	42,357,039	53,495,355	18.00
19.00	Outpatient services	1,482,863	10,308,673	11,791,536	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	PRO FEES	190,237	761,346	951,583	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	21,068,682	53,427,058	74,495,740	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		19,017,408		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	BAD DEBTS	4,120,210			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)		4,120,210		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00	ADJ TO AJE 8	62,166			38.00
39.00	AJE 11	11,663			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		73,829		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		23,063,789		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet G-3 Date/Time Prepared: 1/23/2012 9:16 am
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	74,495,740	1.00
2.00	Less contractual allowances and discounts on patients' accounts	51,533,527	2.00
3.00	Net patient revenues (line 1 minus line 2)	22,962,213	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	23,063,789	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-101,576	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	2,123	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	46,858	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	60,916	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	8,288	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	3,873	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	941	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	DSH PMTS	1,592,812	24.00
24.01	GRANTS	6,370	24.01
24.02	MISC	161,128	24.02
24.03	SILVER SALES	2,892	24.03
24.04	WIC	44,373	24.04
24.05	MGMT FEES	215,921	24.05
24.06	NON RESTR INT INC	1,462,404	24.06
25.00	Total other income (sum of lines 6-24)	3,608,899	25.00
26.00	Total (line 5 plus line 25)	3,507,323	26.00
27.00	UNREAL GAIN/LOSS	1,085,772	27.00
27.01	SWAP	79,282	27.01
27.02	REAL G/L	2,612	27.02
27.03	GAIN/LOSS EXTINGUI	643,231	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	1,810,897	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,696,426	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150038	Period: From 01/01/2011 To 06/30/2011	Worksheet L Parts I-III Date/Time Prepared: 1/23/2012 9:16 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		187,684	1.00
2.00	Capital DRG outlier payments		5,499	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		14.37	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		193,183	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00