This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Falure 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: 141335	Period: From 07/01/2010 To 06/30/2011	Worksheet S Parts I-III Date/Time Prepared: 1/25/2012 2:47 pm

PART I - COST REPORT STATUS

Provider use only

1. [ ] Electronically filed cost report — Date: 1/25/2012 Time: 2:47 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [ ] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [0] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] 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 HARVARD MEMORIAL HOSPITAL for the cost reporting period beginning 07/01/2010 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 V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-65,767	96,930	0	117,809	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	Skilled Nursing Facility	0	0	0		0	7.00
8.00	Nursing Facility	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	-65,767	96,930	0	117,809	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part I | Date/Time Prepared: 1/24/2012 4:29 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 901 GRANT STREET	PO Box:			1.00
2.00	City: HARVARD	State: IL	Zip Code: 60033-	County: MC HENRY	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	HARVARD MEMORIAL HOSPITAL	141335	1600	1	01/01/2004	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF						N	N	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF	CARE CENTER	146014	1600		01/01/2002	N	P	N	9.00
10.00	Hospital-Based NF						N		N	10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC						N	N	N	15.00
16.00	Hospital-Based Health Clinic - FQHC						N	N	N	16.00
17.00	Hospital-Based (CMHC) 1									17.00
17.10	Hospital-Based (CORF) 1						N	N	N	17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2010	06/30/2011	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.	3		23.00

		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of State Medicaid paid days	Out-of State Medicaid eligible days	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.	0	0	0	0	0	0	25.00

		1.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.	2	26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period? Enter (1) for urban or (2) for rural.	2	27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0	35.00

		Beginning: 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part I | Date/Time Prepared: 1/24/2012 4:29 pm

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	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	IME Average	Direct GME Average	
		1.00	2.00	3.00	
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)		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	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	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.				
64.00	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	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part I Date/Time Prepared: 1/24/2012 4:29 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	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	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	71.00
	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.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00

		1.00	
	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141335	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/24/2012 4:29 pm

		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)(ii)? 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.	Y	N	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	N	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)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		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	109.00

		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.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118.00
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.	1,000,000	3,000,000	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141335	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/24/2012 4:29 pm

		1.00	2.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	901041	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: MERCY HOME OFFICE	Contractor's Name: NGS	Contractor's Number: 00450	141.00
142.00	Street: 1000 MINERAL POINT AVE	PO Box:		142.00
143.00	City: JANESVILLE	State: WI	Zip Code: 53547	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	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		0 Name	1.00 County	2.00 State	3.00 Zip Code	4.00 CBSA	5.00 FTE/Campus	
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: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part II | Date/Time Prepared: 1/24/2012 4:29 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	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	12/07/2011	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: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part II | Date/Time Prepared: 1/24/2012 4:29 pm

		Description	Part A Y/N	Part A Date		
		0	1.00	2.00		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N			21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	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.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	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.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?				Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				Y	37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				Y	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				Y	40.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-2 Part II | Date/Time Prepared: 1/24/2012 4:29 pm

		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	12/07/2011	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: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 1/24/2012 4:29 pm

	Cost Center Description	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours		
		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	17	6,205	36,599.00		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)		17	6,205	36,599.00		7.00
8.00	INTENSIVE CARE UNIT	31.00	3	1,095	2,784.00		8.00
9.00	CORONARY CARE UNIT	32.00	0	0	0.00		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)		20	7,300	39,383.00		14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	40.00	0	0			16.00
17.00	SUBPROVIDER - IRF	41.00	0	0			17.00
18.00	SUBPROVIDER	42.00	0	0			18.00
19.00	SKILLED NURSING FACILITY	44.00	14	5,110			19.00
20.00	NURSING FACILITY	45.00	0	0			20.00
21.00	OTHER LONG TERM CARE	46.00	29	10,585			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)		63				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: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 1/24/2012 4:29 pm

	Cost Center Description	I/P Days / O/P Visits / Trips					
		Title V	Title XVIII	Title XIX	Total All Patients		
		5.00	6.00	7.00	8.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	861	91	1,525		1.00
2.00	HMO		0	0			2.00
3.00	HMO IPF		0	0			3.00
4.00	HMO IRF		0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	861	91	1,525		7.00
8.00	INTENSIVE CARE UNIT	0	45	5	116		8.00
9.00	CORONARY CARE UNIT	0	0	0	0		9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	0		0	0		13.00
14.00	Total (see instructions)	0	906	96	1,641		14.00
15.00	CAH visits	0	0	0	0		15.00
16.00	SUBPROVIDER - IPF	0	0	0	0		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	0	3,416	0	3,416		19.00
20.00	NURSING FACILITY	0		0	0		20.00
21.00	OTHER LONG TERM CARE				6,144		21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0		25.10
26.00	RURAL HEALTH CLINIC	0	0	0	0		26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
27.00	Total (sum of lines 14-26)						27.00
28.00	Observation Bed Days	0		0	207		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)			0	0		32.00
33.00	LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 1/24/2012 4:29 pm

	Cost Center Description	Full Time Equivalents			Discharges		
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
		9.00	10.00	11.00	12.00	13.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	293	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	154.07	0.00	0	293	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0.00	0.00	0	0	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	0.00	0.00	0.00			19.00
20.00	NURSING FACILITY	0.00	0.00	0.00			20.00
21.00	OTHER LONG TERM CARE	0.00	0.00	0.00			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	154.07	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: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-3 Part I | Date/Time Prepared: 1/24/2012 4:29 pm

	Cost Center Description	Discharges			
		Title XIX	Total All Patients		
		14.00	15.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	52	594		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)	52	594		14.00
15.00	CAH visits				15.00
16.00	SUBPROVIDER - IPF	0	0		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		151		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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider CCN: 141335	Period: From 07/01/2010 To 06/30/2011	Worksheet S-7 Date/Time Prepared: 1/24/2012 4:29 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.			2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	14	0	14	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	14	0	14	8.00
9.00		RMX	38	0	38	9.00
10.00		RML	230	0	230	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	109	0	109	14.00
15.00		RVC	46	0	46	15.00
16.00		RVB	365	0	365	16.00
17.00		RVA	475	0	475	17.00
18.00		RHC	257	0	257	18.00
19.00		RHB	412	0	412	19.00
20.00		RHA	627	0	627	20.00
21.00		RMC	45	0	45	21.00
22.00		RMB	334	0	334	22.00
23.00		RMA	192	0	192	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	12	0	12	34.00
35.00		HB2	14	0	14	35.00
36.00		HB1	68	0	68	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	4	0	4	42.00
43.00		LB2	30	0	30	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	24	0	24	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	30	0	30	51.00
52.00		CB1	14	0	14	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	24	0	24	54.00
55.00		SE3	2	0	2	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	1	0	1	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet S-7 | Date/Time Prepared: 1/24/2012 4:29 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	29	0	29	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	6	0	6	199.00
200.00	TOTAL		3,416	0	3,416	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	16974	16974	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	0			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141335	Period: From 07/01/2010 To 06/30/2011	Worksheet S-10 Date/Time Prepared: 1/24/2012 4:29 pm

		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)	0.418617	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	998,868	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	6,960,776	6.00
7.00	Medicaid cost (line 1 times line 6)	2,913,899	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,915,031	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	16,297	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,915,031	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	830,323	0	830,323	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	347,587	0	347,587	21.00
22.00	Partial payment by patients approved for charity care	12,643	0	12,643	22.00
23.00	Cost of charity care (line 21 minus line 22)	334,944	0	334,944	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?		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)	2,085,943	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	149,194	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	1,936,749	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	810,756	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	1,145,700	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,060,731	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A | Date/Time Prepared: 1/24/2012 4:29 pm

	Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (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		1,149,947	1,149,947	11,983	1,161,930	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		653,510	653,510	0	653,510	2.00
4.00	EMPLOYEE BENEFITS	133,043	1,548,371	1,681,414	0	1,681,414	4.00
5.00	ADMINISTRATIVE & GENERAL	1,036,436	980,664	2,017,100	-11,983	2,005,117	5.00
7.00	OPERATION OF PLANT	211,250	645,173	856,423	0	856,423	7.00
8.00	LAUNDRY & LINEN SERVICE	0	7,897	7,897	0	7,897	8.00
9.00	HOUSEKEEPING	207,456	78,391	285,847	0	285,847	9.00
10.00	DIETARY	388,209	204,585	592,794	0	592,794	10.00
11.00	CAFETERIA	0	0	0	0	0	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	700,450	62,071	762,521	0	762,521	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	MEDICAL RECORDS & LIBRARY	305,490	31,725	337,215	0	337,215	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	963,041	165,243	1,128,284	0	1,128,284	30.00
31.00	INTENSIVE CARE UNIT	132,340	19,344	151,684	0	151,684	31.00
32.00	CORONARY CARE UNIT	0	0	0	0	0	32.00
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
44.00	SKILLED NURSING FACILITY	463,226	164,276	627,502	0	627,502	44.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
46.00	OTHER LONG TERM CARE	833,155	295,467	1,128,622	0	1,128,622	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,292,166	2,062,420	3,354,586	-488,338	2,866,248	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	15,456	1,685	17,141	0	17,141	53.00
54.00	RADIOLOGY-DIAGNOSTIC	704,631	553,137	1,257,768	0	1,257,768	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
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	496,883	445,119	942,002	0	942,002	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	353,503	58,499	412,002	0	412,002	65.00
66.00	PHYSICAL THERAPY	539,110	37,759	576,869	0	576,869	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	19,980	1,592	21,572	0	21,572	69.00
69.01	CARDIAC REHABILITATION	102,277	20,684	122,961	0	122,961	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	488,338	488,338	72.00
73.00	DRUGS CHARGED TO PATIENTS	336,810	349,909	686,719	0	686,719	73.00
	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
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	470,998	1,565,883	2,036,881	0	2,036,881	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	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	9,705,910	11,103,351	20,809,261	0	20,809,261	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00	TOTAL (SUM OF LINES 118-199)	9,705,910	11,103,351	20,809,261	0	20,809,261	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A | Date/Time Prepared: 1/24/2012 4:29 pm

	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	-5,753	1,156,177		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	176,811	830,321		2.00
4.00	EMPLOYEE BENEFITS	256,695	1,938,109		4.00
5.00	ADMINISTRATIVE & GENERAL	1,196,502	3,201,619		5.00
7.00	OPERATION OF PLANT	88,726	945,149		7.00
8.00	LAUNDRY & LINEN SERVICE	0	7,897		8.00
9.00	HOUSEKEEPING	8,194	294,041		9.00
10.00	DIETARY	-88,738	504,056		10.00
11.00	CAFETERIA	0	0		11.00
12.00	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	NURSING ADMINISTRATION	0	762,521		13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0		14.00
16.00	MEDICAL RECORDS & LIBRARY	4,823	342,038		16.00
17.00	SOCIAL SERVICE	0	0		17.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	113,941	1,242,225		30.00
31.00	INTENSIVE CARE UNIT	0	151,684		31.00
32.00	CORONARY CARE UNIT	0	0		32.00
40.00	SUBPROVIDER - IPF	0	0		40.00
41.00	SUBPROVIDER - IRF	0	0		41.00
42.00	SUBPROVIDER	0	0		42.00
43.00	NURSERY	0	0		43.00
44.00	SKILLED NURSING FACILITY	2,144	629,646		44.00
45.00	NURSING FACILITY	0	0		45.00
46.00	OTHER LONG TERM CARE	3,856	1,132,478		46.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	2,866,248		50.00
51.00	RECOVERY ROOM	0	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	ANESTHESIOLOGY	13,980	31,121		53.00
54.00	RADIOLOGY-DIAGNOSTIC	-10,002	1,247,766		54.00
56.00	RADIOISOTOPE	0	0		56.00
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	-129,469	812,533		60.00
60.01	BLOOD LABORATORY	0	0		60.01
64.00	INTRAVENOUS THERAPY	0	0		64.00
65.00	RESPIRATORY THERAPY	-20,055	391,947		65.00
66.00	PHYSICAL THERAPY	0	576,869		66.00
67.00	OCCUPATIONAL THERAPY	0	0		67.00
68.00	SPEECH PATHOLOGY	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	21,572		69.00
69.01	CARDIAC REHABILITATION	-48,017	74,944		69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	488,338		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	686,719		73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	0		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	CLINIC	0	0		90.00
91.00	EMERGENCY	-222,289	1,814,592		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				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)	1,341,349	22,150,610		118.00
	NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
200.00	TOTAL (SUM OF LINES 118-199)	1,341,349	22,150,610		200.00

RECLASSIFICATIONS | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-6 | Date/Time Prepared: 1/24/2012 4:29 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INSURANCE EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	11,983		1.00
	TOTALS		0	11,983		
	B - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	488,338		1.00
	TOTALS		0	488,338		
500.00	Grand Total: Increases		0	500,321		500.00

RECLASSIFICATIONS | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-6 | Date/Time Prepared: 1/24/2012 4:29 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	11,983	12		1.00
	TOTALS		0	11,983			
	B - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	488,338	0		1.00
	TOTALS		0	488,338			
500.00	Grand Total: Decreases		0	500,321			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/24/2012 4:29 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	0	0	0	0	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	0	0	0	0	0	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	619,506	0	530,441	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	635,898	463	17,149	0	0	2.00
3.00	Total (sum of lines 1-2)	1,255,404	463	547,590	0	0	3.00

		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/24/2012 4:29 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	0	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	0	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	0	0				10.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,149,947				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	653,510				2.00
3.00	Total (sum of lines 1-2)	0	1,803,457				3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	619,506	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	635,898	463	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,255,404	463	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 1/24/2012 4:29 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	524,688	11,983	0	0	1,156,177	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	193,960	0	0	0	830,321	2.00
3.00	Total (sum of lines 1-2)	718,648	11,983	0	0	1,986,498	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8 | Date/Time Prepared: 1/24/2012 4:29 pm

				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)	B	-5,753	NEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - movable equipment (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)		0		0.00	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	7.00
8.00	Television and radio service (chapter 21)		0		0.00	8.00
9.00	Parking lot (chapter 21)		0		0.00	9.00
10.00	Provider-based physician adjustment	A-8-2	-425,146			10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	2,000,779			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Cafeteria-employees and guests	B	-97,887	DIETARY	10.00	14.00
15.00	Rental of quarters to employee and others		0		0.00	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	16.00
17.00	Sale of drugs to other than patients		0		0.00	17.00
18.00	Sale of medical records and abstracts	B	-363	MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00	Vending machines		0		0.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - buildings and fixtures		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - movable equipment		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant		0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	32.00
33.00	OTHER OPERATING REVENUE	B	-4,103	ADMINISTRATIVE & GENERAL	5.00	33.00
34.00	ILLINOIS UNALLOWABLE REAL ESTATE TAX	A	-8,732	OPERATION OF PLANT	7.00	34.00
35.00	LOBBYING EXPENSE	A	-9,624	ADMINISTRATIVE & GENERAL	5.00	35.00
36.00	WELLNESS CENTER REVENUE	B	-48,017	CARDIAC REHABILITATION	69.01	36.00
37.00	MISCELLANEOUS REVENUE - ADMIN	B	-14,329	ADMINISTRATIVE & GENERAL	5.00	37.00
38.00	SICK CHILD CARE REVENUE	B	-30	ADULTS & PEDIATRICS	30.00	38.00
39.00	CASH DISCOUNTS	B	-9,117	ADMINISTRATIVE & GENERAL	5.00	39.00
40.00	CERTIFICATE OF NEED EXPENSES	A	-36,329	ADMINISTRATIVE & GENERAL	5.00	40.00
41.00			0		0.00	41.00
42.00			0		0.00	42.00
43.00			0		0.00	43.00
44.00			0		0.00	44.00
45.00			0		0.00	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,341,349			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8 | Date/Time Prepared: 1/24/2012 4:29 pm

		Wkst. A-7 Ref. 5.00		
1.00	Investment income - buildings and fixtures (chapter 2)	11		1.00
2.00	Investment income - movable equipment (chapter 2)	0		2.00
3.00	Investment income - other (chapter 2)	0		3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0		4.00
5.00	Refunds and rebates of expenses (chapter 8)	0		5.00
6.00	Rental of provider space by suppliers (chapter 8)	0		6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0		7.00
8.00	Television and radio service (chapter 21)	0		8.00
9.00	Parking lot (chapter 21)	0		9.00
10.00	Provider-based physician adjustment	0		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0		11.00
12.00	Related organization transactions (chapter 10)	0		12.00
13.00	Laundry and linen service	0		13.00
14.00	Cafeteria-employees and guests	0		14.00
15.00	Rental of quarters to employee and others	0		15.00
16.00	Sale of medical and surgical supplies to other than patients	0		16.00
17.00	Sale of drugs to other than patients	0		17.00
18.00	Sale of medical records and abstracts	0		18.00
19.00	Nursing school (tuition, fees, books, etc.)	0		19.00
20.00	Vending machines	0		20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0		21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0		22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)			23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)			24.00
25.00	Utilization review - physicians' compensation (chapter 21)			25.00
26.00	Depreciation - 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	OTHER OPERATING REVENUE	0		33.00
34.00	ILLINOIS UNALLOWABLE REAL ESTATE TAX	0		34.00
35.00	LOBBYING EXPENSE	0		35.00
36.00	WELLNESS CENTER REVENUE	0		36.00
37.00	MISCELLANEOUS REVENUE - ADMIN	0		37.00
38.00	SICK CHILD CARE REVENUE	0		38.00
39.00	CASH DISCOUNTS	0		39.00
40.00	CERTIFICATE OF NEED EXPENSES	0		40.00
41.00		0		41.00
42.00		0		42.00
43.00		0		43.00
44.00		0		44.00
45.00		0		45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141335	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-1 Date/Time Prepared: 1/24/2012 4:29 pm

		Line No.	Cost Center	Expense Items	
		1.00	2.00	3.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00		2.00	NEW CAP REL COSTS-MVBLE EQUIP	HO CAPITAL RELATED	1.00
2.00		4.00	EMPLOYEE BENEFITS	HO EMPLOYEE BENEFTS	2.00
3.00		5.00	ADMINISTRATIVE & GENERAL	HO ADMIN & GENERAL	3.00
4.00		7.00	OPERATION OF PLANT	HO PLANT	4.00
4.01		9.00	HOUSEKEEPING	HO HOUSEKEEPING	4.01
4.02		10.00	DIETARY	HO DIETARY	4.02
4.03		16.00	MEDICAL RECORDS & LIBRARY	HO MEDICAL RECORDS	4.03
4.04		30.00	ADULTS & PEDIATRICS	HO ADULTS & PEDS	4.04
4.05		53.00	ANESTHESIOLOGY	HO ANESTHESIOLOGY	4.05
4.06		5.00	ADMINISTRATIVE & GENERAL	HO MEDICAL SUPPLIES	4.06
4.07		91.00	EMERGENCY	HO EMERGENCY	4.07
4.08		30.00	ADULTS & PEDIATRICS	HO INFECTIOUS DISEASE	4.08
4.09		44.00	SKILLED NURSING FACILITY	HO SNF	4.09
4.10		46.00	OTHER LONG TERM CARE	HO OTHER LONG TERM CARE	4.10
4.11		54.00	RADIOLOGY-DIAGNOSTIC	RADIOLOGY	4.11
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				5.00

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

		Symbol (1)	Name	Percentage of Ownership		
		1.00	2.00	3.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-1 | Date/Time Prepared: 1/24/2012 4:29 pm

		Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
		4.00	5.00	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00		217,258	40,447	176,811	11		1.00
2.00		807,564	550,869	256,695	0		2.00
3.00		2,544,770	1,340,828	1,203,942	0		3.00
4.00		97,458	0	97,458	0		4.00
4.01		8,194	0	8,194	0		4.01
4.02		9,149	0	9,149	0		4.02
4.03		5,186	0	5,186	0		4.03
4.04		102,304	0	102,304	0		4.04
4.05		13,980	0	13,980	0		4.05
4.06		66,062	0	66,062	0		4.06
4.07		53,333	0	53,333	0		4.07
4.08		11,667	0	11,667	0		4.08
4.09		2,144	0	2,144	0		4.09
4.10		3,856	0	3,856	0		4.10
4.11		35,871	45,873	-10,002	0		4.11
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	3,978,796	1,978,017	2,000,779			5.00

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

		Related Organization(s) and/or Home Office			
		Name	Percentage of Ownership	Type of Business	
		4.00	5.00	6.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				
6.00		MERCY HOME OFFI	100.00		6.00
7.00			0.00		7.00
8.00			0.00		8.00
9.00			0.00		9.00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/24/2012 4:29 pm

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		60.00	LABORATORY PHYSICIAN FEES	114,469	114,469	1.00
2.00		60.00	HARVARD LAB DIRECTOR	15,000	15,000	2.00
3.00		65.00	SLEEP CENTER PHYSICIAN	20,055	20,055	3.00
4.00		91.00	EMERGENCY ROOM PHYSICIANS	1,413,445	275,622	4.00
5.00		30.00	INFECTIOUS DISEASE - KONKOL	11,667	0	5.00
6.00		30.00	INPATIENT SERVICES - SAREEN	98,105	0	6.00
7.00		5.00	ASSOCIATE DIRECTOR - GOELZER	35,000	0	7.00
8.00		5.00	ASSOCIATE DIRECTOR - KONKOL	30,000	0	8.00
9.00		46.00	CARE CENTER - MUNDOZIE	6,000	0	9.00
10.00		91.00	ER MED DIRECTOR - MILOS	53,333	0	10.00
200.00			TOTAL (lines 1.00 through 199.00)	1,797,074	425,146	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/24/2012 4:29 pm

		Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
		5.00	6.00	7.00	8.00	9.00	
1.00		0	0	0	0	0	1.00
2.00		0	0	0	0	0	2.00
3.00		0	0	0	0	0	3.00
4.00		1,137,823	0	0	0	0	4.00
5.00		11,667	0	0	0	0	5.00
6.00		98,105	0	0	0	0	6.00
7.00		35,000	0	0	0	0	7.00
8.00		30,000	0	0	0	0	8.00
9.00		6,000	0	0	0	0	9.00
10.00		53,333	0	0	0	0	10.00
200.00		1,371,928		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/24/2012 4:29 pm

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet A-8-2 | Date/Time Prepared: 1/24/2012 4:29 pm

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		0	114,469		1.00
2.00		0	15,000		2.00
3.00		0	20,055		3.00
4.00		0	275,622		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
200.00		0	425,146		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I Date/Time Prepared: 1/24/2012 4:29 pm

	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	1,156,177	1,156,177				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	830,321		830,321			2.00
4.00	EMPLOYEE BENEFITS	1,938,109	0	3,167	1,941,276		4.00
5.00	ADMINISTRATIVE & GENERAL	3,201,619	136,752	68,861	210,178	3,617,410	5.00
7.00	OPERATION OF PLANT	945,149	226,835	39,336	42,839	1,254,159	7.00
8.00	LAUNDRY & LINEN SERVICE	7,897	13,164	219	0	21,280	8.00
9.00	HOUSEKEEPING	294,041	5,186	1,396	42,070	342,693	9.00
10.00	DIETARY	504,056	35,089	14,670	78,725	632,540	10.00
11.00	CAFETERIA	0	18,862	0	0	18,862	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	762,521	6,325	9	142,044	910,899	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	MEDICAL RECORDS & LIBRARY	342,038	24,290	4	61,950	428,282	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,242,225	85,821	47,289	195,294	1,570,629	30.00
31.00	INTENSIVE CARE UNIT	151,684	26,185	27,754	26,837	232,460	31.00
32.00	CORONARY CARE UNIT	0	0	0	0	0	32.00
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
44.00	SKILLED NURSING FACILITY	629,646	67,999	9,798	93,937	801,380	44.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
46.00	OTHER LONG TERM CARE	1,132,478	116,807	17,623	168,955	1,435,863	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	2,866,248	116,195	272,915	262,040	3,517,398	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	31,121	0	957	3,134	35,212	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,247,766	32,553	236,527	142,891	1,659,737	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
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	812,533	21,754	18,035	100,762	953,084	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	391,947	18,378	11,657	71,687	493,669	65.00
66.00	PHYSICAL THERAPY	576,869	51,444	15,109	109,326	752,748	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	21,572	0	1,312	4,052	26,936	69.00
69.01	CARDIAC REHABILITATION	74,944	7,123	9,873	20,741	112,681	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	488,338	0	0	0	488,338	72.00
73.00	DRUGS CHARGED TO PATIENTS	686,719	7,693	5,929	68,301	768,642	73.00
	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
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	1,814,592	19,390	6,408	95,513	1,935,903	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					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)	22,150,610	1,037,845	808,848	1,941,276	22,010,805	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	118,332	21,473	0	139,805	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)	22,150,610	1,156,177	830,321	1,941,276	22,150,610	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I | Date/Time Prepared: 1/24/2012 4:29 pm

	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	3,617,410					5.00
7.00	OPERATION OF PLANT	244,793	1,498,952				7.00
8.00	LAUNDRY & LINEN SERVICE	4,154	24,895	50,329			8.00
9.00	HOUSEKEEPING	66,889	9,807	0	419,389		9.00
10.00	DIETARY	123,462	66,361	0	19,007	841,370	10.00
11.00	CAFETERIA	3,682	35,673	0	10,217	211,913	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	177,794	11,963	0	3,426	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	MEDICAL RECORDS & LIBRARY	83,594	45,938	0	13,158	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	306,563	162,305	6,880	46,487	116,749	30.00
31.00	INTENSIVE CARE UNIT	45,373	49,521	430	14,184	0	31.00
32.00	CORONARY CARE UNIT	0	0	0	0	0	32.00
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
44.00	SKILLED NURSING FACILITY	156,417	128,599	8,538	36,833	181,857	44.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
46.00	OTHER LONG TERM CARE	280,259	220,906	15,358	63,272	327,109	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	686,549	219,748	11,268	62,940	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	6,873	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	323,956	61,565	2,138	17,633	0	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
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	186,028	41,142	0	11,784	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	96,357	34,757	96	9,955	0	65.00
66.00	PHYSICAL THERAPY	146,925	97,292	932	27,866	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	5,258	0	0	0	0	69.00
69.01	CARDIAC REHABILITATION	21,994	13,472	0	3,859	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	95,316	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	150,027	14,549	0	4,167	0	73.00
	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
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	377,859	36,670	3,661	10,503	3,742	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)	3,590,122	1,275,163	49,301	355,291	841,370	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	27,288	223,789	1,028	64,098	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)	3,617,410	1,498,952	50,329	419,389	841,370	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I Date/Time Prepared: 1/24/2012 4:29 pm

	Cost Center Description	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
		11.00	12.00	13.00	14.00	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	280,347					11.00
12.00	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	NURSING ADMINISTRATION	17,532	0	1,121,614			13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
16.00	MEDICAL RECORDS & LIBRARY	16,647	0	0	0	587,619	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	33,127	0	250,255	0	90,293	30.00
31.00	INTENSIVE CARE UNIT	3,444	0	21,447	0	0	31.00
32.00	CORONARY CARE UNIT	0	0	0	0	0	32.00
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
44.00	SKILLED NURSING FACILITY	25,832	0	146,702	0	0	44.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
46.00	OTHER LONG TERM CARE	46,449	0	263,866	0	0	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	45,732	0	331,120	0	99,602	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	622	0	5,384	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	22,555	0	0	0	0	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
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	20,689	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	11,457	0	0	0	36,800	65.00
66.00	PHYSICAL THERAPY	11,768	0	0	0	166,623	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	646	0	3,596	0	0	69.00
69.01	CARDIAC REHABILITATION	5,645	0	11,246	0	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	5,525	0	0	0	0	73.00
	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
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	12,677	0	87,998	0	194,301	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)	280,347	0	1,121,614	0	587,619	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	280,347	0	1,121,614	0	587,619	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part I | Date/Time Prepared: 1/24/2012 4:29 pm

	Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		17.00	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
12.00	MAINTENANCE OF PERSONNEL						12.00
13.00	NURSING ADMINISTRATION						13.00
14.00	CENTRAL SERVICES & SUPPLY						14.00
16.00	MEDICAL RECORDS & LIBRARY						16.00
17.00	SOCIAL SERVICE	0					17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	2,583,288	0	2,583,288		30.00
31.00	INTENSIVE CARE UNIT	0	366,859	0	366,859		31.00
32.00	CORONARY CARE UNIT	0	0	0	0		32.00
40.00	SUBPROVIDER - IPF	0	0	0	0		40.00
41.00	SUBPROVIDER - IRF	0	0	0	0		41.00
42.00	SUBPROVIDER	0	0	0	0		42.00
43.00	NURSERY	0	0	0	0		43.00
44.00	SKILLED NURSING FACILITY	0	1,486,158	0	1,486,158		44.00
45.00	NURSING FACILITY	0	0	0	0		45.00
46.00	OTHER LONG TERM CARE	0	2,653,082	0	2,653,082		46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	4,974,357	0	4,974,357		50.00
51.00	RECOVERY ROOM	0	0	0	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	ANESTHESIOLOGY	0	48,091	0	48,091		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	2,087,584	0	2,087,584		54.00
56.00	RADIOISOTOPE	0	0	0	0		56.00
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	1,212,727	0	1,212,727		60.00
60.01	BLOOD LABORATORY	0	0	0	0		60.01
64.00	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	RESPIRATORY THERAPY	0	683,091	0	683,091		65.00
66.00	PHYSICAL THERAPY	0	1,204,154	0	1,204,154		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	36,436	0	36,436		69.00
69.01	CARDIAC REHABILITATION	0	168,897	0	168,897		69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	583,654	0	583,654		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	942,910	0	942,910		73.00
	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
90.00	CLINIC	0	0	0	0		90.00
91.00	EMERGENCY	0	2,663,314	0	2,663,314		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	21,694,602	0	21,694,602		118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	456,008	0	456,008		192.00
200.00	Cross Foot Adjustments		0	0	0		200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	0	22,150,610	0	22,150,610		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II Date/Time Prepared: 1/24/2012 4:29 pm

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		0	1.00	2.00	2A	4.00	
	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	1,541	0	3,167	4,708	4,708	4.00
5.00	ADMINISTRATIVE & GENERAL	12,092	136,752	68,861	217,705	510	5.00
7.00	OPERATION OF PLANT	93	226,835	39,336	266,264	104	7.00
8.00	LAUNDRY & LINEN SERVICE	0	13,164	219	13,383	0	8.00
9.00	HOUSEKEEPING	0	5,186	1,396	6,582	102	9.00
10.00	DIETARY	0	35,089	14,670	49,759	191	10.00
11.00	CAFETERIA	0	18,862	0	18,862	0	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	0	6,325	9	6,334	345	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	MEDICAL RECORDS & LIBRARY	1,650	24,290	4	25,944	150	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	4,179	85,821	47,289	137,289	474	30.00
31.00	INTENSIVE CARE UNIT	1,021	26,185	27,754	54,960	65	31.00
32.00	CORONARY CARE UNIT	0	0	0	0	0	32.00
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
44.00	SKILLED NURSING FACILITY	0	67,999	9,798	77,797	228	44.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
46.00	OTHER LONG TERM CARE	7,890	116,807	17,623	142,320	410	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	11,964	116,195	272,915	401,074	633	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	957	957	8	53.00
54.00	RADIOLOGY-DIAGNOSTIC	559	32,553	236,527	269,639	347	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
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	180	21,754	18,035	39,969	244	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	10,036	18,378	11,657	40,071	174	65.00
66.00	PHYSICAL THERAPY	678	51,444	15,109	67,231	265	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	1,312	1,312	10	69.00
69.01	CARDIAC REHABILITATION	0	7,123	9,873	16,996	50	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	58,177	7,693	5,929	71,799	166	73.00
	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
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	847	19,390	6,408	26,645	232	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				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)	110,907	1,037,845	808,848	1,957,600	4,708	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	118,332	21,473	139,805	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)	110,907	1,156,177	830,321	2,097,405	4,708	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II | Date/Time Prepared: 1/24/2012 4:29 pm

	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	218,215					5.00
7.00	OPERATION OF PLANT	14,766	281,134				7.00
8.00	LAUNDRY & LINEN SERVICE	251	4,669	18,303			8.00
9.00	HOUSEKEEPING	4,035	1,839	0	12,558		9.00
10.00	DIETARY	7,448	12,446	0	569	70,413	10.00
11.00	CAFETERIA	222	6,691	0	306	17,735	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	10,725	2,244	0	103	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	MEDICAL RECORDS & LIBRARY	5,043	8,616	0	394	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	18,493	30,441	2,502	1,392	9,771	30.00
31.00	INTENSIVE CARE UNIT	2,737	9,288	156	425	0	31.00
32.00	CORONARY CARE UNIT	0	0	0	0	0	32.00
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
44.00	SKILLED NURSING FACILITY	9,435	24,119	3,105	1,103	15,219	44.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
46.00	OTHER LONG TERM CARE	16,906	41,432	5,585	1,895	27,375	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	41,417	41,215	4,098	1,885	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	415	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	19,542	11,547	777	528	0	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
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	11,222	7,716	0	353	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	5,812	6,519	35	298	0	65.00
66.00	PHYSICAL THERAPY	8,863	18,247	339	834	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	317	0	0	0	0	69.00
69.01	CARDIAC REHABILITATION	1,327	2,527	0	116	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	5,750	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	9,050	2,729	0	125	0	73.00
	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
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	22,793	6,878	1,332	314	313	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)	216,569	239,163	17,929	10,640	70,413	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	1,646	41,971	374	1,918	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)	218,215	281,134	18,303	12,558	70,413	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II Date/Time Prepared: 1/24/2012 4:29 pm

	Cost Center Description	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
		11.00	12.00	13.00	14.00	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	43,816					11.00
12.00	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	NURSING ADMINISTRATION	2,740	0	22,491			13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
16.00	MEDICAL RECORDS & LIBRARY	2,602	0	0	0	42,749	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	5,177	0	5,018	0	6,569	30.00
31.00	INTENSIVE CARE UNIT	538	0	430	0	0	31.00
32.00	CORONARY CARE UNIT	0	0	0	0	0	32.00
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
44.00	SKILLED NURSING FACILITY	4,037	0	2,942	0	0	44.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
46.00	OTHER LONG TERM CARE	7,260	0	5,291	0	0	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	7,148	0	6,639	0	7,246	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	97	0	108	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	3,525	0	0	0	0	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
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	3,234	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	1,791	0	0	0	2,677	65.00
66.00	PHYSICAL THERAPY	1,839	0	0	0	12,122	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	101	0	72	0	0	69.00
69.01	CARDIAC REHABILITATION	882	0	226	0	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	864	0	0	0	0	73.00
	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
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	1,981	0	1,765	0	14,135	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)	43,816	0	22,491	0	42,749	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	43,816	0	22,491	0	42,749	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B Part II | Date/Time Prepared: 1/24/2012 4:29 pm

	Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		17.00	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
12.00	MAINTENANCE OF PERSONNEL						12.00
13.00	NURSING ADMINISTRATION						13.00
14.00	CENTRAL SERVICES & SUPPLY						14.00
16.00	MEDICAL RECORDS & LIBRARY						16.00
17.00	SOCIAL SERVICE	0					17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	217,126	0	217,126		30.00
31.00	INTENSIVE CARE UNIT	0	68,599	0	68,599		31.00
32.00	CORONARY CARE UNIT	0	0	0	0		32.00
40.00	SUBPROVIDER - IPF	0	0	0	0		40.00
41.00	SUBPROVIDER - IRF	0	0	0	0		41.00
42.00	SUBPROVIDER	0	0	0	0		42.00
43.00	NURSERY	0	0	0	0		43.00
44.00	SKILLED NURSING FACILITY	0	137,985	0	137,985		44.00
45.00	NURSING FACILITY	0	0	0	0		45.00
46.00	OTHER LONG TERM CARE	0	248,474	0	248,474		46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	511,355	0	511,355		50.00
51.00	RECOVERY ROOM	0	0	0	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	ANESTHESIOLOGY	0	1,585	0	1,585		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	305,905	0	305,905		54.00
56.00	RADIOISOTOPE	0	0	0	0		56.00
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	62,738	0	62,738		60.00
60.01	BLOOD LABORATORY	0	0	0	0		60.01
64.00	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	RESPIRATORY THERAPY	0	57,377	0	57,377		65.00
66.00	PHYSICAL THERAPY	0	109,740	0	109,740		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	1,812	0	1,812		69.00
69.01	CARDIAC REHABILITATION	0	22,124	0	22,124		69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	5,750	0	5,750		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	84,733	0	84,733		73.00
	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
90.00	CLINIC	0	0	0	0		90.00
91.00	EMERGENCY	0	76,388	0	76,388		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	1,911,691	0	1,911,691		118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	185,714	0	185,714		192.00
200.00	Cross Foot Adjustments		0	0	0		200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	0	2,097,405	0	2,097,405		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/24/2012 4:29 pm

	Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	81,155					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		653,036				2.00
4.00	EMPLOYEE BENEFITS	0	2,491	9,572,867			4.00
5.00	ADMINISTRATIVE & GENERAL	9,599	54,158	1,036,436	-3,617,410	18,533,200	5.00
7.00	OPERATION OF PLANT	15,922	30,937	211,250	0	1,254,159	7.00
8.00	LAUNDRY & LINEN SERVICE	924	172	0	0	21,280	8.00
9.00	HOUSEKEEPING	364	1,098	207,456	0	342,693	9.00
10.00	DIETARY	2,463	11,538	388,209	0	632,540	10.00
11.00	CAFETERIA	1,324	0	0	0	18,862	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	444	7	700,450	0	910,899	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	MEDICAL RECORDS & LIBRARY	1,705	3	305,490	0	428,282	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	6,024	37,192	963,041	0	1,570,629	30.00
31.00	INTENSIVE CARE UNIT	1,838	21,828	132,340	0	232,460	31.00
32.00	CORONARY CARE UNIT	0	0	0	0	0	32.00
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
44.00	SKILLED NURSING FACILITY	4,773	7,706	463,226	0	801,380	44.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
46.00	OTHER LONG TERM CARE	8,199	13,860	833,155	0	1,435,863	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	8,156	214,645	1,292,166	0	3,517,398	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	753	15,456	0	35,212	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,285	186,025	704,631	0	1,659,737	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
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	1,527	14,184	496,883	0	953,084	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	1,290	9,168	353,503	0	493,669	65.00
66.00	PHYSICAL THERAPY	3,611	11,883	539,110	0	752,748	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	1,032	19,980	0	26,936	69.00
69.01	CARDIAC REHABILITATION	500	7,765	102,277	0	112,681	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	488,338	72.00
73.00	DRUGS CHARGED TO PATIENTS	540	4,663	336,810	0	768,642	73.00
	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
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	1,361	5,040	470,998	0	1,935,903	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)	72,849	636,148	9,572,867	-3,617,410	18,393,395	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	8,306	16,888	0	0	139,805	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)	1,156,177	830,321	1,941,276		3,617,410	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	14.246528	1.271478	0.202789		0.195185	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/24/2012 4:29 pm

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
204.00	Cost to be allocated (per Wkst. B, Part II)			4,708		218,215	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000492		0.011774	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/24/2012 4:29 pm

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FULL TIME EQUIVALENT)	
		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	55,634					7.00
8.00	LAUNDRY & LINEN SERVICE	924	195,456				8.00
9.00	HOUSEKEEPING	364	0	54,346			9.00
10.00	DIETARY	2,463	0	2,463	47,672		10.00
11.00	CAFETERIA	1,324	0	1,324	12,007	11,721	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	444	0	444	0	733	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	MEDICAL RECORDS & LIBRARY	1,705	0	1,705	0	696	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	6,024	26,720	6,024	6,615	1,385	30.00
31.00	INTENSIVE CARE UNIT	1,838	1,671	1,838	0	144	31.00
32.00	CORONARY CARE UNIT	0	0	0	0	0	32.00
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
44.00	SKILLED NURSING FACILITY	4,773	33,159	4,773	10,304	1,080	44.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
46.00	OTHER LONG TERM CARE	8,199	59,640	8,199	18,534	1,942	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	8,156	43,760	8,156	0	1,912	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	26	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,285	8,302	2,285	0	943	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
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	1,527	0	1,527	0	865	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	1,290	373	1,290	0	479	65.00
66.00	PHYSICAL THERAPY	3,611	3,620	3,611	0	492	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	27	69.00
69.01	CARDIAC REHABILITATION	500	0	500	0	236	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	540	0	540	0	231	73.00
	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
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	1,361	14,219	1,361	212	530	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)	47,328	191,464	46,040	47,672	11,721	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	8,306	3,992	8,306	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)	1,498,952	50,329	419,389	841,370	280,347	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	26.943092	0.257495	7.717017	17.649144	23.918352	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	281,134	18,303	12,558	70,413	43,816	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	5.053277	0.093643	0.231075	1.477031	3.738248	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet B-1 | Date/Time Prepared: 1/24/2012 4:29 pm

	Cost Center Description	MAINTENANCE OF PERSONNEL (FULL TIME EQUIVALENT)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		12.00	13.00	14.00	16.00	17.00	
	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
12.00	MAINTENANCE OF PERSONNEL	0					12.00
13.00	NURSING ADMINISTRATION	0	114,790				13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0			14.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	9,469		16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	25,612	0	1,455	0	30.00
31.00	INTENSIVE CARE UNIT	0	2,195	0	0	0	31.00
32.00	CORONARY CARE UNIT	0	0	0	0	0	32.00
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
44.00	SKILLED NURSING FACILITY	0	15,014	0	0	0	44.00
45.00	NURSING FACILITY	0	0	0	0	0	45.00
46.00	OTHER LONG TERM CARE	0	27,005	0	0	0	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	33,888	0	1,605	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	551	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	593	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	2,685	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	368	0	0	0	69.00
69.01	CARDIAC REHABILITATION	0	1,151	0	0	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	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
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	9,006	0	3,131	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)	0	114,790	0	9,469	0	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	0	1,121,614	0	587,619	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	9.771008	0.000000	62.057134	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	22,491	0	42,749	0	204.00

COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 141335	Period: From 07/01/2010 To 06/30/2011	Worksheet B-1 Date/Time Prepared: 1/24/2012 4:29 pm

	Cost Center Description	MAINTENANCE OF PERSONNEL (FULL TIME EQUIVALENT)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		12.00	13.00	14.00	16.00	17.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.195932	0.000000	4.514627	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 1/24/2012 4:29 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,583,288		2,583,288	0	0	30.00
31.00	INTENSIVE CARE UNIT	366,859		366,859	0	0	31.00
32.00	CORONARY CARE UNIT	0		0	0	0	32.00
40.00	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	SUBPROVIDER	0		0	0	0	42.00
43.00	NURSERY	0		0	0	0	43.00
44.00	SKILLED NURSING FACILITY	1,486,158		1,486,158	0	0	44.00
45.00	NURSING FACILITY	0		0	0	0	45.00
46.00	OTHER LONG TERM CARE	2,653,082		2,653,082	0	0	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	4,974,357		4,974,357	0	0	50.00
51.00	RECOVERY ROOM	0		0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	ANESTHESIOLOGY	48,091		48,091	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,087,584		2,087,584	0	0	54.00
56.00	RADIOISOTOPE	0		0	0	0	56.00
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	1,212,727		1,212,727	0	0	60.00
60.01	BLOOD LABORATORY	0		0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	RESPIRATORY THERAPY	683,091	0	683,091	0	0	65.00
66.00	PHYSICAL THERAPY	1,204,154	0	1,204,154	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	36,436		36,436	0	0	69.00
69.01	CARDIAC REHABILITATION	168,897		168,897	0	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	583,654		583,654	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	942,910		942,910	0	0	73.00
	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
90.00	CLINIC	0		0	0	0	90.00
91.00	EMERGENCY	2,663,314		2,663,314	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	308,743		308,743		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						113.00
200.00	Subtotal (see instructions)	22,003,345	0	22,003,345	0	0	200.00
201.00	Less Observation Beds	308,743		308,743		0	201.00
202.00	Total (see instructions)	21,694,602	0	21,694,602	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 1/24/2012 4:29 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,330,114		3,330,114			30.00
31.00	INTENSIVE CARE UNIT	426,130		426,130			31.00
32.00	CORONARY CARE UNIT	0		0			32.00
40.00	SUBPROVIDER - IPF	0		0			40.00
41.00	SUBPROVIDER - IRF	0		0			41.00
42.00	SUBPROVIDER	0		0			42.00
43.00	NURSERY	0		0			43.00
44.00	SKILLED NURSING FACILITY	759,527		759,527			44.00
45.00	NURSING FACILITY	0		0			45.00
46.00	OTHER LONG TERM CARE	1,366,080		1,366,080			46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	4,735,593	14,559,382	19,294,975	0.257806	0.000000	50.00
51.00	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	ANESTHESIOLOGY	0	53,811	53,811	0.893702	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	795,113	7,456,507	8,251,620	0.252991	0.000000	54.00
56.00	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
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	763,421	1,957,777	2,721,198	0.445659	0.000000	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
64.00	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	RESPIRATORY THERAPY	395,018	2,008,366	2,403,384	0.284220	0.000000	65.00
66.00	PHYSICAL THERAPY	1,618,896	1,261,166	2,880,062	0.418100	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	ELECTROCARDIOLOGY	34,277	123,297	157,574	0.231231	0.000000	69.00
69.01	CARDIAC REHABILITATION	0	193,965	193,965	0.870760	0.000000	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	743,317	1,117,472	1,860,789	0.313659	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,176,905	2,948,417	5,125,322	0.183971	0.000000	73.00
	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
90.00	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	EMERGENCY	176,744	3,348,311	3,525,055	0.755538	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	212,429	212,429	1.453394	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)	17,321,135	35,240,900	52,562,035			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	17,321,135	35,240,900	52,562,035			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 1/24/2012 4:29 pm

Title XVIII | Hospital | Cost

	Cost Center Description	PPS Inpatient Ratio		
		11.00		
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS			30.00
31.00	INTENSIVE CARE UNIT			31.00
32.00	CORONARY CARE UNIT			32.00
40.00	SUBPROVIDER - IPF			40.00
41.00	SUBPROVIDER - IRF			41.00
42.00	SUBPROVIDER			42.00
43.00	NURSERY			43.00
44.00	SKILLED NURSING FACILITY			44.00
45.00	NURSING FACILITY			45.00
46.00	OTHER LONG TERM CARE			46.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	0.000000		50.00
51.00	RECOVERY ROOM	0.000000		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	ANESTHESIOLOGY	0.000000		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	RADIOISOTOPE	0.000000		56.00
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
64.00	INTRAVENOUS THERAPY	0.000000		64.00
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
69.01	CARDIAC REHABILITATION	0.000000		69.01
70.00	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	CLINIC	0.000000		90.00
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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 1/24/2012 4:29 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,583,288		2,583,288	0	0	30.00
31.00	INTENSIVE CARE UNIT	366,859		366,859	0	0	31.00
32.00	CORONARY CARE UNIT	0		0	0	0	32.00
40.00	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	SUBPROVIDER	0		0	0	0	42.00
43.00	NURSERY	0		0	0	0	43.00
44.00	SKILLED NURSING FACILITY	1,486,158		1,486,158	0	0	44.00
45.00	NURSING FACILITY	0		0	0	0	45.00
46.00	OTHER LONG TERM CARE	2,653,082		2,653,082	0	0	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	4,974,357		4,974,357	0	0	50.00
51.00	RECOVERY ROOM	0		0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	ANESTHESIOLOGY	48,091		48,091	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,087,584		2,087,584	0	0	54.00
56.00	RADIOISOTOPE	0		0	0	0	56.00
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	1,212,727		1,212,727	0	0	60.00
60.01	BLOOD LABORATORY	0		0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	RESPIRATORY THERAPY	683,091	0	683,091	0	0	65.00
66.00	PHYSICAL THERAPY	1,204,154	0	1,204,154	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	36,436		36,436	0	0	69.00
69.01	CARDIAC REHABILITATION	168,897		168,897	0	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	583,654		583,654	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	942,910		942,910	0	0	73.00
	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
90.00	CLINIC	0		0	0	0	90.00
91.00	EMERGENCY	2,663,314		2,663,314	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	308,743		308,743		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						113.00
200.00	Subtotal (see instructions)	22,003,345	0	22,003,345	0	0	200.00
201.00	Less Observation Beds	308,743		308,743		0	201.00
202.00	Total (see instructions)	21,694,602	0	21,694,602	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 1/24/2012 4:29 pm

Title XIX | Hospital | Cost

	Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,330,114		3,330,114			30.00
31.00	INTENSIVE CARE UNIT	426,130		426,130			31.00
32.00	CORONARY CARE UNIT	0		0			32.00
40.00	SUBPROVIDER - IPF	0		0			40.00
41.00	SUBPROVIDER - IRF	0		0			41.00
42.00	SUBPROVIDER	0		0			42.00
43.00	NURSERY	0		0			43.00
44.00	SKILLED NURSING FACILITY	759,527		759,527			44.00
45.00	NURSING FACILITY	0		0			45.00
46.00	OTHER LONG TERM CARE	1,366,080		1,366,080			46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	4,735,593	14,559,382	19,294,975	0.257806	0.000000	50.00
51.00	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	ANESTHESIOLOGY	0	53,811	53,811	0.893702	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	795,113	7,456,507	8,251,620	0.252991	0.000000	54.00
56.00	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
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	763,421	1,957,777	2,721,198	0.445659	0.000000	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
64.00	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	RESPIRATORY THERAPY	395,018	2,008,366	2,403,384	0.284220	0.000000	65.00
66.00	PHYSICAL THERAPY	1,618,896	1,261,166	2,880,062	0.418100	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	ELECTROCARDIOLOGY	34,277	123,297	157,574	0.231231	0.000000	69.00
69.01	CARDIAC REHABILITATION	0	193,965	193,965	0.870760	0.000000	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	743,317	1,117,472	1,860,789	0.313659	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,176,905	2,948,417	5,125,322	0.183971	0.000000	73.00
	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
90.00	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	EMERGENCY	176,744	3,348,311	3,525,055	0.755538	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	212,429	212,429	1.453394	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)	17,321,135	35,240,900	52,562,035			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	17,321,135	35,240,900	52,562,035			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet C Part I Date/Time Prepared: 1/24/2012 4:29 pm

Title XIX | Hospital | Cost

	Cost Center Description	PPS Inpatient Ratio		
		11.00		
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS			30.00
31.00	INTENSIVE CARE UNIT			31.00
32.00	CORONARY CARE UNIT			32.00
40.00	SUBPROVIDER - IPF			40.00
41.00	SUBPROVIDER - IRF			41.00
42.00	SUBPROVIDER			42.00
43.00	NURSERY			43.00
44.00	SKILLED NURSING FACILITY			44.00
45.00	NURSING FACILITY			45.00
46.00	OTHER LONG TERM CARE			46.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	0.000000		50.00
51.00	RECOVERY ROOM	0.000000		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	ANESTHESIOLOGY	0.000000		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	RADIOISOTOPE	0.000000		56.00
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
64.00	INTRAVENOUS THERAPY	0.000000		64.00
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
69.01	CARDIAC REHABILITATION	0.000000		69.01
70.00	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC	0.000000		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	CLINIC	0.000000		90.00
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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part II Date/Time Prepared: 1/24/2012 4:29 pm

Title XVIII | Hospital | Cost

	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	511,355	19,294,975	0.026502	991,415	26,274	50.00
51.00	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	1,585	53,811	0.029455	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	305,905	8,251,620	0.037072	445,727	16,524	54.00
56.00	RADIOISOTOPE	0	0	0.000000	0	0	56.00
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	62,738	2,721,198	0.023055	373,954	8,622	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	57,377	2,403,384	0.023873	258,751	6,177	65.00
66.00	PHYSICAL THERAPY	109,740	2,880,062	0.038103	79,152	3,016	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	1,812	157,574	0.011499	17,270	199	69.00
69.01	CARDIAC REHABILITATION	22,124	193,965	0.114062	0	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	5,750	1,860,789	0.003090	194,612	601	72.00
73.00	DRUGS CHARGED TO PATIENTS	84,733	5,125,322	0.016532	980,978	16,218	73.00
	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
90.00	CLINIC	0	0	0.000000	0	0	90.00
91.00	EMERGENCY	76,388	3,525,055	0.021670	3,680	80	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	212,429	0.000000	0	0	92.00
200.00	Total (lines 50-199)	1,239,507	46,680,184		3,345,539	77,711	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV Date/Time Prepared: 1/24/2012 4:29 pm

Title XVIII | Hospital | Cost

	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	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	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
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV Date/Time Prepared: 1/24/2012 4:29 pm

Title XVIII | Hospital | Cost

	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	19,294,975	0.000000	0.000000	991,415	50.00
51.00	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	ANESTHESIOLOGY	0	53,811	0.000000	0.000000	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	8,251,620	0.000000	0.000000	445,727	54.00
56.00	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
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	2,721,198	0.000000	0.000000	373,954	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	RESPIRATORY THERAPY	0	2,403,384	0.000000	0.000000	258,751	65.00
66.00	PHYSICAL THERAPY	0	2,880,062	0.000000	0.000000	79,152	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	ELECTROCARDIOLOGY	0	157,574	0.000000	0.000000	17,270	69.00
69.01	CARDIAC REHABILITATION	0	193,965	0.000000	0.000000	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	1,860,789	0.000000	0.000000	194,612	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	5,125,322	0.000000	0.000000	980,978	73.00
	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
90.00	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	EMERGENCY	0	3,525,055	0.000000	0.000000	3,680	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	212,429	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	46,680,184			3,345,539	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV Date/Time Prepared: 1/24/2012 4:29 pm

Title XVIII | Hospital | Cost

	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
51.00	RECOVERY ROOM	0	0	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	ANESTHESIOLOGY	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	RADIOISOTOPE	0	0	0		56.00
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
64.00	INTRAVENOUS THERAPY	0	0	0		64.00
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
69.01	CARDIAC REHABILITATION	0	0	0		69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
	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
90.00	CLINIC	0	0	0		90.00
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: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V Date/Time Prepared: 1/24/2012 4:29 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
		1.00	2.00	3.00	4.00		
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.257806	0	3,087,835	0		50.00
51.00	RECOVERY ROOM	0.000000	0	0	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0		52.00
53.00	ANESTHESIOLOGY	0.893702	0	10,390	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.252991	0	2,328,234	2,483		54.00
56.00	RADIOISOTOPE	0.000000	0	0	0		56.00
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	0.445659	0	665,911	0		60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0		60.01
64.00	INTRAVENOUS THERAPY	0.000000	0	0	0		64.00
65.00	RESPIRATORY THERAPY	0.284220	0	446,800	0		65.00
66.00	PHYSICAL THERAPY	0.418100	0	392,324	0		66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	0		67.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	0		68.00
69.00	ELECTROCARDIOLOGY	0.231231	0	53,992	0		69.00
69.01	CARDIAC REHABILITATION	0.870760	0	101,179	0		69.01
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.313659	0	311,957	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.183971	0	594,693	0		73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000					88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00	CLINIC	0.000000	0	0	0		90.00
91.00	EMERGENCY	0.755538	0	769,622	959		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.453394	0	109,160	155		92.00
200.00	Subtotal (see instructions)		0	8,872,097	3,597		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		0	8,872,097	3,597		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part V Date/Time Prepared: 1/24/2012 4:29 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Costs PPS Services (see instructions)	Costs Cost Services Subject To Ded. & Coins. (see instructions)	Costs Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	796,062	0		50.00
51.00	RECOVERY ROOM	0	0	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	ANESTHESIOLOGY	0	9,286	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	589,022	628		54.00
56.00	RADIOISOTOPE	0	0	0		56.00
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	296,769	0		60.00
60.01	BLOOD LABORATORY	0	0	0		60.01
64.00	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	RESPIRATORY THERAPY	0	126,989	0		65.00
66.00	PHYSICAL THERAPY	0	164,031	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	12,485	0		69.00
69.01	CARDIAC REHABILITATION	0	88,103	0		69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	97,848	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	109,406	0		73.00
	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
90.00	CLINIC	0	0	0		90.00
91.00	EMERGENCY	0	581,479	725		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	158,652	225		92.00
200.00	Subtotal (see instructions)	0	3,030,132	1,578		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	0	3,030,132	1,578		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141335 | Component CCN: 146014 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV | Date/Time Prepared: 1/24/2012 4:29 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	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
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141335 | Component CCN: 146014 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV | Date/Time Prepared: 1/24/2012 4:29 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	19,294,975	0.000000	0.000000	72,636	50.00
51.00	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	ANESTHESIOLOGY	0	53,811	0.000000	0.000000	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	8,251,620	0.000000	0.000000	22,858	54.00
56.00	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
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	2,721,198	0.000000	0.000000	57,814	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	RESPIRATORY THERAPY	0	2,403,384	0.000000	0.000000	2,222	65.00
66.00	PHYSICAL THERAPY	0	2,880,062	0.000000	0.000000	1,254,419	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	ELECTROCARDIOLOGY	0	157,574	0.000000	0.000000	0	69.00
69.01	CARDIAC REHABILITATION	0	193,965	0.000000	0.000000	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	1,860,789	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	5,125,322	0.000000	0.000000	0	73.00
	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
90.00	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	EMERGENCY	0	3,525,055	0.000000	0.000000	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	212,429	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	46,680,184			1,409,949	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141335 | Component CCN: 146014 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D Part IV | Date/Time Prepared: 1/24/2012 4:29 pm

Title XVIII | Skilled Nursing Facility | 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
51.00	RECOVERY ROOM	0	0	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	ANESTHESIOLOGY	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	RADIOISOTOPE	0	0	0		56.00
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
64.00	INTRAVENOUS THERAPY	0	0	0		64.00
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
69.01	CARDIAC REHABILITATION	0	0	0		69.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
	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
90.00	CLINIC	0	0	0		90.00
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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-1 | Date/Time Prepared: 1/24/2012 4:29 pm

Title XVIII | Hospital | Cost

	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)	1,732	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,732	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)	1,732	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)	861	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)	2,583,288	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)	2,583,288	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	3,330,114	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	3,330,114	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.775736	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)	1,922.70	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)	2,583,288	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)	1,491.51	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,284,190	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)	1,284,190	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-1 | Date/Time Prepared: 1/24/2012 4:29 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	366,859	116	3,162.58	45	142,316	43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	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)	889,936	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,316,442	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)	207	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,491.51	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	308,743	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-1 | Date/Time Prepared: 1/24/2012 4:29 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141335 Component CCN: 146014	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/24/2012 4:29 pm
	Title XVIII	Skilled Nursing Facility	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)	3,416	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,416	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)	3,416	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,416	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)	0	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)	0	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	759,527	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	759,527	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)	222.34	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)	0	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141335	Period: From 07/01/2010	Worksheet D-1
Component CCN: 146014	To 06/30/2011	Date/Time Prepared: 1/24/2012 4:29 pm
Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)	0	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	0.00	71.00
72.00	Program routine service cost (line 9 x line 71)	0	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	0	83.00
84.00	Program inpatient ancillary services (see instructions)	575,379	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	575,379	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: 141335 Component CCN: 146014	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/24/2012 4:29 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141335	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/24/2012 4:29 pm
	Title XIX	Hospital	Cost

	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)	1,732	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,732	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)	1,732	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)	91	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)	2,583,288	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)	2,583,288	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	3,330,114	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	3,330,114	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.775736	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)	1,922.70	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)	2,583,288	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)	1,491.51	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	135,727	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)	135,727	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-1 | Date/Time Prepared: 1/24/2012 4:29 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	366,859	116	3,162.58	5	15,813	43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	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)	167,023	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	318,563	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)	207	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,491.51	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	308,743	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141335	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/24/2012 4:29 pm
	Title XIX	Hospital	Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-3 | Date/Time Prepared: 1/24/2012 4:29 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		1,810,133		30.00
31.00	INTENSIVE CARE UNIT		210,057		31.00
32.00	CORONARY CARE UNIT		0		32.00
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	0.257806	991,415	255,593	50.00
51.00	RECOVERY ROOM	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	0.893702	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.252991	445,727	112,765	54.00
56.00	RADIOISOTOPE	0.000000	0	0	56.00
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	0.445659	373,954	166,656	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
64.00	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	0.284220	258,751	73,542	65.00
66.00	PHYSICAL THERAPY	0.418100	79,152	33,093	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.231231	17,270	3,993	69.00
69.01	CARDIAC REHABILITATION	0.870760	0	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.313659	194,612	61,042	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.183971	980,978	180,472	73.00
	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
90.00	CLINIC	0.000000	0	0	90.00
91.00	EMERGENCY	0.755538	3,680	2,780	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.453394	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		3,345,539	889,936	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)		3,345,539		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141335	Period: From 07/01/2010	Worksheet D-3
Component CCN: 146014	To 06/30/2011	Date/Time Prepared: 1/24/2012 4:29 pm
Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
32.00	CORONARY CARE UNIT		0		32.00
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	0.257806	72,636	18,726	50.00
51.00	RECOVERY ROOM	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	0.893702	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.252991	22,858	5,783	54.00
56.00	RADIOISOTOPE	0.000000	0	0	56.00
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	0.445659	57,814	25,765	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
64.00	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	0.284220	2,222	632	65.00
66.00	PHYSICAL THERAPY	0.418100	1,254,419	524,473	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.231231	0	0	69.00
69.01	CARDIAC REHABILITATION	0.870760	0	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.313659	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.183971	0	0	73.00
	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
90.00	CLINIC	0.000000	0	0	90.00
91.00	EMERGENCY	0.755538	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.453394	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,409,949	575,379	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)		1,409,949		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet D-3 | Date/Time Prepared: 1/24/2012 4:29 pm

Title XIX | Hospital | Cost

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		148,198		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
32.00	CORONARY CARE UNIT		0		32.00
40.00	SUBPROVIDER - IPF		0		40.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY		0		43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.257806	307,923	79,384	50.00
51.00	RECOVERY ROOM	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	0.893702	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.252991	64,461	16,308	54.00
56.00	RADIOISOTOPE	0.000000	0	0	56.00
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	0.445659	54,349	24,221	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
64.00	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	0.284220	6,695	1,903	65.00
66.00	PHYSICAL THERAPY	0.418100	1,169	489	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.231231	7,238	1,674	69.00
69.01	CARDIAC REHABILITATION	0.870760	0	0	69.01
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.313659	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.183971	102,994	18,948	73.00
	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
90.00	CLINIC	0.000000	0	0	90.00
91.00	EMERGENCY	0.755538	31,892	24,096	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.453394	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		576,721	167,023	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)		576,721		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141335	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/24/2012 4:29 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,031,710	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,031,710	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 chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	3,062,027	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)	18,836	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,637,147	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)	1,406,044	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)	1,406,044	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,406,044	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)	131,039	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	131,039	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	108,282	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	1,537,083	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	1,537,083	40.00
41.00	Interim payments	1,440,153	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)	96,930	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: 141335 Component CCN: 146014	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/24/2012 4:29 pm
	Title XVIII	Skilled Nursing Facility	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		3.00
4.00	Outlier payment (see instructions)		4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		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 chargebasis 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)		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		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)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet E-1 Part I | Date/Time Prepared: 1/24/2012 4:29 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,041,481		1,528,265	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	05/27/2011	234,691	05/27/2011	52,515	3.01
3.02		01/21/2011	26,390		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	02/25/2011	115,434	02/25/2011	63,320	3.50
3.51			0	01/21/2011	77,307	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)		145,647		-88,112	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)		2,187,128		1,440,153	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		96,930	6.01
6.02	SETTLEMENT TO PROGRAM		65,767		0	6.02
7.00	Total Medicare program liability (see instructions)		2,121,361		1,537,083	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: 141335 | Component CCN: 146014 | Period: From 07/01/2010 To 06/30/2011 | Worksheet E-1 Part I | Date/Time Prepared: 1/24/2012 4:29 pm

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,162,576		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,162,576		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,162,576		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 141335	Period: From 07/01/2010 To 06/30/2011	Worksheet E-1 Part II Date/Time Prepared: 1/24/2012 4:29 pm
	Title XVIII	Hospital	Cost

		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	594	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	906	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	1,641	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	52,562,035	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	830,323	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: 141335	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part V Date/Time Prepared: 1/24/2012 4:29 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	2,316,442	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	2,316,442	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 5 less line 6) . For CAH (see instructions)	2,339,606	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,339,606	19.00
20.00	Deductibles (exclude professional component)	236,400	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus sum of lines 20 and 21)	2,103,206	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,103,206	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	18,155	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	18,155	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	12,083	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26(line 26 hospital and subprovider only))	2,121,361	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	2,121,361	30.00
31.00	Interim payments	2,187,128	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)	-65,767	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141335 Component CCN: 146014	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part VI Date/Time Prepared: 1/24/2012 4:29 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,435,360	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,435,360	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	272,784	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Allowable reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)	1,162,576	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14	1,162,576	15.00
16.00	Interim payments	1,162,576	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus the sum of lines 16 and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141335	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part VII Date/Time Prepared: 1/24/2012 4:29 pm
	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	318,563	1.00
2.00	Medical and other services	0	2.00
3.00	Organ acquisition (certified transplant centers only)	0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	318,563	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)	318,563	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable Charges		
8.00	Routine service charges	148,198	8.00
9.00	Ancillary service charges	576,721	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)	724,919	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)	724,919	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 7) (see instructions)	406,356	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)	318,563	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)	318,563	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)	318,563	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)	318,563	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	37.00
38.00	Subtotal (line 36 ± line 37)	318,563	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)	318,563	40.00
41.00	Interim payments	200,754	41.00
42.00	Balance due provider/program (line 40 minus 41)	117,809	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: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G | Date/Time Prepared: 1/24/2012 4:29 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURENT ASSETS					
1.00	Cash on hand in banks	806,339	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	4,221,346	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	648,041	0	0	0	7.00
8.00	Prepaid expenses	108,381	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	226,855	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,010,962	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	222,604	0	0	0	12.00
13.00	Land improvements	693,778	0	0	0	13.00
14.00	Accumulated depreciation	-467,451	0	0	0	14.00
15.00	Buildings	16,567,598	0	0	0	15.00
16.00	Accumulated depreciation	-9,568,549	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	9,001,662	0	0	0	23.00
24.00	Accumulated depreciation	-7,080,833	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	9,368,809	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	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	15,379,771	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	287,632	0	0	0	37.00
38.00	Salaries, wages, and fees payable	786,186	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,480	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	1,567,479	0	0	0	43.00
44.00	Other current liabilities	104,482	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,747,259	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,471	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	13,678,621	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	13,686,092	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	16,433,351	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-1,053,580				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)	-1,053,580	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	15,379,771	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G-1 | Date/Time Prepared: 1/24/2012 4:29 pm

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		-2,519,000		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,465,000				2.00
3.00	Total (sum of line 1 and line 2)		-1,054,000		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)		-1,054,000		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)		-1,054,000		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G-1 | Date/Time Prepared: 1/24/2012 4:29 pm

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141335 | Period: From 07/01/2010 To 06/30/2011 | Worksheet G-2 Parts | Date/Time Prepared: 1/24/2012 4:29 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,330,117		3,330,117	1.00
2.00	SUBPROVIDER - IPF	0		0	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	0		0	7.00
8.00	NURSING FACILITY	759,527		759,527	8.00
9.00	OTHER LONG TERM CARE	1,366,080		1,366,080	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,455,724		5,455,724	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	426,130		426,130	11.00
12.00	CORONARY CARE UNIT	0		0	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)	426,130		426,130	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,881,854		5,881,854	17.00
18.00	Ancillary services	11,439,284	35,240,900	46,680,184	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL REVENUE	1,248,141	0	1,248,141	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	18,569,279	35,240,900	53,810,179	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		20,809,261		29.00
30.00	BAD DEBT EXPNESE	2,220,605			30.00
31.00	W/S A TO F/S VARIANCE	2,134			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)		2,222,739		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		23,032,000		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141335	Period: From 07/01/2010 To 06/30/2011	Worksheet G-3 Date/Time Prepared: 1/24/2012 4:29 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	53,810,179	1.00
2.00	Less contractual allowances and discounts on patients' accounts	29,402,545	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,407,634	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	23,032,000	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,375,634	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00		89,366	24.00
25.00	Total other income (sum of lines 6-24)	89,366	25.00
26.00	Total (line 5 plus line 25)	1,465,000	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,465,000	29.00