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: 140040	Period: From 05/01/2011 To 04/30/2012	Worksheet S Parts I-III Date/Time Prepared: 9/25/2012 11:46 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 9/25/2012 Time: 11:46 am
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. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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 GALESBURG COTTAGE HOSPITAL for the cost reporting period beginning 05/01/2011 and ending 04/30/2012 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	-3,541	-484	0	0	1.00
2.00	Subprovider - IPF	0	889	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	974	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	-1,678	-484	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 9/24/2012 5:51 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 695 NORTH KELLOGG STREET	PO Box:			1.00
2.00	City: GALESBURG	State: IL	Zip Code: 61401	County: KNOX	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	GALESBURG COTTAGE HOSPITAL	140040	99914	1	07/06/1966	N	P	P	3.00
4.00	Subprovider - IPF	GALEBSURG COTTAGE PSYCH	14S040	99914	4	05/01/2006	N	P	N	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	GALESBURG COTTAGE SKILLED UNIT	145690	99914		01/11/1991	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						N	N	N	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						N	N	N	17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	05/01/2011	04/30/2012	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid 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 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 paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	3,037	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.	2		26.00
27.00	For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	1		37.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 9/24/2012 5:51 pm

		Beginning:	Ending:	
		1.00	2.00	
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.	05/01/2011	04/30/2012	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.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME Average	Direct GME Average	
		1.00	2.00	3.00	
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00
	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 in column 1. 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	If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-2 Part I Date/Time Prepared: 9/24/2012 5:51 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. Use subscripted lines 65.01 through 65.50 for each additional primary care program. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. (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	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-2 Part I Date/Time Prepared: 9/24/2012 5:51 pm

		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.	Y			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N	N	0	71.00
	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	Are you a long term care hospital (LTCH)? Enter in column 1 "Y" for yes and "N" for no. LTCHs can only exist as independent/freestanding facilities. An independent or freestanding facility may exist as an unrelated hospital within a hospital, it must meet the separateness (from the host/co-located provider) requirements identified in 42 CFR 412.22(e.)	N	80.00
	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.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	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.					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.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-2 Part I | Date/Time Prepared: 9/24/2012 5:51 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	Enter the total amount of malpractice premiums paid in column 1, enter the total amount of paid losses in column 2, and enter the total amount of self insurance paid in column 3.	119,284	356,433	0	118.01

		1.00	2.00	
118.02	Indicate if malpractice premiums and paid losses are reported in other than the Administrative and General cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	If this is an SCH (or EACH), regardless of bed size, or is rural hospital with 100 or fewer beds that qualifies for the outpatient hold harmless provision in accordance with ACA, section 3121, as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108; the Temporary Payroll Tax Cut Continuation Act of 2011, section 308; and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002, enter "Y" for yes or "N" for no in column 1 or column 2, respectively. Note that for SCHs (and EACHs) the outpatient hold harmless provision is effective for services rendered from January 1, 2010 through February 29, 2012 regardless of bed size and from March 1, 2012 through December 31, 2012 to all SCHs (and EACHs) with 100 or fewer beds. These responses impact the TOPs calculation on Worksheet E, Part B, line 8.	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
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	449008	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: COMMUNITY HEALTH SYSTEMS	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 5201	141.00
142.00	Street: 4000 MERIDIAN BOULEVARD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	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, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	Y	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	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	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	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-2 Part I Date/Time Prepared: 9/24/2012 5:51 pm

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	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

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						1.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-2 Part II | Date/Time Prepared: 9/24/2012 5:51 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.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		
		Description	Y/N	Date	
		0	1.00	2.00	
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	08/13/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-2 Part II Date/Time Prepared: 9/24/2012 5:51 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.				N	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.	Y	12/31/2011	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	HEATHER	MANGEOT	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(615) 465-7557	HEATHER_MANGEOT@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-2 Part II Date/Time Prepared: 9/24/2012 5:51 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)	Y	08/13/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
			3.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-3 Part I Date/Time Prepared: 9/24/2012 5:51 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	115	42,090	0.00		1.00
2.00	HMO						2.00
3.00	HMO IPF						3.00
4.00	HMO IRF						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		115	42,090	0.00		7.00
8.00	INTENSIVE CARE UNIT	31.00	12	4,392	0.00		8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00					13.00
14.00	Total (see instructions)		127	46,482	0.00		14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	40.00	12	4,392			16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	34	12,444			19.00
20.00	NURSING FACILITY	45.00	0	0			20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC	99.00					25.00
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)		173				27.00
28.00	Observation Bed Days						28.00
28.01	SUBPROVIDER - IPF	40.00					28.01
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: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 9/24/2012 5:51 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	7,357	2,063	11,805		1.00
2.00	HMO		1,387	0			2.00
3.00	HMO IPF		9	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	7,357	2,063	11,805		7.00
8.00	INTENSIVE CARE UNIT	0	1,678	162	2,294		8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	0		812	1,054		13.00
14.00	Total (see instructions)	0	9,035	3,037	15,153		14.00
15.00	CAH visits	0	0	0	0		15.00
16.00	SUBPROVIDER - IPF	0	2,350	0	2,716		16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	7,062	0	7,873		19.00
20.00	NURSING FACILITY	0		0	0		20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0		22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC	0	0	0	0		25.00
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	611		28.00
28.01	SUBPROVIDER - IPF				0		28.01
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: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 9/24/2012 5:51 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	1,869	1.00
2.00	HMO					30	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	350.06	0.00	0	1,869	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	15.97	0.00	0	200	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00	31.68	0.00			19.00
20.00	NURSING FACILITY	0.00	0.00	0.00			20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00	0.00	0.00			22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC	0.00	0.00	0.00			25.00
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	397.71	0.00			27.00
28.00	Observation Bed Days						28.00
28.01	SUBPROVIDER - IPF						28.01
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: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-3 Part I | Date/Time Prepared: 9/24/2012 5:51 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)	629	3,484		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)	629	3,484		14.00
15.00	CAH visits				15.00
16.00	SUBPROVIDER - IPF	6	226		16.00
17.00	SUBPROVIDER - IRF				17.00
18.00	SUBPROVIDER				18.00
19.00	SKILLED NURSING FACILITY				19.00
20.00	NURSING FACILITY				20.00
21.00	OTHER LONG TERM CARE				21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00	HOSPICE				24.00
25.00	CMHC - CMHC				25.00
26.00	RURAL HEALTH CLINIC				26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00	Total (sum of lines 14-26)				27.00
28.00	Observation Bed Days				28.00
28.01	SUBPROVIDER - IPF				28.01
29.00	Ambulance Trips				29.00
30.00	Employee discount days (see instruction)				30.00
31.00	Employee discount days - IRF				31.00
32.00	Labor & delivery days (see instructions)				32.00
33.00	LTCH non-covered days				33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-3 Part II Date/Time Prepared: 9/24/2012 5:51 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
		1.00	2.00	3.00	4.00	5.00	
	PART II - WAGE DATA						
	SALARIES						
1.00	Total salaries (see instructions)	200.00	20,177,314	0	20,177,314	827,246.00	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	8.00
9.00	SNF	44.00	1,446,888	0	1,446,888	65,904.00	9.00
10.00	Excluded area salaries (see instructions)		872,266	-10,436	861,830	37,496.00	10.00
	OTHER WAGES & RELATED COSTS						
11.00	Contract labor (see instructions)		1,228,851	0	1,228,851	31,306.00	11.00
12.00	Contract management and administrative services		0	0	0	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		45,412	0	45,412	422.50	13.00
14.00	Home office salaries & wage-related costs		1,308,591	0	1,308,591	19,987.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	15.00
16.00	Home office and Contract Physicians Part A - Administrative		0	0	0	0.00	16.00
	WAGE-RELATED COSTS						
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		4,760,026	0	4,760,026		17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV line 25		0	0	0		18.00
19.00	Excluded areas		615,021	0	615,021		19.00
20.00	Non-physician anesthetist Part A		0	0	0		20.00
21.00	Non-physician anesthetist Part B		0	0	0		21.00
22.00	Physician Part A - Administrative		0	0	0		22.00
22.01	Physician Part A - Teaching		0	0	0		22.01
23.00	Physician Part B		0	0	0		23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0		24.00
25.00	Interns & residents (in an approved program)		0	0	0		25.00
	OVERHEAD COSTS - DIRECT SALARIES						
26.00	Employee Benefits	4.00	87,696	0	87,696	4,263.00	26.00
27.00	Administrative & General	5.00	2,355,870	-142,083	2,213,787	103,849.00	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	29.00
30.00	Operation of Plant	7.00	426,156	0	426,156	20,535.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	31.00
32.00	Housekeeping	9.00	555,297	0	555,297	49,562.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	34.00
35.00	Dietary under contract (see instructions)		916,382	0	916,382	42,492.53	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	37.00
38.00	Nursing Administration	13.00	1,060,243	61,001	1,121,244	33,260.00	38.00
39.00	Central Services and Supply	14.00	104,208	0	104,208	8,340.00	39.00
40.00	Pharmacy	15.00	670,932	0	670,932	21,633.00	40.00
41.00	Medical Records & Medical Records Library	16.00	329,612	0	329,612	21,630.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-3 Part II | Date/Time Prepared: 9/24/2012 5:51 pm

		Average Hourly Wage (col. 4 ÷ col. 5)		
		6.00		
	PART II - WAGE DATA			
	SALARIES			
1.00	Total salaries (see instructions)	24.39		1.00
2.00	Non-physician anesthetist Part A	0.00		2.00
3.00	Non-physician anesthetist Part B	0.00		3.00
4.00	Physician-Part A - Administrative	0.00		4.00
4.01	Physicians - Part A - Teaching	0.00		4.01
5.00	Physician-Part B	0.00		5.00
6.00	Non-physician-Part B	0.00		6.00
7.00	Interns & residents (in an approved program)	0.00		7.00
7.01	Contracted interns and residents (in an approved programs)	0.00		7.01
8.00	Home office personnel	0.00		8.00
9.00	SNF	21.95		9.00
10.00	Excluded area salaries (see instructions)	22.98		10.00
	OTHER WAGES & RELATED COSTS			
11.00	Contract labor (see instructions)	39.25		11.00
12.00	Contract management and administrative services	0.00		12.00
13.00	Contract labor: Physician-Part A - Administrative	107.48		13.00
14.00	Home office salaries & wage-related costs	65.47		14.00
15.00	Home office: Physician Part A - Administrative	0.00		15.00
16.00	Home office and Contract Physicians Part A - Administrative	0.00		16.00
	WAGE-RELATED COSTS			
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24			17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV line 25			18.00
19.00	Excluded areas			19.00
20.00	Non-physician anesthetist Part A			20.00
21.00	Non-physician anesthetist Part B			21.00
22.00	Physician Part A - Administrative			22.00
22.01	Physician Part A - Teaching			22.01
23.00	Physician Part B			23.00
24.00	Wage-related costs (RHC/FQHC)			24.00
25.00	Interns & residents (in an approved program)			25.00
	OVERHEAD COSTS - DIRECT SALARIES			
26.00	Employee Benefits	20.57		26.00
27.00	Administrative & General	21.32		27.00
28.00	Administrative & General under contract (see inst.)	0.00		28.00
29.00	Maintenance & Repairs	0.00		29.00
30.00	Operation of Plant	20.75		30.00
31.00	Laundry & Linen Service	0.00		31.00
32.00	Housekeeping	11.20		32.00
33.00	Housekeeping under contract (see instructions)	0.00		33.00
34.00	Dietary	0.00		34.00
35.00	Dietary under contract (see instructions)	21.57		35.00
36.00	Cafeteria	0.00		36.00
37.00	Maintenance of Personnel	0.00		37.00
38.00	Nursing Administration	33.71		38.00
39.00	Central Services and Supply	12.49		39.00
40.00	Pharmacy	31.01		40.00
41.00	Medical Records & Medical Records Library	15.24		41.00
42.00	Social Service	0.00		42.00
43.00	Other General Service	0.00		43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-3 Part III Date/Time Prepared: 9/24/2012 5:51 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
		1.00	2.00	3.00	4.00	5.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY						
1.00	Net salaries (see instructions)		21,093,696	0	21,093,696	869,738.53	1.00
2.00	Excluded area salaries (see instructions)		2,319,154	-10,436	2,308,718	103,400.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)		18,774,542	10,436	18,784,978	766,338.53	3.00
4.00	Subtotal other wages & related costs (see inst.)		2,582,854	0	2,582,854	51,715.50	4.00
5.00	Subtotal wage-related costs (see inst.)		4,760,026	0	4,760,026	0.00	5.00
6.00	Total (sum of lines 3 thru 5)		26,117,422	10,436	26,127,858	818,054.03	6.00
7.00	Total overhead cost (see instructions)		6,506,396	-81,082	6,425,314	305,564.53	7.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-3 Part III Date/Time Prepared: 9/24/2012 5:51 pm

		Average Hourly Wage (col. 4 ÷ col. 5)		
		6.00		
	PART III - HOSPITAL WAGE INDEX SUMMARY			
1.00	Net salaries (see instructions)	24.25		1.00
2.00	Excluded area salaries (see instructions)	22.33		2.00
3.00	Subtotal salaries (line 1 minus line 2)	24.51		3.00
4.00	Subtotal other wages & related costs (see inst.)	49.94		4.00
5.00	Subtotal wage-related costs (see inst.)	25.34		5.00
6.00	Total (sum of lines 3 thru 5)	31.94		6.00
7.00	Total overhead cost (see instructions)	21.03		7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-3 Part IV Date/Time Prepared: 9/24/2012 5:51 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	490,538	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost (see instructions)	0	3.00
4.00	Pension Service Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	2,921,941	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	42,003	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	26,231	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	18,225	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	276,405	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,142,808	17.00
18.00	Medicare Taxes - Employers Portion Only	267,270	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	158,082	20.00
	OTHER		
21.00	Executive Deferred Compensation (see instructions)	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,343,503	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	31,545	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-3 Part V Date/Time Prepared: 9/24/2012 5:51 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	293,375	0	1.00
2.00	Hospital	293,375	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC	0	0	16.00
17.00	Renal Dialysis	0	0	17.00
18.00		0	0	18.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-5 | Date/Time Prepared: 9/24/2012 5:51 pm

		Outpatient		Training			
		Regular	High Flux	Hemodialysis	CAPD / CCPD		
		1.00	2.00	3.00	4.00		
1.00	Number of patients in program at end of cost reporting period	0	0	0	0		1.00
2.00	Number of times per week patient receives dialysis	0.00	0.00	0.00	0.00		2.00
3.00	Average patient dialysis time including setup	0.00	0.00	0.00	0.00		3.00
4.00	CAPD exchanges per day				0.00		4.00
5.00	Number of days in year dialysis furnished	0	0				5.00
6.00	Number of stations	0	0	0	0		6.00
7.00	Treatment capacity per day per station	0	0				7.00
8.00	Utilization (see instructions)	0.00	0.00				8.00
9.00	Average times dialyzers re-used	0.00	0.00				9.00
10.00	Percentage of patients re-using dialyzers	0.00	0.00				10.00
	TRANSPLANT INFORMATION						
11.00	Number of patients on transplant list	0					11.00
12.00	Number of patients transplanted during the cost reporting period	0					12.00
	EPOETIN						
13.00	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider.	0					13.00
14.00	Epoetin amount from Worksheet A for Home Dialysis program	0					14.00
15.00	Number of EPO units furnished relating to the renal dialysis department	0					15.00
16.00	Number of EPO units furnished relating to the home dialysis department	0					16.00
	ARANESP						
17.00	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider.	0					17.00
18.00	ARANESP amount from Worksheet A for Home Dialysis program	0					18.00
19.00	Number of ARANESP units furnished relating to the renal dialysis department	0					19.00
20.00	Number of ARANESP units furnished relating to the home dialysis department	0					20.00
					MCP	INITIAL METHOD	
					1.00	2.00	
	PHYSICIAN PAYMENT METHOD						
21.00	enter "X" if method(s) is applicable				X		21.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-5 | Date/Time Prepared: 9/24/2012 5:51 pm

		Home		
		Hemodialysis	CAPD / CCPD	
		5.00	6.00	
1.00	Number of patients in program at end of cost reporting period	0	0	1.00
2.00	Number of times per week patient receives dialysis	0.00	0.00	2.00
3.00	Average patient dialysis time including setup			3.00
4.00	CAPD exchanges per day		0.00	4.00
5.00	Number of days in year dialysis furnished			5.00
6.00	Number of stations			6.00
7.00	Treatment capacity per day per station			7.00
8.00	Utilization (see instructions)			8.00
9.00	Average times dialyzers re-used			9.00
10.00	Percentage of patients re-using dialyzers			10.00
	TRANSPLANT INFORMATION			
11.00	Number of patients on transplant list			11.00
12.00	Number of patients transplanted during the cost reporting period			12.00
	EPOETIN			
13.00	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider.			13.00
14.00	Epoetin amount from Worksheet A for Home Dialysis program			14.00
15.00	Number of EPO units furnished relating to the renal dialysis department			15.00
16.00	Number of EPO units furnished relating to the home dialysis department			16.00
	ARANESP			
17.00	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider.			17.00
18.00	ARANESP amount from Worksheet A for Home Dialysis program			18.00
19.00	Number of ARANESP units furnished relating to the renal dialysis department			19.00
20.00	Number of ARANESP units furnished relating to the home dialysis department			20.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-7 | Date/Time Prepared: 9/24/2012 5:51 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.	N		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	16	0	16	3.00
4.00		RUL	7	0	7	4.00
5.00		RVX	89	0	89	5.00
6.00		RVL	1	0	1	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	60	0	60	8.00
9.00		RMX	17	0	17	9.00
10.00		RML	69	0	69	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	57	0	57	12.00
13.00		RUB	79	0	79	13.00
14.00		RUA	26	0	26	14.00
15.00		RVC	279	0	279	15.00
16.00		RVB	470	0	470	16.00
17.00		RVA	515	0	515	17.00
18.00		RHC	783	0	783	18.00
19.00		RHB	552	0	552	19.00
20.00		RHA	1,519	0	1,519	20.00
21.00		RMC	260	0	260	21.00
22.00		RMB	336	0	336	22.00
23.00		RMA	836	0	836	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	5	0	5	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	14	0	14	27.00
28.00		ES1	41	0	41	28.00
29.00		HE2	14	0	14	29.00
30.00		HE1	34	0	34	30.00
31.00		HD2	6	0	6	31.00
32.00		HD1	194	0	194	32.00
33.00		HC2	14	0	14	33.00
34.00		HC1	65	0	65	34.00
35.00		HB2	28	0	28	35.00
36.00		HB1	121	0	121	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	14	0	14	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	67	0	67	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	22	0	22	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	6	0	6	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	4	0	4	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	126	0	126	48.00
49.00		CC2	11	0	11	49.00
50.00		CC1	83	0	83	50.00
51.00		CB2	20	0	20	51.00
52.00		CB1	75	0	75	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	85	0	85	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	3	0	3	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: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-7 | Date/Time Prepared: 9/24/2012 5:51 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	7	0	7	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	11	0	11	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	3	0	3	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	18	0	18	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		7,062	0	7,062	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).	99914	99914	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)	4,555,004			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet S-10 | Date/Time Prepared: 9/24/2012 5:51 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)	0.146572	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,396,223	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	4,418,977	5.00
6.00	Medicaid charges	47,086,830	6.00
7.00	Medicaid cost (line 1 times line 6)	6,901,611	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	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)	3,127	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	15,204	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	2,228	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,402,765	119,771	1,522,536	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	205,606	17,555	223,161	21.00
22.00	Partial payment by patients approved for charity care	273	200	473	22.00
23.00	Cost of charity care (line 21 minus line 22)	205,333	17,355	222,688	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,557,541	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	455,936	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	3,101,605	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	454,608	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	677,296	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	677,296	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A | Date/Time Prepared: 9/24/2012 5:51 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	00100	CAP REL COSTS-BLDG & FIXT		790,310	790,310	775,954	1,566,264	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,714,505	1,714,505	768,682	2,483,187	2.00
4.00	00400	EMPLOYEE BENEFITS	87,696	193,054	280,750	3,777,810	4,058,560	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,355,870	18,343,950	20,699,820	-4,886,566	15,813,254	5.00
7.00	00700	OPERATION OF PLANT	426,156	1,261,000	1,687,156	0	1,687,156	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	276,895	276,895	0	276,895	8.00
9.00	00900	HOUSEKEEPING	555,297	238,371	793,668	0	793,668	9.00
10.00	01000	DIETARY	0	1,107,978	1,107,978	-570,551	537,427	10.00
11.00	01100	CAFETERIA	0	0	0	569,951	569,951	11.00
13.00	01300	NURSING ADMINISTRATION	1,060,243	162,973	1,223,216	63,208	1,286,424	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	104,208	3,841,757	3,945,965	-3,446,837	499,128	14.00
15.00	01500	PHARMACY	670,932	2,590,636	3,261,568	-2,517,093	744,475	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	329,612	367,586	697,198	-6,764	690,434	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,570,799	484,106	3,054,905	563,370	3,618,275	30.00
31.00	03100	INTENSIVE CARE UNIT	1,316,734	244,776	1,561,510	-12,288	1,549,222	31.00
40.00	04000	SUBPROVIDER - IPF	744,806	155,506	900,312	-7,505	892,807	40.00
43.00	04300	NURSERY	0	1,189	1,189	312,474	313,663	43.00
44.00	04400	SKILLED NURSING FACILITY	1,446,888	267,528	1,714,416	-7,399	1,707,017	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,248,398	1,416,085	2,664,483	478,297	3,142,780	50.00
51.00	05100	RECOVERY ROOM	398,730	44,787	443,517	-443,517	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	930,984	297,734	1,228,718	-903,340	325,378	52.00
53.00	05300	ANESTHESIOLOGY	1,439,954	327,828	1,767,782	0	1,767,782	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	699,659	861,015	1,560,674	911,873	2,472,547	54.00
54.01	05401	ULTRASOUND	100,059	76,677	176,736	-176,736	0	54.01
56.00	05600	RADIOISOTOPE	122,721	302,626	425,347	-425,347	0	56.00
57.00	05700	CT SCAN	133,308	155,881	289,189	-289,189	0	57.00
58.00	05800	MRI	114,720	277,400	392,120	-392,120	0	58.00
60.00	06000	LABORATORY	1,066,870	1,898,127	2,964,997	-4,112	2,960,885	60.00
65.00	06500	RESPIRATORY THERAPY	361,217	153,276	514,493	54,082	568,575	65.00
66.00	06600	PHYSICAL THERAPY	0	577,274	577,274	333,855	911,129	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	242,769	242,769	-242,769	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	91,086	91,086	-91,086	0	68.00
69.00	06900	ELECTROCARDIOLOGY	461,186	381,869	843,055	0	843,055	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	906,677	906,677	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,476,988	2,476,988	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,309,435	2,309,435	73.00
74.00	07400	RENAL DIALYSIS	0	89,147	89,147	0	89,147	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	74,178	16,567	90,745	-90,745	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	169,478	501,240	670,718	-2,211	668,507	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	1,059,151	576,429	1,635,580	796,961	2,432,541	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	91,518	708,559	800,077	-800,077	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,141,372	41,038,496	61,179,868	-216,635	60,963,233	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	216,635	216,635	194.01
194.02	07952	SENIOR CIRCLE	35,942	13,933	49,875	0	49,875	194.02
194.03	07953	UNUSED SPACE	0	0	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118-199)	20,177,314	41,052,429	61,229,743	0	61,229,743	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A | Date/Time Prepared: 9/24/2012 5:51 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,185,756	3,752,020		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	203,787	2,686,974		2.00
4.00	00400	EMPLOYEE BENEFITS	-7,688	4,050,872		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-9,407,308	6,405,946		5.00
7.00	00700	OPERATION OF PLANT	-11,149	1,676,007		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	276,895		8.00
9.00	00900	HOUSEKEEPING	0	793,668		9.00
10.00	01000	DIETARY	0	537,427		10.00
11.00	01100	CAFETERIA	80,608	650,559		11.00
13.00	01300	NURSING ADMINISTRATION	-2,750	1,283,674		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	499,128		14.00
15.00	01500	PHARMACY	0	744,475		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,408	687,026		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,618,275		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,549,222		31.00
40.00	04000	SUBPROVIDER - IPF	0	892,807		40.00
43.00	04300	NURSERY	0	313,663		43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,707,017		44.00
45.00	04500	NURSING FACILITY	0	0		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	3,142,780		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	325,378		52.00
53.00	05300	ANESTHESIOLOGY	0	1,767,782		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,472,547		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	-68,700	2,892,185		60.00
65.00	06500	RESPIRATORY THERAPY	0	568,575		65.00
66.00	06600	PHYSICAL THERAPY	0	911,129		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	843,055		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	906,677		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,476,988		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,309,435		73.00
74.00	07400	RENAL DIALYSIS	0	89,147		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0		76.00
76.01	03561	SLEEP LAB	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
76.03	03950	WOUND CARE	0	668,507		76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00	09100	EMERGENCY	-941,789	1,490,752		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
99.00	09900	CMHC	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-7,972,641	52,990,592		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
194.01	07951	MARKETING	0	216,635		194.01
194.02	07952	SENIOR CIRCLE	0	49,875		194.02
194.03	07953	UNUSED SPACE	0	0		194.03
194.04	07954	GUEST MEALS	0	0		194.04
200.00		TOTAL (SUM OF LINES 118-199)	-7,972,641	53,257,102		200.00

RECLASSIFICATIONS | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A-6 | Date/Time Prepared: 9/24/2012 5:51 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS	4.00	0	3,779,490		1.00
	TOTALS		0	3,779,490		
	B - OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	126,457		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	TOTALS		0	126,457		
	C - RENTAL AND LEASE EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	763,899		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
	TOTALS		0	763,899		
	D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	72,852		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,783		2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	703,102		3.00
	TOTALS		0	780,737		
	E - MARKETING DEPARTMENT					
1.00	MARKETING	194.01	81,082	135,553		1.00
	TOTALS		81,082	135,553		
	F - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	780,220		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,476,988		2.00
3.00	OPERATING ROOM	50.00	0	61,050		3.00
	TOTALS		0	3,318,258		
	G - COST OF DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,309,435		1.00
	TOTALS		0	2,309,435		
	H - LABOR AND DELIVERY COSTS					
1.00	ADULTS & PEDIATRICS	30.00	446,511	142,693		1.00
2.00	NURSERY	43.00	237,179	75,295		2.00
	TOTALS		683,690	217,988		
	I - PT, OT, AND SP COSTS					
1.00	PHYSICAL THERAPY	66.00	0	333,855		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	333,855		
	J - MISCELLANEOUS DEPARTMENTS					
1.00	NURSING ADMINISTRATION	13.00	61,001	8,312		1.00
2.00	OPERATING ROOM	50.00	398,730	44,235		2.00
3.00	RESPIRATORY THERAPY	65.00	74,178	16,567		3.00
4.00	EMERGENCY	91.00	91,518	708,559		4.00
	TOTALS		625,427	777,673		
	K - OTHER RADIOLOGY COSTS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	470,808	639,565		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	TOTALS		470,808	639,565		
	L - PORTION OF COSTS TO CAFETERIA					
1.00	CAFETERIA	11.00	0	569,951		1.00
	TOTALS		0	569,951		
500.00	Grand Total: Increases		1,861,007	13,752,861		500.00

RECLASSIFICATIONS | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A-6 | Date/Time Prepared: 9/24/2012 5:51 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,779,490	0		1.00
	TOTALS		0	3,779,490			
	B - OXYGEN COSTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	126,361	0		1.00
2.00	OPERATING ROOM	50.00	0	47	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	20	0		3.00
4.00	WOUND CARE	76.03	0	29	0		4.00
	TOTALS		0	126,457			
	C - RENTAL AND LEASE EXPENSE						
1.00	EMPLOYEE BENEFITS	4.00	0	1,680	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	40,391	0		2.00
3.00	DIETARY	10.00	0	600	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	6,105	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,218	0		5.00
6.00	PHARMACY	15.00	0	207,658	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	6,764	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	25,834	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	12,288	0		9.00
10.00	SUBPROVIDER - IPF	40.00	0	7,505	0		10.00
11.00	SKILLED NURSING FACILITY	44.00	0	7,399	0		11.00
12.00	OPERATING ROOM	50.00	0	25,671	0		12.00
13.00	RECOVERY ROOM	51.00	0	552	0		13.00
14.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,662	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	198,500	0		15.00
16.00	MRI	58.00	0	173,019	0		16.00
17.00	LABORATORY	60.00	0	4,112	0		17.00
18.00	RESPIRATORY THERAPY	65.00	0	36,643	0		18.00
19.00	WOUND CARE	76.03	0	2,182	0		19.00
20.00	EMERGENCY	91.00	0	3,116	0		20.00
	TOTALS		0	763,899			
	D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	780,737	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	13		3.00
	TOTALS		0	780,737			
	E - MARKETING DEPARTMENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	81,082	135,553	0		1.00
	TOTALS		81,082	135,553			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,318,258	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	3,318,258			
	G - COST OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	2,309,435	0		1.00
	TOTALS		0	2,309,435			
	H - LABOR AND DELIVERY COSTS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	683,690	217,988	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		683,690	217,988			
	I - PT, OT, AND SP COSTS						
1.00	OCCUPATIONAL THERAPY	67.00	0	242,769	0		1.00
2.00	SPEECH PATHOLOGY	68.00	0	91,086	0		2.00
	TOTALS		0	333,855			
	J - MISCELLANEOUS DEPARTMENTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	61,001	8,312	0		1.00
2.00	RECOVERY ROOM	51.00	398,730	44,235	0		2.00
3.00	SLEEP LAB	76.01	74,178	16,567	0		3.00
4.00	AMBULANCE SERVICES	95.00	91,518	708,559	0		4.00
	TOTALS		625,427	777,673			
	K - OTHER RADIOLOGY COSTS						
1.00	ULTRASOUND	54.01	100,059	76,677	0		1.00
2.00	RADIOISOTOPE	56.00	122,721	302,626	0		2.00
3.00	CT SCAN	57.00	133,308	155,881	0		3.00
4.00	MRI	58.00	114,720	104,381	0		4.00
	TOTALS		470,808	639,565			
	L - PORTION OF COSTS TO CAFETERIA						
1.00	DIETARY	10.00	0	569,951	0		1.00
	TOTALS		0	569,951			
500.00	Grand Total: Decreases		1,861,007	13,752,861			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 9/24/2012 5:51 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	1,943,661	0	0	0	0	1.00
2.00	Land Improvements	893,124	61,659	0	61,659	0	2.00
3.00	Buildings and Fixtures	52,872,280	143	0	143	0	3.00
4.00	Building Improvements	5,283,072	2,336,970	0	2,336,970	12,860	4.00
5.00	Fixed Equipment	3,100,876	144,803	0	144,803	0	5.00
6.00	Movable Equipment	41,213,816	2,065,453	0	2,065,453	305,004	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	105,306,829	4,609,028	0	4,609,028	317,864	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	105,306,829	4,609,028	0	4,609,028	317,864	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	CAP REL COSTS-BLDG & FIXT	790,310	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,714,505	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,504,815	0	0	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	CAP REL COSTS-BLDG & FIXT	63,378,049	0	63,378,049	0.578277	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	46,219,945	0	46,219,945	0.421723	0	2.00
3.00	Total (sum of lines 1-2)	109,597,994	0	109,597,994	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 9/24/2012 5:51 pm

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,943,661	0	1.00
2.00	Land Improvements	954,783	0	2.00
3.00	Buildings and Fixtures	52,872,423	0	3.00
4.00	Building Improvements	7,607,182	0	4.00
5.00	Fixed Equipment	3,245,679	0	5.00
6.00	Movable Equipment	42,974,265	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	109,597,993	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	109,597,993	0	10.00

		SUMMARY OF CAPITAL		
	Cost Center Description	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	790,310	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,714,505	2.00
3.00	Total (sum of lines 1-2)	0	2,504,815	3.00

		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
	Cost Center Description	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	CAP REL COSTS-BLDG & FIXT	0	0	0	1,615,431	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,763,311	763,899	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,378,742	763,899	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A-7 Parts I-III | Date/Time Prepared: 9/24/2012 5:51 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	CAP REL COSTS-BLDG & FIXT	1,060,380	72,852	703,102	300,255	3,752,020	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,783	0	154,981	2,686,974	2.00
3.00	Total (sum of lines 1-2)	1,060,380	77,635	703,102	455,236	6,438,994	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A-8 | Date/Time Prepared: 9/24/2012 5:51 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	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)	A	-2,724	ADMINISTRATIVE & GENERAL	5.00	7.00
8.00	Television and radio service (chapter 21)	A	-5,635	CAP REL COSTS-MVBLE EQUIP	2.00	8.00
9.00	Parking lot (chapter 21)		0		0.00	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,013,239			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	279,803			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Cafeteria-employees and guests	B	80,608	CAFETERIA	11.00	14.00
15.00	Rental of quarters to employee and others	B	-6,630	CAP REL COSTS-BLDG & FIXT	1.00	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	-3,408	MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00	Vending machines		0		0.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	825,121	CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	32,051	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 ADJUSTMENTS (SPECIFY) (3)		0		0.00	33.00
35.00	HEALTHY WOMAN SPONSORSHIP	B	-11,000	ADMINISTRATIVE & GENERAL	5.00	35.00
36.00	OTHER MISCELLANEOUS REVENUE	B	-6,793	ADMINISTRATIVE & GENERAL	5.00	36.00
37.00	DEPRECIATION - ADMIN AND GENERAL	A	-6,981	ADMINISTRATIVE & GENERAL	5.00	37.00
38.00	HOSPITAL BAD DEBT	B	-6,390,145	ADMINISTRATIVE & GENERAL	5.00	38.00
39.00	PATIENT PHONES WAGE COST	A	-28,858	ADMINISTRATIVE & GENERAL	5.00	39.00
40.00	PATIENT PHONES BENEFITS COST	A	-7,688	EMPLOYEE BENEFITS	4.00	40.00
41.00	PATIENT PHONES DEPRECIATION COST	A	-1,787	CAP REL COSTS-MVBLE EQUIP	2.00	41.00
42.00	PATIENT TV CABLE EXPENSE	A	-11,149	OPERATION OF PLANT	7.00	42.00
43.00	MARKETING EXP - EXCL MARKETING DEPT	A	-369,204	ADMINISTRATIVE & GENERAL	5.00	43.00
44.00	ILLINOIS PROVIDER TAX	A	-1,399,186	ADMINISTRATIVE & GENERAL	5.00	44.00
45.00	PHYSICIAN RECRUITING	A	-131,792	ADMINISTRATIVE & GENERAL	5.00	45.00
46.00	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-26,268	ADMINISTRATIVE & GENERAL	5.00	46.00
47.00	CHARITABLE CONTRIBUTIONS	A	-3,596	ADMINISTRATIVE & GENERAL	5.00	47.00
48.00	PENALTIES	A	-372	ADMINISTRATIVE & GENERAL	5.00	48.00
49.00	CLUB DUES	A	-1,913	ADMINISTRATIVE & GENERAL	5.00	49.00
49.01	MINORITY INTEREST	A	268,286	CAP REL COSTS-BLDG & FIXT	1.00	49.01
49.02	NONALLOWABLE LEGAL FEES	A	-28,077	ADMINISTRATIVE & GENERAL	5.00	49.02
49.06	MEDICAL STAFF RELATIONS	A	-2,065	ADMINISTRATIVE & GENERAL	5.00	49.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,972,641			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A-8 | Date/Time Prepared: 9/24/2012 5:51 pm

	Cost Center Description	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	9	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	14	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	9	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 ADJUSTMENTS (SPECIFY) (3)	0	33.00
35.00	HEALTHY WOMAN SPONSORSHIP	0	35.00
36.00	OTHER MISCELLANEOUS REVENUE	0	36.00
37.00	DEPRECIATION - ADMIN AND GENERAL	0	37.00
38.00	HOSPITAL BAD DEBT	0	38.00
39.00	PATIENT PHONES WAGE COST	0	39.00
40.00	PATIENT PHONES BENEFITS COST	0	40.00
41.00	PATIENT PHONES DEPRECIATION COST	9	41.00
42.00	PATIENT TV CABLE EXPENSE	0	42.00
43.00	MARKETING EXP - EXCL MARKETING DEPT	0	43.00
44.00	ILLINOIS PROVIDER TAX	0	44.00
45.00	PHYSICIAN RECRUITING	0	45.00
46.00	LOBBYING EXPENSE IN ASSOCIATION DUES	0	46.00
47.00	CHARITABLE CONTRIBUTIONS	0	47.00
48.00	PENALTIES	0	48.00
49.00	CLUB DUES	0	49.00
49.01	MINORITY INTEREST	14	49.01
49.02	NONALLOWABLE LEGAL FEES	0	49.02
49.06	MEDICAL STAFF RELATIONS	0	49.06
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: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A-8-1 | Date/Time Prepared: 9/24/2012 5:51 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		1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL RELATED INTEREST	1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	OPERATING INTEREST	2.00
3.00		5.00	ADMINISTRATIVE & GENERAL	PASI OPERATING COSTS	3.00
4.00		1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS	4.00
4.01		1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BLDG AND FIXTURES	4.01
4.02		2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MVABLE EQUIPMENT	4.02
4.03		5.00	ADMINISTRATIVE & GENERAL	NON CAPITAL HO COSTS	4.03
4.04		5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	4.04
4.05		5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	4.05
4.06		5.00	ADMINISTRATIVE & GENERAL	PASI FEES	4.06
4.07		5.00	ADMINISTRATIVE & GENERAL	401K FEES	4.07
4.08		5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	4.08
4.09		2.00	CAP REL COSTS-MVBLE EQUIP	CIG LEASED EQUIPMENT	4.09
4.10		2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS	4.10
4.11		5.00	ADMINISTRATIVE & GENERAL	AUDIT FEES	4.11
4.12		5.00	ADMINISTRATIVE & GENERAL	MIS FEES	4.12
4.13		5.00	ADMINISTRATIVE & GENERAL	MANAGED CARE	4.13
4.14		5.00	ADMINISTRATIVE & GENERAL	CASE MANAGEMENT	4.14
4.15		5.00	ADMINISTRATIVE & GENERAL	PURCHASE & ANCILLARY	4.15
4.16		5.00	ADMINISTRATIVE & GENERAL	EMERGENCY ROOM	4.16
4.17		5.00	ADMINISTRATIVE & GENERAL	PPSI FEES	4.17
4.18		5.00	ADMINISTRATIVE & GENERAL	COMPLIANCE/HIM/CCA FEES	4.18
4.19		5.00	ADMINISTRATIVE & GENERAL	SENIOR CIRCLE	4.19
4.20		5.00	ADMINISTRATIVE & GENERAL	EBOS FEES	4.20
4.21		5.00	ADMINISTRATIVE & GENERAL	PASI LIEN UNIT COLLECTION FEES	4.21
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		B		0.00		7.00
8.00				0.00		8.00
9.00				0.00		9.00
10.00				0.00		10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A-8-1 | Date/Time Prepared: 9/24/2012 5:51 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		1,060,380	0	1,060,380	11		1.00
2.00		34,468	0	34,468	0		2.00
3.00		194,865	0	194,865	0		3.00
4.00		13,763	0	13,763	14		4.00
4.01		24,836	0	24,836	14		4.01
4.02		154,981	0	154,981	14		4.02
4.03		1,201,425	0	1,201,425	0		4.03
4.04		0	-717,481	717,481	0		4.04
4.05		0	1,772,793	-1,772,793	0		4.05
4.06		0	337,465	-337,465	0		4.06
4.07		0	2,164	-2,164	0		4.07
4.08		475,717	813,139	-337,422	0		4.08
4.09		173,784	158,023	15,761	9		4.09
4.10		8,416	0	8,416	9		4.10
4.11		0	44,656	-44,656	0		4.11
4.12		0	403,299	-403,299	0		4.12
4.13		0	19,671	-19,671	0		4.13
4.14		0	68,990	-68,990	0		4.14
4.15		0	7,213	-7,213	0		4.15
4.16		0	41,966	-41,966	0		4.16
4.17		0	14,250	-14,250	0		4.17
4.18		0	19,900	-19,900	0		4.18
4.19		0	16,832	-16,832	0		4.19
4.20		0	638	-638	0		4.20
4.21		0	59,314	-59,314	0		4.21
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	3,342,635	3,062,832	279,803			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		COMMUNITY HEALT	100.00	HOSPITAL COMPAN	6.00
7.00		PASI	100.00	COLLECTION AGEN	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: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 9/24/2012 5:51 pm

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		13.00	NURSING ADMINISTRATION	10,125	0	1.00
2.00		60.00	LABORATORY	68,700	68,700	2.00
3.00		91.00	EMERGENCY	941,789	941,789	3.00
4.00		0.00		0	0	4.00
5.00		0.00		0	0	5.00
6.00		0.00		0	0	6.00
7.00		0.00		0	0	7.00
8.00		0.00		0	0	8.00
9.00		0.00		0	0	9.00
10.00		0.00		0	0	10.00
200.00				1,020,614	1,010,489	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 9/24/2012 5:51 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		10,125	159,800	96	7,375	369	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		10,125		96	7,375	369	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 9/24/2012 5:51 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	7,375	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	7,375	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet A-8-2 | Date/Time Prepared: 9/24/2012 5:51 pm

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		2,750	2,750		1.00
2.00		0	68,700		2.00
3.00		0	941,789		3.00
4.00		0	0		4.00
5.00		0	0		5.00
6.00		0	0		6.00
7.00		0	0		7.00
8.00		0	0		8.00
9.00		0	0		9.00
10.00		0	0		10.00
200.00		2,750	1,013,239		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet B Part I | Date/Time Prepared: 9/24/2012 5:51 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,752,020	3,752,020				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,686,974		2,686,974			2.00
4.00	00400	EMPLOYEE BENEFITS	4,050,872	13,122	9,397	4,073,391		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,405,946	490,043	350,940	448,870	7,695,799	5.00
7.00	00700	OPERATION OF PLANT	1,676,007	1,113,520	797,438	86,408	3,673,373	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	276,895	27,777	19,892	0	324,564	8.00
9.00	00900	HOUSEKEEPING	793,668	39,908	28,580	112,593	974,749	9.00
10.00	01000	DIETARY	537,427	101,504	72,691	0	711,622	10.00
11.00	01100	CAFETERIA	650,559	49,454	35,416	0	735,429	11.00
13.00	01300	NURSING ADMINISTRATION	1,283,674	55,142	39,489	227,345	1,605,650	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	499,128	112,950	80,888	21,129	714,095	14.00
15.00	01500	PHARMACY	744,475	40,038	28,672	136,039	949,224	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	687,026	111,180	79,620	66,832	944,658	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,618,275	414,240	296,654	611,790	4,940,959	30.00
31.00	03100	INTENSIVE CARE UNIT	1,549,222	63,284	45,320	266,982	1,924,808	31.00
40.00	04000	SUBPROVIDER - IPF	892,807	86,471	61,925	151,018	1,192,221	40.00
43.00	04300	NURSERY	313,663	16,496	11,814	48,091	390,064	43.00
44.00	04400	SKILLED NURSING FACILITY	1,707,017	171,561	122,862	293,372	2,294,812	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,142,780	224,968	161,108	333,973	3,862,829	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	325,378	0	0	50,142	375,520	52.00
53.00	05300	ANESTHESIOLOGY	1,767,782	5,050	3,617	291,967	2,068,416	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,472,547	158,238	113,321	237,325	2,981,431	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,892,185	86,624	62,035	216,320	3,257,164	60.00
65.00	06500	RESPIRATORY THERAPY	568,575	32,521	23,290	88,281	712,667	65.00
66.00	06600	PHYSICAL THERAPY	911,129	17,629	12,625	0	941,383	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	843,055	101,905	72,978	93,511	1,111,449	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	906,677	0	0	0	906,677	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,476,988	0	0	0	2,476,988	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,309,435	0	0	0	2,309,435	73.00
74.00	07400	RENAL DIALYSIS	89,147	0	0	0	89,147	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	668,507	66,363	47,526	34,364	816,760	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	1,490,752	73,432	52,587	233,311	1,850,082	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	52,990,592	3,673,420	2,630,685	4,049,663	52,831,975	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	34,515	24,718	0	59,233	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,962	7,850	0	18,812	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	216,635	0	0	16,440	233,075	194.01
194.02	07952	SENIOR CIRCLE	49,875	0	0	7,288	57,163	194.02
194.03	07953	UNUSED SPACE	0	33,123	23,721	0	56,844	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
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)	53,257,102	3,752,020	2,686,974	4,073,391	53,257,102	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet B Part I Date/Time Prepared: 9/24/2012 5:51 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	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,695,799					5.00
7.00	00700	OPERATION OF PLANT	620,473	4,293,846				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	54,822	55,856	435,242			8.00
9.00	00900	HOUSEKEEPING	164,646	80,249	0	1,219,644		9.00
10.00	01000	DIETARY	120,201	204,110	0	59,874	1,095,807	10.00
11.00	01100	CAFETERIA	124,222	99,445	0	29,171	0	11.00
13.00	01300	NURSING ADMINISTRATION	271,212	110,882	0	32,526	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	120,619	227,126	5,463	66,626	0	14.00
15.00	01500	PHARMACY	160,334	80,510	0	23,617	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	159,563	223,567	0	65,582	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	834,577	832,975	156,173	244,349	382,063	30.00
31.00	03100	INTENSIVE CARE UNIT	325,121	127,254	32,920	37,329	39,796	31.00
40.00	04000	SUBPROVIDER - IPF	201,379	173,880	19,686	51,006	87,554	40.00
43.00	04300	NURSERY	65,886	33,172	0	9,731	0	43.00
44.00	04400	SKILLED NURSING FACILITY	387,619	344,984	53,956	101,198	230,839	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	652,474	452,377	58,603	132,702	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	63,429	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	349,378	10,156	178	2,979	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	503,596	318,194	21,647	93,340	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	550,171	174,188	2,709	51,097	0	60.00
65.00	06500	RESPIRATORY THERAPY	120,377	65,395	710	19,183	0	65.00
66.00	06600	PHYSICAL THERAPY	159,010	35,450	0	10,399	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	187,736	204,916	6,884	60,111	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	153,148	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	418,391	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	390,089	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	15,058	0	29,947	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	137,960	133,447	6,601	39,146	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	312,499	147,660	37,315	43,315	55,719	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,623,990	4,135,793	432,792	1,173,281	795,971	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,005	69,405	0	20,359	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,178	22,043	2,450	6,466	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	39,369	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	9,655	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	9,602	66,605	0	19,538	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	299,836	194.04
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)	7,695,799	4,293,846	435,242	1,219,644	1,095,807	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet B Part I | Date/Time Prepared: 9/24/2012 5:51 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	988,267					11.00
13.00	01300	NURSING ADMINISTRATION	50,641	2,070,911				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,700	0	1,146,629			14.00
15.00	01500	PHARMACY	32,937	0	2,741	1,249,363		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	32,937	0	2,470	0	1,428,777	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	194,707	514,518	42,671	0	103,074	30.00
31.00	03100	INTENSIVE CARE UNIT	74,837	224,532	22,411	0	39,297	31.00
40.00	04000	SUBPROVIDER - IPF	50,577	127,006	5,156	0	26,483	40.00
43.00	04300	NURSERY	13,111	40,444	235	0	6,502	43.00
44.00	04400	SKILLED NURSING FACILITY	100,331	246,726	20,443	0	18,115	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	102,421	280,872	184,279	0	304,588	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,682	42,169	26,029	0	6,780	52.00
53.00	05300	ANESTHESIOLOGY	25,875	245,544	18,583	0	113,699	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	69,738	0	23,615	0	188,396	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	84,654	0	102,933	0	218,612	60.00
65.00	06500	RESPIRATORY THERAPY	32,240	74,244	15,174	0	27,132	65.00
66.00	06600	PHYSICAL THERAPY	0	0	878	0	20,609	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	25,906	78,642	2,835	0	55,497	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	153,944	0	44,989	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	488,729	0	63,041	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,249,363	99,543	73.00
74.00	07400	RENAL DIALYSIS	0	0	2	0	1,377	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	9,058	0	6,964	0	11,283	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	55,391	196,214	26,344	0	79,760	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	981,743	2,070,911	1,146,436	1,249,363	1,428,777	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	3,325	0	45	0	0	194.01
194.02	07952	SENIOR CIRCLE	3,199	0	148	0	0	194.02
194.03	07953	UNUSED SPACE	0	0	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
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)	988,267	2,070,911	1,146,629	1,249,363	1,428,777	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet B Part I Date/Time Prepared: 9/24/2012 5:51 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	8,246,066	0	8,246,066		30.00
31.00	03100	INTENSIVE CARE UNIT	2,848,305	0	2,848,305		31.00
40.00	04000	SUBPROVIDER - IPF	1,934,948	0	1,934,948		40.00
43.00	04300	NURSERY	559,145	0	559,145		43.00
44.00	04400	SKILLED NURSING FACILITY	3,799,023	0	3,799,023		44.00
45.00	04500	NURSING FACILITY	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	6,031,145	0	6,031,145		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	527,609	0	527,609		52.00
53.00	05300	ANESTHESIOLOGY	2,834,808	0	2,834,808		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,199,957	0	4,199,957		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	4,441,528	0	4,441,528		60.00
65.00	06500	RESPIRATORY THERAPY	1,067,122	0	1,067,122		65.00
66.00	06600	PHYSICAL THERAPY	1,167,729	0	1,167,729		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	1,733,976	0	1,733,976		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,258,758	0	1,258,758		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,447,149	0	3,447,149		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,048,430	0	4,048,430		73.00
74.00	07400	RENAL DIALYSIS	135,531	0	135,531		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0		76.00
76.01	03561	SLEEP LAB	0	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.02
76.03	03950	WOUND CARE	1,161,219	0	1,161,219		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	2,804,299	0	2,804,299		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
99.00	09900	CMHC	0	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	52,246,747	0	52,246,747		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	159,002	0	159,002		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	52,949	0	52,949		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
194.01	07951	MARKETING	275,814	0	275,814		194.01
194.02	07952	SENIOR CIRCLE	70,165	0	70,165		194.02
194.03	07953	UNUSED SPACE	152,589	0	152,589		194.03
194.04	07954	GUEST MEALS	299,836	0	299,836		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	53,257,102	0	53,257,102		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet B Part II | Date/Time Prepared: 9/24/2012 5:51 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	13,122	9,397	22,519	22,519	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	490,043	350,940	840,983	2,482	5.00
7.00	00700	OPERATION OF PLANT	0	1,113,520	797,438	1,910,958	478	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	27,777	19,892	47,669	0	8.00
9.00	00900	HOUSEKEEPING	0	39,908	28,580	68,488	622	9.00
10.00	01000	DIETARY	0	101,504	72,691	174,195	0	10.00
11.00	01100	CAFETERIA	0	49,454	35,416	84,870	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	55,142	39,489	94,631	1,257	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	112,950	80,888	193,838	117	14.00
15.00	01500	PHARMACY	0	40,038	28,672	68,710	752	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	111,180	79,620	190,800	369	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	414,240	296,654	710,894	3,382	30.00
31.00	03100	INTENSIVE CARE UNIT	0	63,284	45,320	108,604	1,476	31.00
40.00	04000	SUBPROVIDER - IPF	0	86,471	61,925	148,396	835	40.00
43.00	04300	NURSERY	0	16,496	11,814	28,310	266	43.00
44.00	04400	SKILLED NURSING FACILITY	0	171,561	122,862	294,423	1,622	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	224,968	161,108	386,076	1,846	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	277	52.00
53.00	05300	ANESTHESIOLOGY	0	5,050	3,617	8,667	1,614	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	158,238	113,321	271,559	1,312	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	86,624	62,035	148,659	1,196	60.00
65.00	06500	RESPIRATORY THERAPY	0	32,521	23,290	55,811	488	65.00
66.00	06600	PHYSICAL THERAPY	0	17,629	12,625	30,254	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	101,905	72,978	174,883	517	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	66,363	47,526	113,889	190	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	73,432	52,587	126,019	1,290	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,673,420	2,630,685	6,304,105	22,388	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	34,515	24,718	59,233	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,962	7,850	18,812	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	91	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	40	194.02
194.03	07953	UNUSED SPACE	0	33,123	23,721	56,844	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	3,752,020	2,686,974	6,438,994	22,519	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet B Part II | Date/Time Prepared: 9/24/2012 5:51 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	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	843,465					5.00
7.00	00700	OPERATION OF PLANT	68,005	1,979,441				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,009	25,749	79,427			8.00
9.00	00900	HOUSEKEEPING	18,046	36,994	0	124,150		9.00
10.00	01000	DIETARY	13,174	94,093	0	6,095	287,557	10.00
11.00	01100	CAFETERIA	13,615	45,843	0	2,969	0	11.00
13.00	01300	NURSING ADMINISTRATION	29,725	51,116	0	3,311	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,220	104,704	997	6,782	0	14.00
15.00	01500	PHARMACY	17,573	37,115	0	2,404	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17,488	103,063	0	6,676	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	91,460	383,998	28,500	24,872	100,258	30.00
31.00	03100	INTENSIVE CARE UNIT	35,634	58,663	6,008	3,800	10,443	31.00
40.00	04000	SUBPROVIDER - IPF	22,072	80,158	3,592	5,192	22,976	40.00
43.00	04300	NURSERY	7,221	15,292	0	991	0	43.00
44.00	04400	SKILLED NURSING FACILITY	42,484	159,036	9,846	10,301	60,576	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	71,513	208,544	10,694	13,508	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,952	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	38,293	4,682	33	303	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,195	146,686	3,950	9,501	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	60,300	80,300	494	5,201	0	60.00
65.00	06500	RESPIRATORY THERAPY	13,194	30,147	130	1,953	0	65.00
66.00	06600	PHYSICAL THERAPY	17,428	16,342	0	1,059	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	20,576	94,465	1,256	6,119	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,785	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	45,856	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	42,755	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,650	0	5,465	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	15,121	61,518	1,205	3,985	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	34,251	68,071	6,810	4,409	14,622	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	835,595	1,906,579	78,980	119,431	208,875	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,097	31,995	0	2,072	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	348	10,162	447	658	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	4,315	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	1,058	0	0	0	0	194.02
194.03	07953	UNUSED SPACE	1,052	30,705	0	1,989	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	78,682	194.04
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)	843,465	1,979,441	79,427	124,150	287,557	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet B Part II | Date/Time Prepared: 9/24/2012 5:51 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	147,297					11.00
13.00	01300	NURSING ADMINISTRATION	7,548	187,588				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,893	0	321,551			14.00
15.00	01500	PHARMACY	4,909	0	769	132,232		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,909	0	693	0	323,998	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,022	46,609	11,966	0	23,378	30.00
31.00	03100	INTENSIVE CARE UNIT	11,154	20,338	6,285	0	8,913	31.00
40.00	04000	SUBPROVIDER - IPF	7,538	11,504	1,446	0	6,006	40.00
43.00	04300	NURSERY	1,954	3,663	66	0	1,475	43.00
44.00	04400	SKILLED NURSING FACILITY	14,954	22,349	5,733	0	4,109	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,265	25,442	51,678	0	69,026	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,039	3,820	7,300	0	1,538	52.00
53.00	05300	ANESTHESIOLOGY	3,856	22,242	5,211	0	25,787	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,394	0	6,623	0	42,729	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	12,617	0	28,866	0	49,582	60.00
65.00	06500	RESPIRATORY THERAPY	4,805	6,725	4,255	0	6,154	65.00
66.00	06600	PHYSICAL THERAPY	0	0	246	0	4,674	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,861	7,123	795	0	12,587	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	43,171	0	10,204	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	137,053	0	14,298	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	132,232	22,577	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	312	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	1,350	0	1,953	0	2,559	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	8,256	17,773	7,388	0	18,090	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	146,324	187,588	321,497	132,232	323,998	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	496	0	13	0	0	194.01
194.02	07952	SENIOR CIRCLE	477	0	41	0	0	194.02
194.03	07953	UNUSED SPACE	0	0	0	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
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)	147,297	187,588	321,551	132,232	323,998	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet B Part II | Date/Time Prepared: 9/24/2012 5:51 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,454,339	0	1,454,339		30.00
31.00	03100	INTENSIVE CARE UNIT	271,318	0	271,318		31.00
40.00	04000	SUBPROVIDER - IPF	309,715	0	309,715		40.00
43.00	04300	NURSERY	59,238	0	59,238		43.00
44.00	04400	SKILLED NURSING FACILITY	625,433	0	625,433		44.00
45.00	04500	NURSING FACILITY	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	853,592	0	853,592		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,926	0	21,926		52.00
53.00	05300	ANESTHESIOLOGY	110,688	0	110,688		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	547,949	0	547,949		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	387,215	0	387,215		60.00
65.00	06500	RESPIRATORY THERAPY	123,662	0	123,662		65.00
66.00	06600	PHYSICAL THERAPY	70,003	0	70,003		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	322,182	0	322,182		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	70,160	0	70,160		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	197,207	0	197,207		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	197,564	0	197,564		73.00
74.00	07400	RENAL DIALYSIS	7,427	0	7,427		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0		76.00
76.01	03561	SLEEP LAB	0	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.02
76.03	03950	WOUND CARE	201,770	0	201,770		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	306,979	0	306,979		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
99.00	09900	CMHC	0	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,138,367	0	6,138,367		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	94,397	0	94,397		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	30,427	0	30,427		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
194.01	07951	MARKETING	4,915	0	4,915		194.01
194.02	07952	SENIOR CIRCLE	1,616	0	1,616		194.02
194.03	07953	UNUSED SPACE	90,590	0	90,590		194.03
194.04	07954	GUEST MEALS	78,682	0	78,682		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	6,438,994	0	6,438,994		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet B-1 | Date/Time Prepared: 9/24/2012 5:51 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	317,967					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		317,967				2.00
4.00	00400	EMPLOYEE BENEFITS	1,112	1,112	20,089,618			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	41,529	41,529	2,213,787	-7,695,799	45,561,303	5.00
7.00	00700	OPERATION OF PLANT	94,366	94,366	426,156	0	3,673,373	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,354	2,354	0	0	324,564	8.00
9.00	00900	HOUSEKEEPING	3,382	3,382	555,297	0	974,749	9.00
10.00	01000	DIETARY	8,602	8,602	0	0	711,622	10.00
11.00	01100	CAFETERIA	4,191	4,191	0	0	735,429	11.00
13.00	01300	NURSING ADMINISTRATION	4,673	4,673	1,121,244	0	1,605,650	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,572	9,572	104,208	0	714,095	14.00
15.00	01500	PHARMACY	3,393	3,393	670,932	0	949,224	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,422	9,422	329,612	0	944,658	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,105	35,105	3,017,310	0	4,940,959	30.00
31.00	03100	INTENSIVE CARE UNIT	5,363	5,363	1,316,734	0	1,924,808	31.00
40.00	04000	SUBPROVIDER - IPF	7,328	7,328	744,806	0	1,192,221	40.00
43.00	04300	NURSERY	1,398	1,398	237,179	0	390,064	43.00
44.00	04400	SKILLED NURSING FACILITY	14,539	14,539	1,446,888	0	2,294,812	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,065	19,065	1,647,128	0	3,862,829	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	247,294	0	375,520	52.00
53.00	05300	ANESTHESIOLOGY	428	428	1,439,954	0	2,068,416	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,410	13,410	1,170,467	0	2,981,431	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	7,341	7,341	1,066,870	0	3,257,164	60.00
65.00	06500	RESPIRATORY THERAPY	2,756	2,756	435,395	0	712,667	65.00
66.00	06600	PHYSICAL THERAPY	1,494	1,494	0	0	941,383	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,636	8,636	461,186	0	1,111,449	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	906,677	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,476,988	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,309,435	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	89,147	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	5,624	5,624	169,478	0	816,760	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	6,223	6,223	1,150,669	0	1,850,082	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	311,306	311,306	19,972,594	-7,695,799	45,136,176	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,925	2,925	0	0	59,233	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	929	929	0	0	18,812	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	81,082	0	233,075	194.01
194.02	07952	SENIOR CIRCLE	0	0	35,942	0	57,163	194.02
194.03	07953	UNUSED SPACE	2,807	2,807	0	0	56,844	194.03
194.04	07954	GUEST MEALS	0	0	0	0	0	194.04
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)	3,752,020	2,686,974	4,073,391		7,695,799	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.800030	8.450481	0.202761		0.168911	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet B-1 | Date/Time Prepared: 9/24/2012 5:51 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	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)			22,519		843,465	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001121		0.018513	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet B-1 | Date/Time Prepared: 9/24/2012 5:51 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	180,960					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,354	566,095				8.00
9.00	00900	HOUSEKEEPING	3,382	0	175,224			9.00
10.00	01000	DIETARY	8,602	0	8,602	94,419		10.00
11.00	01100	CAFETERIA	4,191	0	4,191	0	31,205	11.00
13.00	01300	NURSING ADMINISTRATION	4,673	0	4,673	0	1,599	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,572	7,105	9,572	0	401	14.00
15.00	01500	PHARMACY	3,393	0	3,393	0	1,040	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,422	0	9,422	0	1,040	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,105	203,126	35,105	32,920	6,148	30.00
31.00	03100	INTENSIVE CARE UNIT	5,363	42,817	5,363	3,429	2,363	31.00
40.00	04000	SUBPROVIDER - IPF	7,328	25,604	7,328	7,544	1,597	40.00
43.00	04300	NURSERY	1,398	0	1,398	0	414	43.00
44.00	04400	SKILLED NURSING FACILITY	14,539	70,178	14,539	19,890	3,168	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,065	76,221	19,065	0	3,234	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	432	52.00
53.00	05300	ANESTHESIOLOGY	428	232	428	0	817	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,410	28,155	13,410	0	2,202	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	7,341	3,523	7,341	0	2,673	60.00
65.00	06500	RESPIRATORY THERAPY	2,756	924	2,756	0	1,018	65.00
66.00	06600	PHYSICAL THERAPY	1,494	0	1,494	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,636	8,954	8,636	0	818	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	38,950	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	5,624	8,585	5,624	0	286	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	6,223	48,534	6,223	4,801	1,749	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	174,299	562,908	168,563	68,584	30,999	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,925	0	2,925	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	929	3,187	929	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	105	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	101	194.02
194.03	07953	UNUSED SPACE	2,807	0	2,807	0	0	194.03
194.04	07954	GUEST MEALS	0	0	0	25,835	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,293,846	435,242	1,219,644	1,095,807	988,267	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.728150	0.768850	6.960485	11.605789	31.670149	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,979,441	79,427	124,150	287,557	147,297	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet B-1 | Date/Time Prepared: 9/24/2012 5:51 pm

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	10.938555	0.140307	0.708522	3.045542	4.720301	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet B-1 | Date/Time Prepared: 9/24/2012 5:51 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	12,144,543					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,811,355				14.00
15.00	01500	PHARMACY	0	13,890	2,309,435			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,516	0	359,226,998		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,017,310	216,264	0	25,917,581		30.00
31.00	03100	INTENSIVE CARE UNIT	1,316,734	113,583	0	9,881,153		31.00
40.00	04000	SUBPROVIDER - IPF	744,806	26,132	0	6,658,932		40.00
43.00	04300	NURSERY	237,179	1,189	0	1,635,006		43.00
44.00	04400	SKILLED NURSING FACILITY	1,446,888	103,609	0	4,555,004		44.00
45.00	04500	NURSING FACILITY	0	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,647,128	933,967	0	76,553,973		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	247,294	131,923	0	1,704,734		52.00
53.00	05300	ANESTHESIOLOGY	1,439,954	94,183	0	28,589,210		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	119,687	0	47,371,501		54.00
54.01	05401	ULTRASOUND	0	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	0	521,687	0	54,969,158		60.00
65.00	06500	RESPIRATORY THERAPY	435,395	76,903	0	6,822,246		65.00
66.00	06600	PHYSICAL THERAPY	0	4,451	0	5,182,104		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	461,186	14,366	0	13,954,499		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	780,220	0	11,312,357		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,476,988	0	15,851,382		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,309,435	25,029,670		73.00
74.00	07400	RENAL DIALYSIS	0	8	0	346,154		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0		76.00
76.01	03561	SLEEP LAB	0	0	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0		76.02
76.03	03950	WOUND CARE	0	35,293	0	2,836,963		76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
91.00	09100	EMERGENCY	1,150,669	133,519	0	20,055,371		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
99.00	09900	CMHC	0	0	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,144,543	5,810,378	2,309,435	359,226,998		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.00
194.01	07951	MARKETING	0	229	0	0		194.01
194.02	07952	SENIOR CIRCLE	0	748	0	0		194.02
194.03	07953	UNUSED SPACE	0	0	0	0		194.03
194.04	07954	GUEST MEALS	0	0	0	0		194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,070,911	1,146,629	1,249,363	1,428,777		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.170522	0.197308	0.540982	0.003977		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	187,588	321,551	132,232	323,998		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet B-1 | Date/Time Prepared: 9/24/2012 5:51 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	0.015446	0.055332	0.057257	0.000902		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet C Part I Date/Time Prepared: 9/24/2012 5:51 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,246,066		8,246,066	0	8,246,066	30.00
31.00	03100	INTENSIVE CARE UNIT	2,848,305		2,848,305	0	2,848,305	31.00
40.00	04000	SUBPROVIDER - IPF	1,934,948		1,934,948	0	1,934,948	40.00
43.00	04300	NURSERY	559,145		559,145	0	559,145	43.00
44.00	04400	SKILLED NURSING FACILITY	3,799,023		3,799,023	0	3,799,023	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,031,145		6,031,145	0	6,031,145	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	527,609		527,609	0	527,609	52.00
53.00	05300	ANESTHESIOLOGY	2,834,808		2,834,808	0	2,834,808	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,199,957		4,199,957	0	4,199,957	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	4,441,528		4,441,528	0	4,441,528	60.00
65.00	06500	RESPIRATORY THERAPY	1,067,122	0	1,067,122	0	1,067,122	65.00
66.00	06600	PHYSICAL THERAPY	1,167,729	0	1,167,729	0	1,167,729	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,733,976		1,733,976	0	1,733,976	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,258,758		1,258,758	0	1,258,758	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,447,149		3,447,149	0	3,447,149	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,048,430		4,048,430	0	4,048,430	73.00
74.00	07400	RENAL DIALYSIS	135,531		135,531	0	135,531	74.00
76.00	03560	OTHER ANCILLARY COSTS	0		0	0	0	76.00
76.01	03561	SLEEP LAB	0		0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0		0	0	0	76.02
76.03	03950	WOUND CARE	1,161,219		1,161,219	0	1,161,219	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	09100	EMERGENCY	2,804,299		2,804,299	0	2,804,299	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	405,796		405,796		405,796	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
99.00	09900	CMHC	0		0		0	99.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	52,652,543	0	52,652,543	0	52,652,543	200.00
201.00		Less Observation Beds	405,796		405,796		405,796	201.00
202.00		Total (see instructions)	52,246,747	0	52,246,747	0	52,246,747	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet C Part I Date/Time Prepared: 9/24/2012 5:51 pm

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		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	03000	ADULTS & PEDIATRICS	24,045,548		24,045,548			30.00
31.00	03100	INTENSIVE CARE UNIT	9,881,153		9,881,153			31.00
40.00	04000	SUBPROVIDER - IPF	6,658,932		6,658,932			40.00
43.00	04300	NURSERY	1,635,006		1,635,006			43.00
44.00	04400	SKILLED NURSING FACILITY	4,555,004		4,555,004			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,742,642	47,811,331	76,553,973	0.078783	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,456,501	248,233	1,704,734	0.309496	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	11,680,035	16,909,175	28,589,210	0.099157	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,436,816	36,934,685	47,371,501	0.088660	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	18,228,416	36,740,742	54,969,158	0.080800	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	4,950,339	1,871,907	6,822,246	0.156418	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,102,928	79,176	5,182,104	0.225339	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	4,461,712	9,492,787	13,954,499	0.124259	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,838,305	3,474,052	11,312,357	0.111273	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,455,190	6,396,192	15,851,382	0.217467	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,809,904	5,219,766	25,029,670	0.161745	0.000000	73.00
74.00	07400	RENAL DIALYSIS	332,797	13,357	346,154	0.391534	0.000000	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0.000000	0.000000	76.00
76.01	03561	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0.000000	0.000000	76.02
76.03	03950	WOUND CARE	9,147	2,827,816	2,836,963	0.409318	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
91.00	09100	EMERGENCY	3,948,782	16,106,589	20,055,371	0.139828	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	105,536	1,766,497	1,872,033	0.216768	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
99.00	09900	CMHC	0	0	0			99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	173,334,693	185,892,305	359,226,998			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	173,334,693	185,892,305	359,226,998			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet C Part I Date/Time Prepared: 9/24/2012 5:51 pm

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		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.078783		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.309496		52.00
53.00	05300	ANESTHESIOLOGY	0.099157		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.088660		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.080800		60.00
65.00	06500	RESPIRATORY THERAPY	0.156418		65.00
66.00	06600	PHYSICAL THERAPY	0.225339		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.124259		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.111273		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.217467		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.161745		73.00
74.00	07400	RENAL DIALYSIS	0.391534		74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000		76.00
76.01	03561	SLEEP LAB	0.000000		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.02
76.03	03950	WOUND CARE	0.409318		76.03
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
91.00	09100	EMERGENCY	0.139828		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.216768		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
99.00	09900	CMHC			99.00
101.00	10100	HOME HEALTH AGENCY			101.00
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: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet C Part I Date/Time Prepared: 9/24/2012 5:51 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,246,066		8,246,066	0	8,246,066	30.00
31.00	03100	INTENSIVE CARE UNIT	2,848,305		2,848,305	0	2,848,305	31.00
40.00	04000	SUBPROVIDER - IPF	1,934,948		1,934,948	0	1,934,948	40.00
43.00	04300	NURSERY	559,145		559,145	0	559,145	43.00
44.00	04400	SKILLED NURSING FACILITY	3,799,023		3,799,023	0	3,799,023	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,031,145		6,031,145	0	6,031,145	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	527,609		527,609	0	527,609	52.00
53.00	05300	ANESTHESIOLOGY	2,834,808		2,834,808	0	2,834,808	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,199,957		4,199,957	0	4,199,957	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	4,441,528		4,441,528	0	4,441,528	60.00
65.00	06500	RESPIRATORY THERAPY	1,067,122	0	1,067,122	0	1,067,122	65.00
66.00	06600	PHYSICAL THERAPY	1,167,729	0	1,167,729	0	1,167,729	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,733,976		1,733,976	0	1,733,976	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,258,758		1,258,758	0	1,258,758	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,447,149		3,447,149	0	3,447,149	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,048,430		4,048,430	0	4,048,430	73.00
74.00	07400	RENAL DIALYSIS	135,531		135,531	0	135,531	74.00
76.00	03560	OTHER ANCILLARY COSTS	0		0	0	0	76.00
76.01	03561	SLEEP LAB	0		0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0		0	0	0	76.02
76.03	03950	WOUND CARE	1,161,219		1,161,219	0	1,161,219	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	09100	EMERGENCY	2,804,299		2,804,299	0	2,804,299	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	405,796		405,796		405,796	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
99.00	09900	CMHC	0		0		0	99.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	52,652,543	0	52,652,543	0	52,652,543	200.00
201.00		Less Observation Beds	405,796		405,796		405,796	201.00
202.00		Total (see instructions)	52,246,747	0	52,246,747	0	52,246,747	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet C Part I Date/Time Prepared: 9/24/2012 5:51 pm

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		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	03000	ADULTS & PEDIATRICS	24,045,548		24,045,548			30.00
31.00	03100	INTENSIVE CARE UNIT	9,881,153		9,881,153			31.00
40.00	04000	SUBPROVIDER - IPF	6,658,932		6,658,932			40.00
43.00	04300	NURSERY	1,635,006		1,635,006			43.00
44.00	04400	SKILLED NURSING FACILITY	4,555,004		4,555,004			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,742,642	47,811,331	76,553,973	0.078783	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,456,501	248,233	1,704,734	0.309496	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	11,680,035	16,909,175	28,589,210	0.099157	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,436,816	36,934,685	47,371,501	0.088660	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	18,228,416	36,740,742	54,969,158	0.080800	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	4,950,339	1,871,907	6,822,246	0.156418	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,102,928	79,176	5,182,104	0.225339	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	4,461,712	9,492,787	13,954,499	0.124259	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,838,305	3,474,052	11,312,357	0.111273	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,455,190	6,396,192	15,851,382	0.217467	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,809,904	5,219,766	25,029,670	0.161745	0.000000	73.00
74.00	07400	RENAL DIALYSIS	332,797	13,357	346,154	0.391534	0.000000	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0.000000	0.000000	76.00
76.01	03561	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0.000000	0.000000	76.02
76.03	03950	WOUND CARE	9,147	2,827,816	2,836,963	0.409318	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
91.00	09100	EMERGENCY	3,948,782	16,106,589	20,055,371	0.139828	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	105,536	1,766,497	1,872,033	0.216768	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
99.00	09900	CMHC	0	0	0			99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	173,334,693	185,892,305	359,226,998			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	173,334,693	185,892,305	359,226,998			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet C Part I Date/Time Prepared: 9/24/2012 5:51 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.078783		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.309496		52.00
53.00	05300	ANESTHESIOLOGY	0.099157		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.088660		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.080800		60.00
65.00	06500	RESPIRATORY THERAPY	0.156418		65.00
66.00	06600	PHYSICAL THERAPY	0.225339		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.124259		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.111273		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.217467		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.161745		73.00
74.00	07400	RENAL DIALYSIS	0.391534		74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000		76.00
76.01	03561	SLEEP LAB	0.000000		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.02
76.03	03950	WOUND CARE	0.409318		76.03
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
91.00	09100	EMERGENCY	0.139828		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.216768		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
99.00	09900	CMHC			99.00
101.00	10100	HOME HEALTH AGENCY			101.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet C Part II Date/Time Prepared: 9/24/2012 5:51 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,031,145	853,592	5,177,553	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	527,609	21,926	505,683	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,834,808	110,688	2,724,120	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,199,957	547,949	3,652,008	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	4,441,528	387,215	4,054,313	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,067,122	123,662	943,460	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,167,729	70,003	1,097,726	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,733,976	322,182	1,411,794	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,258,758	70,160	1,188,598	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,447,149	197,207	3,249,942	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,048,430	197,564	3,850,866	0	0	73.00
74.00	07400	RENAL DIALYSIS	135,531	7,427	128,104	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	1,161,219	201,770	959,449	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	2,804,299	306,979	2,497,320	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	405,796	71,569	334,227	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
200.00		Subtotal (sum of lines 50 thru 199)	35,265,056	3,489,893	31,775,163	0	0	200.00
201.00		Less Observation Beds	405,796	71,569	334,227	0	0	201.00
202.00		Total (line 200 minus line 201)	34,859,260	3,418,324	31,440,936	0	0	202.00

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

Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet C Part II Date/Time Prepared: 9/24/2012 5:51 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	6,031,145	76,553,973	0.078783		50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	527,609	1,704,734	0.309496		52.00
53.00	05300	ANESTHESIOLOGY	2,834,808	28,589,210	0.099157		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,199,957	47,371,501	0.088660		54.00
54.01	05401	ULTRASOUND	0	0	0.000000		54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000		56.00
57.00	05700	CT SCAN	0	0	0.000000		57.00
58.00	05800	MRI	0	0	0.000000		58.00
60.00	06000	LABORATORY	4,441,528	54,969,158	0.080800		60.00
65.00	06500	RESPIRATORY THERAPY	1,067,122	6,822,246	0.156418		65.00
66.00	06600	PHYSICAL THERAPY	1,167,729	5,182,104	0.225339		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	1,733,976	13,954,499	0.124259		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,258,758	11,312,357	0.111273		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,447,149	15,851,382	0.217467		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,048,430	25,029,670	0.161745		73.00
74.00	07400	RENAL DIALYSIS	135,531	346,154	0.391534		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000		76.00
76.01	03561	SLEEP LAB	0	0	0.000000		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000		76.02
76.03	03950	WOUND CARE	1,161,219	2,836,963	0.409318		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000		89.00
91.00	09100	EMERGENCY	2,804,299	20,055,371	0.139828		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	405,796	1,872,033	0.216768		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000		95.00
99.00	09900	CMHC	0	0	0.000000		99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
200.00		Subtotal (sum of lines 50 thru 199)	35,265,056	312,451,355			200.00
201.00		Less Observation Beds	405,796	0			201.00
202.00		Total (line 200 minus line 201)	34,859,260	312,451,355			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part I Date/Time Prepared: 9/24/2012 5:51 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,454,339	0	1,454,339	12,416	117.13	30.00
31.00	03100	INTENSIVE CARE UNIT	271,318		271,318	2,294	118.27	31.00
40.00	04000	SUBPROVIDER - IPF	309,715	0	309,715	2,716	114.03	40.00
43.00	04300	NURSERY	59,238		59,238	1,054	56.20	43.00
44.00	04400	SKILLED NURSING FACILITY	625,433		625,433	7,873	79.44	44.00
45.00	04500	NURSING FACILITY	0		0	0	0.00	45.00
200.00		Total (lines 30-199)	2,720,043		2,720,043	26,353		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part I Date/Time Prepared: 9/24/2012 5:51 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
			6.00	7.00		
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	7,357	861,725		30.00
31.00	03100	INTENSIVE CARE UNIT	1,678	198,457		31.00
40.00	04000	SUBPROVIDER - IPF	2,350	267,971		40.00
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	7,062	561,005		44.00
45.00	04500	NURSING FACILITY	0	0		45.00
200.00		Total (lines 30-199)	18,447	1,889,158		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part II Date/Time Prepared: 9/24/2012 5:51 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	853,592	76,553,973	0.011150	18,283,844	203,865	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,926	1,704,734	0.012862	4,708	61	52.00
53.00	05300	ANESTHESIOLOGY	110,688	28,589,210	0.003872	7,303,928	28,281	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	547,949	47,371,501	0.011567	6,922,528	80,073	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	387,215	54,969,158	0.007044	10,466,573	73,727	60.00
65.00	06500	RESPIRATORY THERAPY	123,662	6,822,246	0.018126	2,580,266	46,770	65.00
66.00	06600	PHYSICAL THERAPY	70,003	5,182,104	0.013509	1,193,832	16,127	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	322,182	13,954,499	0.023088	3,250,960	75,058	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	70,160	11,312,357	0.006202	4,057,443	25,164	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	197,207	15,851,382	0.012441	6,815,727	84,794	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	197,564	25,029,670	0.007893	9,681,893	76,419	73.00
74.00	07400	RENAL DIALYSIS	7,427	346,154	0.021456	263,717	5,658	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0	0	76.02
76.03	03950	WOUND CARE	201,770	2,836,963	0.071122	5,515	392	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100	EMERGENCY	306,979	20,055,371	0.015307	2,687,300	41,135	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	71,569	1,872,033	0.038231	86,797	3,318	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	3,489,893	312,451,355		73,605,031	760,842	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part III Date/Time Prepared: 9/24/2012 5:51 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
45.00	04500	NURSING FACILITY	0	0	0		0	45.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part III Date/Time Prepared: 9/24/2012 5:51 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,416	0.00	7,357	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,294	0.00	1,678	0		31.00
40.00	04000	SUBPROVIDER - IPF	2,716	0.00	2,350	0		40.00
43.00	04300	NURSERY	1,054	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	7,873	0.00	7,062	0		44.00
45.00	04500	NURSING FACILITY	0	0.00	0	0		45.00
200.00		Total (lines 30-199)	26,353		18,447	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part IV | Date/Time Prepared: 9/24/2012 5:51 pm

Title XVIII | Hospital | 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	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part IV Date/Time Prepared: 9/24/2012 5:51 pm

Title XVIII | Hospital | 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	05000	OPERATING ROOM	0	76,553,973	0.000000	0.000000	18,283,844	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,704,734	0.000000	0.000000	4,708	52.00
53.00	05300	ANESTHESIOLOGY	0	28,589,210	0.000000	0.000000	7,303,928	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	47,371,501	0.000000	0.000000	6,922,528	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	54,969,158	0.000000	0.000000	10,466,573	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,822,246	0.000000	0.000000	2,580,266	65.00
66.00	06600	PHYSICAL THERAPY	0	5,182,104	0.000000	0.000000	1,193,832	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	13,954,499	0.000000	0.000000	3,250,960	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,312,357	0.000000	0.000000	4,057,443	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,851,382	0.000000	0.000000	6,815,727	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,029,670	0.000000	0.000000	9,681,893	73.00
74.00	07400	RENAL DIALYSIS	0	346,154	0.000000	0.000000	263,717	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0.000000	0	76.00
76.01	03561	SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0.000000	0	76.02
76.03	03950	WOUND CARE	0	2,836,963	0.000000	0.000000	5,515	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100	EMERGENCY	0	20,055,371	0.000000	0.000000	2,687,300	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,872,033	0.000000	0.000000	86,797	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	312,451,355			73,605,031	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part IV Date/Time Prepared: 9/24/2012 5:51 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	15,711,463	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,788	0		52.00
53.00	05300	ANESTHESIOLOGY	0	4,926,712	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,574,372	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	1,011,206	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	609,769	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,589,798	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,277,709	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,964,006	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,090,746	0		73.00
74.00	07400	RENAL DIALYSIS	0	1,088	0		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0		76.00
76.01	03561	SLEEP LAB	0	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.02
76.03	03950	WOUND CARE	0	1,604,815	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	0	2,906,023	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	536,760	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	50,812,255	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part V Date/Time Prepared: 9/24/2012 5:51 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	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	05000	OPERATING ROOM	0.078783	15,711,463	0	0		50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.309496	7,788	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0.099157	4,926,712	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.088660	12,574,372	0	0		54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0		56.00
57.00	05700	CT SCAN	0.000000	0	0	0		57.00
58.00	05800	MRI	0.000000	0	0	0		58.00
60.00	06000	LABORATORY	0.080800	1,011,206	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0.156418	609,769	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0.225339	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0.124259	4,589,798	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.111273	1,277,709	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.217467	2,964,006	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.161745	2,090,746	0	1,475		73.00
74.00	07400	RENAL DIALYSIS	0.391534	1,088	0	0		74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	0		76.00
76.01	03561	SLEEP LAB	0.000000	0	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0		76.02
76.03	03950	WOUND CARE	0.409318	1,604,815	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000					88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
91.00	09100	EMERGENCY	0.139828	2,906,023	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.216768	536,760	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		50,812,255	0	1,475		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		50,812,255	0	1,475		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part V Date/Time Prepared: 9/24/2012 5:51 pm

Title XVIII | Hospital | PPS

		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	05000	OPERATING ROOM	1,237,796	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,410	0	0		52.00
53.00	05300	ANESTHESIOLOGY	488,518	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,114,844	0	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	81,705	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	95,379	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	570,324	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	142,175	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	644,573	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	338,168	0	239		73.00
74.00	07400	RENAL DIALYSIS	426	0	0		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0		76.00
76.01	03561	SLEEP LAB	0	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.02
76.03	03950	WOUND CARE	656,880	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	406,343	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	116,352	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES		0			95.00
200.00		Subtotal (see instructions)	5,895,893	0	239		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,895,893	0	239		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part II Date/Time Prepared: 9/24/2012 5:51 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	853,592	76,553,973	0.011150	9,454	105	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,926	1,704,734	0.012862	0	0	52.00
53.00	05300	ANESTHESIOLOGY	110,688	28,589,210	0.003872	2,938	11	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	547,949	47,371,501	0.011567	397,530	4,598	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	387,215	54,969,158	0.007044	803,111	5,657	60.00
65.00	06500	RESPIRATORY THERAPY	123,662	6,822,246	0.018126	45,546	826	65.00
66.00	06600	PHYSICAL THERAPY	70,003	5,182,104	0.013509	168,844	2,281	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	322,182	13,954,499	0.023088	70,446	1,626	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	70,160	11,312,357	0.006202	820	5	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	197,207	15,851,382	0.012441	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	197,564	25,029,670	0.007893	669,777	5,287	73.00
74.00	07400	RENAL DIALYSIS	7,427	346,154	0.021456	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0	0	76.02
76.03	03950	WOUND CARE	201,770	2,836,963	0.071122	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100	EMERGENCY	306,979	20,055,371	0.015307	161,764	2,476	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	71,569	1,872,033	0.038231	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	3,489,893	312,451,355		2,330,230	22,872	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part IV | Date/Time Prepared: 9/24/2012 5:51 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 140040 | Component CCN: 14S040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part IV | Date/Time Prepared: 9/24/2012 5:51 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	76,553,973	0.000000	0.000000	9,454	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,704,734	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	28,589,210	0.000000	0.000000	2,938	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	47,371,501	0.000000	0.000000	397,530	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	54,969,158	0.000000	0.000000	803,111	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,822,246	0.000000	0.000000	45,546	65.00
66.00	06600	PHYSICAL THERAPY	0	5,182,104	0.000000	0.000000	168,844	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	13,954,499	0.000000	0.000000	70,446	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,312,357	0.000000	0.000000	820	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,851,382	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,029,670	0.000000	0.000000	669,777	73.00
74.00	07400	RENAL DIALYSIS	0	346,154	0.000000	0.000000	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0.000000	0	76.00
76.01	03561	SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0.000000	0	76.02
76.03	03950	WOUND CARE	0	2,836,963	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100	EMERGENCY	0	20,055,371	0.000000	0.000000	161,764	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,872,033	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	312,451,355			2,330,230	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part IV | Date/Time Prepared: 9/24/2012 5:51 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,454	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	53	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	809	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	247	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0		76.00
76.01	03561	SLEEP LAB	0	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.02
76.03	03950	WOUND CARE	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	5,563	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part V | Date/Time Prepared: 9/24/2012 5:51 pm

Title XVIII | Subprovider - IPF | PPS

		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	05000	OPERATING ROOM	0.078783	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.309496	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0.099157	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.088660	4,454	0	0		54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0		56.00
57.00	05700	CT SCAN	0.000000	0	0	0		57.00
58.00	05800	MRI	0.000000	0	0	0		58.00
60.00	06000	LABORATORY	0.080800	53	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0.156418	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0.225339	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0.124259	809	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.111273	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.217467	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.161745	247	0	0		73.00
74.00	07400	RENAL DIALYSIS	0.391534	0	0	0		74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	0		76.00
76.01	03561	SLEEP LAB	0.000000	0	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0		76.02
76.03	03950	WOUND CARE	0.409318	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000					88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
91.00	09100	EMERGENCY	0.139828	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.216768	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		5,563	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		5,563	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part V Date/Time Prepared: 9/24/2012 5:51 pm

Title XVIII | Subprovider - IPF | PPS

		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	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	395	0	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	4	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	101	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0		76.00
76.01	03561	SLEEP LAB	0	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.02
76.03	03950	WOUND CARE	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES		0			95.00
200.00		Subtotal (see instructions)	540	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00		Net Charges (line 200 +/- line 201)	540	0	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Component CCN: 145690 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part IV Date/Time Prepared: 9/24/2012 5:51 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	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 140040 | Component CCN: 145690 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part IV Date/Time Prepared: 9/24/2012 5:51 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	05000	OPERATING ROOM	0	76,553,973	0.000000	0.000000	31,132	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,704,734	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	28,589,210	0.000000	0.000000	8,864	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	47,371,501	0.000000	0.000000	360,829	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	54,969,158	0.000000	0.000000	1,904,927	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,822,246	0.000000	0.000000	1,327,657	65.00
66.00	06600	PHYSICAL THERAPY	0	5,182,104	0.000000	0.000000	2,878,783	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	13,954,499	0.000000	0.000000	204,153	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,312,357	0.000000	0.000000	2,040,803	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,851,382	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,029,670	0.000000	0.000000	3,958,932	73.00
74.00	07400	RENAL DIALYSIS	0	346,154	0.000000	0.000000	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0.000000	0	76.00
76.01	03561	SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0.000000	0	76.02
76.03	03950	WOUND CARE	0	2,836,963	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100	EMERGENCY	0	20,055,371	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,872,033	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	312,451,355			12,716,080	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Component CCN: 145690 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part IV | Date/Time Prepared: 9/24/2012 5:51 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	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0		76.00
76.01	03561	SLEEP LAB	0	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.02
76.03	03950	WOUND CARE	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part I Date/Time Prepared: 9/24/2012 5:51 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,454,339	0	1,454,339	12,416	117.13	30.00
31.00	03100	INTENSIVE CARE UNIT	271,318		271,318	2,294	118.27	31.00
40.00	04000	SUBPROVIDER - IPF	309,715	0	309,715	2,716	114.03	40.00
43.00	04300	NURSERY	59,238		59,238	1,054	56.20	43.00
44.00	04400	SKILLED NURSING FACILITY	625,433		625,433	7,873	79.44	44.00
45.00	04500	NURSING FACILITY	0		0	0	0.00	45.00
200.00		Total (lines 30-199)	2,720,043		2,720,043	26,353		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part I Date/Time Prepared: 9/24/2012 5:51 pm

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
			6.00	7.00		
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	2,063	241,639		30.00
31.00	03100	INTENSIVE CARE UNIT	162	19,160		31.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
43.00	04300	NURSERY	812	45,634		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
45.00	04500	NURSING FACILITY	0	0		45.00
200.00		Total (lines 30-199)	3,037	306,433		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part II Date/Time Prepared: 9/24/2012 5:51 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	853,592	76,553,973	0.011150	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,926	1,704,734	0.012862	0	0	52.00
53.00	05300	ANESTHESIOLOGY	110,688	28,589,210	0.003872	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	547,949	47,371,501	0.011567	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	387,215	54,969,158	0.007044	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	123,662	6,822,246	0.018126	0	0	65.00
66.00	06600	PHYSICAL THERAPY	70,003	5,182,104	0.013509	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	322,182	13,954,499	0.023088	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	70,160	11,312,357	0.006202	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	197,207	15,851,382	0.012441	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	197,564	25,029,670	0.007893	0	0	73.00
74.00	07400	RENAL DIALYSIS	7,427	346,154	0.021456	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0	0	76.02
76.03	03950	WOUND CARE	201,770	2,836,963	0.071122	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100	EMERGENCY	306,979	20,055,371	0.015307	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	71,569	1,872,033	0.038231	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	3,489,893	312,451,355		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part III Date/Time Prepared: 9/24/2012 5:51 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
45.00	04500	NURSING FACILITY	0	0	0		0	45.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part III Date/Time Prepared: 9/24/2012 5:51 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,416	0.00	2,063	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,294	0.00	162	0		31.00
40.00	04000	SUBPROVIDER - IPF	2,716	0.00	0	0		40.00
43.00	04300	NURSERY	1,054	0.00	812	0		43.00
44.00	04400	SKILLED NURSING FACILITY	7,873	0.00	0	0		44.00
45.00	04500	NURSING FACILITY	0	0.00	0	0		45.00
200.00		Total (lines 30-199)	26,353		3,037	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part IV Date/Time Prepared: 9/24/2012 5:51 pm

Title XIX | Hospital | 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	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part IV Date/Time Prepared: 9/24/2012 5:51 pm

Title XIX | Hospital | 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	05000	OPERATING ROOM	0	76,553,973	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,704,734	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	28,589,210	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	47,371,501	0.000000	0.000000	0	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	54,969,158	0.000000	0.000000	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,822,246	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,182,104	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	13,954,499	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,312,357	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,851,382	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,029,670	0.000000	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0	346,154	0.000000	0.000000	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0.000000	0	76.00
76.01	03561	SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0.000000	0	76.02
76.03	03950	WOUND CARE	0	2,836,963	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100	EMERGENCY	0	20,055,371	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,872,033	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	312,451,355			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part IV Date/Time Prepared: 9/24/2012 5:51 pm

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0		76.00
76.01	03561	SLEEP LAB	0	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.02
76.03	03950	WOUND CARE	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part II Date/Time Prepared: 9/24/2012 5:51 pm

Title XIX | Subprovider - IPF

		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	05000	OPERATING ROOM	853,592	76,553,973	0.011150	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,926	1,704,734	0.012862	0	0	52.00
53.00	05300	ANESTHESIOLOGY	110,688	28,589,210	0.003872	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	547,949	47,371,501	0.011567	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	387,215	54,969,158	0.007044	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	123,662	6,822,246	0.018126	0	0	65.00
66.00	06600	PHYSICAL THERAPY	70,003	5,182,104	0.013509	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	322,182	13,954,499	0.023088	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	70,160	11,312,357	0.006202	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	197,207	15,851,382	0.012441	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	197,564	25,029,670	0.007893	0	0	73.00
74.00	07400	RENAL DIALYSIS	7,427	346,154	0.021456	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0	0	76.02
76.03	03950	WOUND CARE	201,770	2,836,963	0.071122	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100	EMERGENCY	306,979	20,055,371	0.015307	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	71,569	1,872,033	0.038231	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	3,489,893	312,451,355		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part IV | Date/Time Prepared: 9/24/2012 5:51 pm

Title XIX | Subprovider - IPF

		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	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.01	03561	SLEEP LAB	0	0	0	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 140040 | Component CCN: 14S040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part IV | Date/Time Prepared: 9/24/2012 5:51 pm

Title XIX | Subprovider - IPF

		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	05000	OPERATING ROOM	0	76,553,973	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,704,734	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	28,589,210	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	47,371,501	0.000000	0.000000	0	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	54,969,158	0.000000	0.000000	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,822,246	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,182,104	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	13,954,499	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,312,357	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,851,382	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,029,670	0.000000	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0	346,154	0.000000	0.000000	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0.000000	0.000000	0	76.00
76.01	03561	SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0.000000	0.000000	0	76.02
76.03	03950	WOUND CARE	0	2,836,963	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100	EMERGENCY	0	20,055,371	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,872,033	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	312,451,355			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D Part IV | Date/Time Prepared: 9/24/2012 5:51 pm

Title XIX | Subprovider - IPF

		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	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03560	OTHER ANCILLARY COSTS	0	0	0		76.00
76.01	03561	SLEEP LAB	0	0	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.02
76.03	03950	WOUND CARE	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D-1 | Date/Time Prepared: 9/24/2012 5:51 pm

Title XVIII | Hospital | 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)	12,416	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,416	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	2,999	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	8,806	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)	7,357	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)	8,246,066	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)	8,246,066	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	24,045,548	28.00
29.00	Private room charges (excluding swing-bed charges)	6,311,579	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	17,733,969	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.342935	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	2,104.56	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	2,013.85	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	90.71	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	31.11	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	93,299	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	8,152,767	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)	664.15	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,886,152	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)	4,886,152	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D-1 | Date/Time Prepared: 9/24/2012 5:51 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,848,305	2,294	1,241.63	1,678	2,083,455	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	8,701,941	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	15,671,548	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)	1,060,182	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	760,842	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,821,024	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	13,850,524	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)	611	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	664.15	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	405,796	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D-1 | Date/Time Prepared: 9/24/2012 5:51 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,454,339	8,246,066	0.176368	405,796	71,569	90.00
91.00	Nursing School cost	0	8,246,066	0.000000	405,796	0	91.00
92.00	Allied health cost	0	8,246,066	0.000000	405,796	0	92.00
93.00	All other Medical Education	0	8,246,066	0.000000	405,796	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140040 Component CCN: 14S040	Period: From 05/01/2011 To 04/30/2012	Worksheet D-1 Date/Time Prepared: 9/24/2012 5:51 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,716	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,716	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,716	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,350	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,934,948	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,934,948	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	6,658,932	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	6,658,932	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.290579	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)	2,451.74	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,934,948	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)	712.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,674,211	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)	1,674,211	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D-1 | Date/Time Prepared: 9/24/2012 5:51 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	286,140	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,960,351	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)	267,971	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	22,872	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	290,843	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,669,508	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D-1

Component CCN: 14S040 | Date/Time Prepared: 9/24/2012 5:51 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	309,715	1,934,948	0.160064	0	0	90.00
91.00	Nursing School cost	0	1,934,948	0.000000	0	0	91.00
92.00	Allied health cost	0	1,934,948	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,934,948	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140040 Component CCN: 145690	Period: From 05/01/2011 To 04/30/2012	Worksheet D-1 Date/Time Prepared: 9/24/2012 5:51 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)	7,873	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,873	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	41	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	7,832	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)	7,062	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)	3,799,023	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)	3,799,023	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	4,555,004	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	4,555,004	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.834033	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)	581.59	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,799,023	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: 140040 | Component CCN: 145690 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D-1 | Date/Time Prepared: 9/24/2012 5:51 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)	3,799,023	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	482.54	71.00
72.00	Program routine service cost (line 9 x line 71)	3,407,697	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)	3,407,697	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)	3,407,697	83.00
84.00	Program inpatient ancillary services (see instructions)	1,938,403	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)	5,346,100	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: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D-1

Component CCN: 145690 | Date/Time Prepared: 9/24/2012 5:51 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: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D-1 | Date/Time Prepared: 9/24/2012 5:51 pm

Title XIX | Hospital | 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)	12,416	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,416	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	2,999	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	8,806	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,063	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)	1,054	15.00
16.00	Nursery days (title V or XIX only)	812	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)	8,246,066	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)	8,246,066	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	24,045,548	28.00
29.00	Private room charges (excluding swing-bed charges)	6,311,579	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	17,733,969	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.342935	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	2,104.56	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	2,013.85	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	90.71	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	31.11	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	93,299	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	8,152,767	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)	664.15	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,370,141	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)	1,370,141	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D-1 | Date/Time Prepared: 9/24/2012 5:51 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	559,145	1,054	530.50	812	430,766	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,848,305	2,294	1,241.63	162	201,144	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,002,051	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)	306,433	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)	306,433	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,695,618	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)	611	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	664.15	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	405,796	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D-1 | Date/Time Prepared: 9/24/2012 5:51 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,454,339	8,246,066	0.176368	405,796	71,569	90.00
91.00	Nursing School cost	0	8,246,066	0.000000	405,796	0	91.00
92.00	Allied health cost	0	8,246,066	0.000000	405,796	0	92.00
93.00	All other Medical Education	0	8,246,066	0.000000	405,796	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140040 Component CCN: 14S040	Period: From 05/01/2011 To 04/30/2012	Worksheet D-1 Date/Time Prepared: 9/24/2012 5:51 pm
	Title XIX	Subprovider - IPF	

	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)	2,716	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,716	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,716	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	1,054	15.00
16.00	Nursery days (title V or XIX only)	812	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,934,948	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,934,948	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	6,658,932	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	6,658,932	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.290579	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)	2,451.74	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,934,948	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)	712.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D-1

Component CCN: 14S040 | Date/Time Prepared: 9/24/2012 5:51 pm

Title XIX | Subprovider - IPF

	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	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

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

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D-1

Component CCN: 14S040 | Date/Time Prepared: 9/24/2012 5:51 pm

Title XIX | Subprovider - IPF

	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	309,715	1,934,948	0.160064	0	0	90.00
91.00	Nursing School cost	0	1,934,948	0.000000	0	0	91.00
92.00	Allied health cost	0	1,934,948	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,934,948	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D-3 | Date/Time Prepared: 9/24/2012 5:51 pm

Title XVIII | Hospital | 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	03000	ADULTS & PEDIATRICS		14,788,032		30.00
31.00	03100	INTENSIVE CARE UNIT		7,221,201		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.078783	18,283,844	1,440,456	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.309496	4,708	1,457	52.00
53.00	05300	ANESTHESIOLOGY	0.099157	7,303,928	724,236	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.088660	6,922,528	613,751	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.080800	10,466,573	845,699	60.00
65.00	06500	RESPIRATORY THERAPY	0.156418	2,580,266	403,600	65.00
66.00	06600	PHYSICAL THERAPY	0.225339	1,193,832	269,017	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.124259	3,250,960	403,961	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.111273	4,057,443	451,484	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.217467	6,815,727	1,482,196	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.161745	9,681,893	1,565,998	73.00
74.00	07400	RENAL DIALYSIS	0.391534	263,717	103,254	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	76.00
76.01	03561	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	76.02
76.03	03950	WOUND CARE	0.409318	5,515	2,257	76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100	EMERGENCY	0.139828	2,687,300	375,760	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.216768	86,797	18,815	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		73,605,031	8,701,941	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)		73,605,031		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140040 | Component CCN: 14S040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D-3 | Date/Time Prepared: 9/24/2012 5:51 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		5,678,377		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.078783	9,454	745	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.309496	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.099157	2,938	291	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.088660	397,530	35,245	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.080800	803,111	64,891	60.00
65.00	06500	RESPIRATORY THERAPY	0.156418	45,546	7,124	65.00
66.00	06600	PHYSICAL THERAPY	0.225339	168,844	38,047	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.124259	70,446	8,754	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.111273	820	91	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.217467	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.161745	669,777	108,333	73.00
74.00	07400	RENAL DIALYSIS	0.391534	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	76.00
76.01	03561	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	76.02
76.03	03950	WOUND CARE	0.409318	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100	EMERGENCY	0.139828	161,764	22,619	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.216768	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		2,330,230	286,140	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)		2,330,230		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140040 | Component CCN: 145690 | Period: From 05/01/2011 To 04/30/2012 | Worksheet D-3 | Date/Time Prepared: 9/24/2012 5:51 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	03000	ADULTS & PEDIATRICS		4,085,913		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.078783	31,132	2,453	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.309496	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.099157	8,864	879	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.088660	360,829	31,991	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.080800	1,904,927	153,918	60.00
65.00	06500	RESPIRATORY THERAPY	0.156418	1,327,657	207,669	65.00
66.00	06600	PHYSICAL THERAPY	0.225339	2,878,783	648,702	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.124259	204,153	25,368	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.111273	2,040,803	227,086	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.217467	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.161745	3,958,932	640,337	73.00
74.00	07400	RENAL DIALYSIS	0.391534	0	0	74.00
76.00	03560	OTHER ANCILLARY COSTS	0.000000	0	0	76.00
76.01	03561	SLEEP LAB	0.000000	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	76.02
76.03	03950	WOUND CARE	0.409318	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100	EMERGENCY	0.139828	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.216768	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		12,716,080	1,938,403	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)		12,716,080		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet E Part A Date/Time Prepared: 9/24/2012 5:51 pm

Title XVIII | Hospital | PPS

		before 1/1	on/after 1/1	
		1.00	1.01	
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS			
1.00	DRG Amounts Other than Outlier Payments	11,991,062		1.00
2.00	Outlier payments for discharges. (see instructions)	373,743		2.00
2.01	For inpatient PPS services rendered during the cost reporting period enter the operating outlier reconciliation amount for operating expenses from line 92.	0		2.01
3.00	Managed Care Simulated Payments	170,803		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	125.33		4.00
	Indirect Medical Education Adjustment			
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.	0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00		11.00
12.00	Current year allowable FTE (see instructions)	0.00		12.00
13.00	Total allowable FTE count for the prior year.	0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00		15.00
16.00	Adjustment for residents in initial years of the program	0.00		16.00
17.00	Adjusment for residents displaced by program or hospital closure	0.00		17.00
18.00	Adjusted rolling average FTE count	0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000		21.00
22.00	IME payment adjustment (see instructions)	0		22.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA			
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000		26.00
27.00	IME payments adjustment. (see instructions)	0.000000		27.00
28.00	IME Adjustment (see instructions)	0		28.00
29.00	Total IME payment (sum of lines 22 and 28)	0		29.00
	Disproportionate Share Adjustment			
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.50		30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)	20.04		31.00
32.00	Sum of lines 30 and 31	23.54		32.00
33.00	Allowable disproportionate share percentage (see instructions)	8.64		33.00
34.00	Disproportionate share adjustment (see instructions)	1,036,028		34.00
	Additional payment for high percentage of ESRD beneficiary discharges			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)	0		46.00
47.00	Subtotal (see instructions)	13,400,833		47.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140040	Period: From 05/01/2011 To 04/30/2012	Worksheet E Part A Date/Time Prepared: 9/24/2012 5:51 pm
	Title XVIII	Hospital	PPS

		before 1/1	on/after 1/1	
		1.00	1.01	
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	14,041,128		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	13,881,054		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)	1,038,589		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)	0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).	0		52.00
53.00	Nursing and Allied Health Managed Care payment	0		53.00
54.00	Special add-on payments for new technologies	0		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)	0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)	0		56.00
57.00	Routine service other pass through costs	0		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)	0		58.00
59.00	Total (sum of amounts on lines 49 through 58)	14,919,643		59.00
60.00	Primary payer payments	8,240		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	14,911,403		61.00
62.00	Deductibles billed to program beneficiaries	1,461,568		62.00
63.00	Coinsurance billed to program beneficiaries	100,733		63.00
64.00	Allowable bad debts (see instructions)	311,429		64.00
65.00	Adjusted reimbursable bad debts (see instructions)	218,000		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	241,297		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	13,567,102		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)	0		68.00
69.00	Enter the time value of money for operating expenses, the capital outlier reconciliation amount and time value of money for capital related expenses by entering the sum of lines 93, 95 and 96. For SCH, if the hospital specific payment amount on line 48, is greater than the federal specific payment amount on line 47, do not complete this line.	0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		70.00
70.95	Recovery of Accelerated Depreciation	0		70.95
70.96	Low Volume Payment-1	0		70.96
70.97	Low Volume Payment-2	0		70.97
70.98	Low Volume Payment-3	0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)	13,567,102		71.00
72.00	Interim payments	13,570,643		72.00
73.00	Tentative settlement (for contractor use only)	0		73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)	-3,541		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	578,972		75.00
	TO BE COMPLETED BY CONTRACTOR			
90.00	Operating outlier amount from Worksheet E, Part A line 2	0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2	0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)	0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)	0		93.00
94.00	The rate used to calculate the Time Value of Money	0.00		94.00
95.00	Time Value of Money for operating expenses(see instructions)	0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)	0		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140040	Period: From 05/01/2011 To 04/30/2012	Worksheet E Part B Date/Time Prepared: 9/24/2012 5:51 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	239	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	5,895,893	2.00
3.00	PPS payments	5,622,419	3.00
4.00	Outlier payment (see instructions)	61,353	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	1.000	5.00
6.00	Line 2 times line 5	5,895,893	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	96.40	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)	239	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,475	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)	1,475	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)	1,475	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,236	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)	239	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)	5,683,772	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)	1,319,865	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)	4,364,146	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)	4,364,146	30.00
31.00	Primary payer payments	805	31.00
32.00	Subtotal (line 30 minus line 31)	4,363,341	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)	297,675	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	208,373	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	271,474	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	4,571,714	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)	4,571,714	40.00
41.00	Interim payments	4,572,198	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)	-484	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: 140040 Component CCN: 14S040	Period: From 05/01/2011 To 04/30/2012	Worksheet E Part B Date/Time Prepared: 9/24/2012 5:51 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	540	2.00
3.00	PPS payments	393	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a 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)	393	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)	79	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)	314	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)	314	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	314	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)	314	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)	314	40.00
41.00	Interim payments	314	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)	0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet E-1 Part I | Date/Time Prepared: 9/24/2012 5:51 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		13,551,843		4,547,698	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	01/23/2012	18,800	01/23/2012	24,500	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)		18,800		24,500	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)		13,570,643		4,572,198	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		3,541		484	6.02
7.00	Total Medicare program liability (see instructions)		13,567,102		4,571,714	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: 140040 | Component CCN: 14S040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet E-1 Part I | Date/Time Prepared: 9/24/2012 5:51 pm

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,921,708		314	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)		1,921,708		314	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		889		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,922,597		314	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: 140040 | Component CCN: 145690 | Period: From 05/01/2011 To 04/30/2012 | Worksheet E-1 Part I | Date/Time Prepared: 9/24/2012 5:51 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		2,227,005		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		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)		2,227,005		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		974		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,227,979		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	Provider CCN: 140040	Period: From 05/01/2011 To 04/30/2012	Worksheet E-3 Part III Date/Time Prepared: 9/24/2012 5:51 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	0	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0000	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	0	3.00
4.00	Outlier Payments	0	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	32.254098	10.00
11.00	Medical Education Adjustment Factor {((1 + (line 9/line 10)) raised to the power of .6876 -1}.	0.000000	11.00
12.00	Medical Education Adjustment (line 1 multiplied by line 11).	0	12.00
13.00	Total PPS Payment (sum of lines 1, 3, 4 and 12)	0	13.00
14.00	Nursing and Allied Health Managed Care payment (see instruction)	0	14.00
15.00	Organ acquisition	0	15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	16.00
17.00	Subtotal (see instructions)	0	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	0	19.00
20.00	Deductibles	0	20.00
21.00	Subtotal (line 19 minus line 20)	0	21.00
22.00	Coinsurance	0	22.00
23.00	Subtotal (line 21 minus line 22)	0	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	0	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	0	32.00
33.00	Interim payments	13,570,643	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus the sum lines 33 and 34)	-13,570,643	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part III, line 4	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140040 Component CCN: 14S040	Period: From 05/01/2011 To 04/30/2012	Worksheet E-3 Part II Date/Time Prepared: 9/24/2012 5:51 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2,031,893	1.00
2.00	Net IPF PPS Outlier Payments	983	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	7.420765	9.00
10.00	Medical Education Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Medical Education Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2,032,876	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition	0	14.00
15.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	15.00
16.00	Subtotal (see instructions)	2,032,876	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	2,032,876	18.00
19.00	Deductibles	129,744	19.00
20.00	Subtotal (line 18 minus line 19)	1,903,132	20.00
21.00	Coinsurance	7,924	21.00
22.00	Subtotal (line 20 minus line 21)	1,895,208	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	39,127	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	27,389	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	38,009	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,922,597	26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,922,597	31.00
32.00	Interim payments	1,921,708	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus the sum lines 32 and 33)	889	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140040 Component CCN: 145690	Period: From 05/01/2011 To 04/30/2012	Worksheet E-3 Part VI Date/Time Prepared: 9/24/2012 5:51 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)	2,478,982	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)	2,478,982	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	253,177	7.00
8.00	Allowable bad debts (see instructions)	3,106	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Allowable reimbursable bad debts (see instructions)	2,174	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)	2,227,979	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	2,227,979	15.00
16.00	Interim payments	2,227,005	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)	974	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet G | Date/Time Prepared: 9/24/2012 5:51 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-221,303	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	13,829,373	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,060,708	0	0	0	6.00
7.00	Inventory	1,783,284	0	0	0	7.00
8.00	Prepaid expenses	322,845	0	0	0	8.00
9.00	Other current assets	402,972	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	14,056,463	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	433,029	0	0	0	12.00
13.00	Land improvements	551,760	0	0	0	13.00
14.00	Accumulated depreciation	-246,507	0	0	0	14.00
15.00	Buildings	15,612,685	0	0	0	15.00
16.00	Accumulated depreciation	-3,995,283	0	0	0	16.00
17.00	Leasehold improvements	7,706,063	0	0	0	17.00
18.00	Accumulated depreciation	-1,599,254	0	0	0	18.00
19.00	Fixed equipment	1,574,106	0	0	0	19.00
20.00	Accumulated depreciation	-444,544	0	0	0	20.00
21.00	Automobiles and trucks	31,608	0	0	0	21.00
22.00	Accumulated depreciation	-5,846	0	0	0	22.00
23.00	Major movable equipment	9,711,519	0	0	0	23.00
24.00	Accumulated depreciation	-5,242,615	0	0	0	24.00
25.00	Minor equipment depreciable	4,667,001	0	0	0	25.00
26.00	Accumulated depreciation	-2,429,158	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)	26,324,564	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	4,165,502	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,165,502	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	44,546,529	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,769,767	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,922,730	0	0	0	38.00
39.00	Payroll taxes payable	687	0	0	0	39.00
40.00	Notes and loans payable (short term)	33,336	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	-63,557,425	0	0	0	43.00
44.00	Other current liabilities	1,069,160	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-57,761,745	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	11,112	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	11,112	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	-57,750,633	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	102,297,162				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)	102,297,162	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	44,546,529	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet G-1 | Date/Time Prepared: 9/24/2012 5:51 pm

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		82,551,088		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		19,746,077				2.00
3.00	Total (sum of line 1 and line 2)		102,297,165		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)		102,297,165		0		11.00
12.00	ROUNDING	3		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)		3		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		102,297,162		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet G-1 | Date/Time Prepared: 9/24/2012 5:51 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	ROUNDING	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: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet G-2 Parts | Date/Time Prepared: 9/24/2012 5:51 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	25,680,554		25,680,554	1.00
2.00	SUBPROVIDER - IPF	6,658,932		6,658,932	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	4,555,004		4,555,004	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	36,894,490		36,894,490	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	9,881,153		9,881,153	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	9,881,153		9,881,153	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	46,775,643		46,775,643	17.00
18.00	Ancillary services	122,504,732	168,019,219	290,523,951	18.00
19.00	Outpatient services	4,054,318	17,873,086	21,927,404	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		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC		0	0	24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	INDUSTRIAL MEDICINE	0	-4,015,119	-4,015,119	27.00
27.01	PHYSICIAN REVENUE	0	4,317,924	4,317,924	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	173,334,693	186,195,110	359,529,803	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		61,229,743		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		61,229,743		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140040	Period: From 05/01/2011 To 04/30/2012	Worksheet G-3 Date/Time Prepared: 9/24/2012 5:51 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	359,529,803	1.00
2.00	Less contractual allowances and discounts on patients' accounts	278,819,832	2.00
3.00	Net patient revenues (line 1 minus line 2)	80,709,971	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	61,229,743	4.00
5.00	Net income from service to patients (line 3 minus line 4)	19,480,228	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	OTHER (SPECIFY)	265,849	24.00
25.00	Total other income (sum of lines 6-24)	265,849	25.00
26.00	Total (line 5 plus line 25)	19,746,077	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)	19,746,077	29.00

CALCULATION OF CAPITAL PAYMENT | Provider CCN: 140040 | Period: From 05/01/2011 To 04/30/2012 | Worksheet L Parts I-III Date/Time Prepared: 9/24/2012 5:51 pm

Title XVIII | Hospital | PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	964,098	1.00
2.00	Capital DRG outlier payments	74,491	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	38.52	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)	0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)	1,038,589	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00