

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet S Parts I-III Date/Time Prepared: 5/25/2012 12:23 pm
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**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/25/2012 Time: 12:23 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RIVERVIEW HOSPITAL for the cost reporting period beginning 01/01/2011 and ending 12/31/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

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

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	82,929	102,142	0	1,415,416	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	-66,991	0		139,206	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	0		0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0	0	0		0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0		0	11.00
12.00 CMHC I	0	0	0		0	12.00
200.00 Total	0	15,938	102,142	0	1,554,622	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 150059		Period: From 01/01/2011 To 12/31/2011		Worksheet S-2 Part I Date/Time Prepared: 5/25/2012 12:22 pm			
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 395 WESTFIELD ROAD			PO Box:						1.00	
2.00	City: NOBLESVILLE			State: IN		Zip Code: 46060-		County: HAMILTON		2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
				1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00
								V	XVIII	XIX	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		RIVERVIEW HOSPITAL	150059	26900	1	07/07/1966	N	P	O	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF		RIVERVIEW HOSPITAL REHAB	15T059	26900	5	01/01/1994	N	P	O	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		RIVERVIEW HOSPITAL SNF	155669	26900		10/26/1999	N	P	N	9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) 1										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)						01/01/2011	12/31/2011		20.00	
21.00	Type of Control (see instructions)						9		21.00		
Inpatient PPS Information											
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00	
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.						3	N		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	1,320	1,364	0	0	534	0		24.00		
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.	179	33	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.						1			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).						1			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0			35.00	
							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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/25/2012 12:22 pm		
		Beginning:	Ending:			
		1.00	2.00			
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V	XVIII	XIX		
		1.00	2.00	3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00	61.00	
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01	
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
<b>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.</b>						
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: 150059

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

Worksheet S-2  
Part I  
Date/Time Prepared:  
5/25/2012 12:22 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
65.00	If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. Use subscripted lines 65.01 through 65.50 for each additional primary care program. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4.			0.00	0.00	0.000000	65.00	
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
				1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00	
						1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N		70.00	
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	71.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150059		Period: From 01/01/2011 To 12/31/2011		Worksheet S-2 Part I Date/Time Prepared: 5/25/2012 12:22 pm	
				1.00	2.00	3.00	
<b>Inpatient Rehabilitation Facility PPS</b>							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			N		0	76.00
					1.00		
<b>Long Term Care Hospital PPS</b>							
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.					N	80.00
<b>TEFRA Providers</b>							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(i)? Enter "Y" for yes and "N" for no.					N	86.00
				V	XIX		
				1.00	2.00		
<b>Title V or XIX Inpatient Services</b>							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N		Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00		0.00	97.00
<b>Rural Providers</b>							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N			106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)			N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N			108.00
				Physical	Occupational	Speech	Respiratory
				1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			N	N	N	N
						1.00	2.00
<b>Miscellaneous Cost Reporting Information</b>							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.			N			115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.					2	118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.			250,000		7,500,000	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.			N		N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.			Y			121.00
<b>Transplant Center Information</b>							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.			N			125.00

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		1.00		2.00			
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00		
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00		
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00		
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00		
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00		
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00		
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00		
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00		
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00		
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y		140.00		
		1.00		2.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:			
142.00	Street:	PO Box:		Zip Code:			
143.00	City:	State:					
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?		Y		144.00		
145.00	If costs for renal services are claimed on Worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		Y		145.00		
				1.00			
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 1.00	Part B 2.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital		N		N		
156.00	Subprovider - IPF		N		N		
157.00	Subprovider - IRF		N		N		
158.00	SUBPROVIDER		N		N		
159.00	SNF		N		N		
160.00	HOME HEALTH AGENCY		N		N		
161.00	CMHC				N		
					1.00		
Multi campus							
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		
		Name 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 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
							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
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part II Date/Time Prepared: 5/25/2012 12:22 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				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	03/09/2012		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: 150059

Period:  
From 01/01/2011  
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Worksheet S-2  
Part II  
Date/Time Prepared:  
5/25/2012 12:22 pm

		Part A			
		Description	Y/N	Date	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	1.00 N	2.00	21.00
					1.00
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		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
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		N		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
					Y/N
					Date
					1.00
					2.00
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 150059

Period:  
From 01/01/2011  
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Worksheet S-2  
Part II  
Date/Time Prepared:  
5/25/2012 12:22 pm

		Part B		
		Y/N	Date	
		3.00	4.00	
<b>PS&amp;R Data</b>				
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	03/09/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150059

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/25/2012 12:22 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days	CAH Hours		
	Line Number		Avai lable			
	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	90	32,850	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)		90	32,850	0.00		7.00
8.00 INTENSIVE CARE UNIT	31.00	15	5,475	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)		105	38,325	0.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	24	8,760			17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	25	9,125			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)		154				27.00
28.00 Observation Bed Days						28.00
28.02 SUBPROVIDER - IRF	41.00					28.02
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: 150059

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
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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	6,769	1,315	15,982		1.00
2.00 HMO		1,286	1,898			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		13	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	6,769	1,315	15,982		7.00
8.00 INTENSIVE CARE UNIT	0	1,372	0	2,993		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	0		0	0		13.00
14.00 Total (see instructions)	0	8,141	1,315	18,975		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	4,335	212	6,195		17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0	3,710	0	5,330		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	0		0	1,825		28.00
28.02 SUBPROVIDER - IRF				0		28.02
29.00 Ambulance Trips		230				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)			5	7		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150059

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/25/2012 12:22 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	1,836	1.00
2.00 HMO					295	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	1,250.37	0.00	0	1,836	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	52.06	0.00	0	331	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00	0.00	0.00			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)	0.00	1,302.43	0.00			27.00
28.00 Observation Bed Days						28.00
28.02 SUBPROVIDER - IRF						28.02
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: 150059

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/25/2012 12:22 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)	335	4,452		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)	335	4,452		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF	13	469		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
28.02 SUBPROVIDER - IRF				28.02
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: 150059

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/25/2012 12:22 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
	1.00	2.00	3.00	4.00	5.00	
<b>PART II - WAGE DATA</b>						
<b>SALARIES</b>						
1.00	Total salaries (see instructions)	200.00	57,770,136	2,706,995	60,477,131	1,901,351.00 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		0	0	0	0.00 4.00
4.01	Physicians - Part A - direct teaching		0	0	0	0.00 4.01
5.00	Physician-Part B		0	0	0	0.00 5.00
6.00	Non-physician-Part B		0	0	0	0.00 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00 7.00
7.01	Contracted interns and residents (in approved programs)		0	0	0	0.00 7.01
8.00	Home office personnel		0	0	0	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00 9.00
10.00	Excluded area salaries (see instructions)		19,205,606	58,973	19,264,579	515,449.00 10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>						
11.00	Contract labor (see instructions)		7,764	0	7,764	105.00 11.00
12.00	Management and administrative services		0	0	0	0.00 12.00
13.00	Contract labor: physician-Part A		448,165	0	448,165	2,419.00 13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00 14.00
15.00	Home office: physician Part A		0	0	0	0.00 15.00
16.00	Teaching physician salaries (see instructions)		0	0	0	0.00 16.00
<b>WAGE-RELATED COSTS</b>						
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24		9,647,434	0	9,647,434	17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV Line 25		0	0	0	18.00
19.00	Excluded areas		3,102,259	0	3,102,259	19.00
20.00	Non-physician anesthetist Part A		0	0	0	20.00
21.00	Non-physician anesthetist Part B		0	0	0	21.00
22.00	Physician Part A		0	0	0	22.00
23.00	Physician Part B		0	0	0	23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0	24.00
25.00	Interns & residents (in an approved program)		0	0	0	25.00
<b>OVERHEAD COSTS - DIRECT SALARIES</b>						
26.00	Employee Benefits	4.00	570,530	0	570,530	20,459.00 26.00
27.00	Administrative & General	5.00	6,907,242	0	6,907,242	270,461.00 27.00
28.00	Administrative & General under contract (see inst.)		1,070,412	0	1,070,412	5,949.00 28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00 29.00
30.00	Operation of Plant	7.00	1,595,941	0	1,595,941	70,015.00 30.00
31.00	Laundry & Linen Service	8.00	78,032	0	78,032	6,073.00 31.00
32.00	Housekeeping	9.00	940,446	0	940,446	72,114.00 32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00 33.00
34.00	Dietary	10.00	947,106	-673,937	273,169	20,122.00 34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00 35.00
36.00	Cafeteria	11.00	0	614,964	614,964	45,300.00 36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00 37.00
38.00	Nursing Administration	13.00	756,384	0	756,384	16,895.00 38.00
39.00	Central Services and Supply	14.00	375,992	219,421	595,413	27,354.00 39.00
40.00	Pharmacy	15.00	1,793,948	0	1,793,948	43,509.00 40.00
41.00	Medical Records & Medical Records Library	16.00	723,589	0	723,589	36,022.00 41.00
42.00	Social Service	17.00	290,827	0	290,827	9,081.00 42.00
43.00	Other General Service	18.00	0	0	0	0.00 43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150059

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/25/2012 12:22 pm

		Average Hourly Wage (col. 4 ÷ col. 5)	
		6.00	
<b>PART II - WAGE DATA</b>			
<b>SALARIES</b>			
1.00	Total salaries (see instructions)	31.81	1.00
2.00	Non-physician anesthetist Part A	0.00	2.00
3.00	Non-physician anesthetist Part B	0.00	3.00
4.00	Physician-Part A	0.00	4.00
4.01	Physicians - Part A - direct teaching	0.00	4.01
5.00	Physician-Part B	0.00	5.00
6.00	Non-physician-Part B	0.00	6.00
7.00	Interns & residents (in an approved program)	0.00	7.00
7.01	Contracted interns and residents (in approved programs)	0.00	7.01
8.00	Home office personnel	0.00	8.00
9.00	SNF	0.00	9.00
10.00	Excluded area salaries (see instructions)	37.37	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>			
11.00	Contract labor (see instructions)	73.94	11.00
12.00	Management and administrative services	0.00	12.00
13.00	Contract labor: physician-Part A	185.27	13.00
14.00	Home office salaries & wage-related costs	0.00	14.00
15.00	Home office: physician Part A	0.00	15.00
16.00	Teaching physician salaries (see instructions)	0.00	16.00
<b>WAGE-RELATED COSTS</b>			
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24		17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV Line 25		18.00
19.00	Excluded areas		19.00
20.00	Non-physician anesthetist Part A		20.00
21.00	Non-physician anesthetist Part B		21.00
22.00	Physician Part A		22.00
23.00	Physician Part B		23.00
24.00	Wage-related costs (RHC/FOHC)		24.00
25.00	Interns & residents (in an approved program)		25.00
<b>OVERHEAD COSTS - DIRECT SALARIES</b>			
26.00	Employee Benefits	27.89	26.00
27.00	Administrative & General	25.54	27.00
28.00	Administrative & General under contract (see inst.)	179.93	28.00
29.00	Maintenance & Repairs	0.00	29.00
30.00	Operation of Plant	22.79	30.00
31.00	Laundry & Linen Service	12.85	31.00
32.00	Housekeeping	13.04	32.00
33.00	Housekeeping under contract (see instructions)	0.00	33.00
34.00	Dietary	13.58	34.00
35.00	Dietary under contract (see instructions)	0.00	35.00
36.00	Cafeteria	13.58	36.00
37.00	Maintenance of Personnel	0.00	37.00
38.00	Nursing Administration	44.77	38.00
39.00	Central Services and Supply	21.77	39.00
40.00	Pharmacy	41.23	40.00
41.00	Medical Records & Medical Records Library	20.09	41.00
42.00	Social Service	32.03	42.00
43.00	Other General Service	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 150059		Period: From 01/01/2011 To 12/31/2011		Worksheet S-3 Part III Date/Time Prepared: 5/25/2012 12:22 pm	
	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4		
	1.00	2.00	3.00	4.00	5.00		
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	58,840,548	2,706,995	61,547,543	1,907,300.00		1.00
2.00	Excluded area salaries (see instructions)	19,205,606	58,973	19,264,579	515,449.00		2.00
3.00	Subtotal salaries (line 1 minus line 2)	39,634,942	2,648,022	42,282,964	1,391,851.00		3.00
4.00	Subtotal other wages & related costs (see inst.)	455,929	0	455,929	2,524.00		4.00
5.00	Subtotal wage-related costs (see inst.)	9,647,434	0	9,647,434	0.00		5.00
6.00	Total (sum of lines 3 thru 5)	49,738,305	2,648,022	52,386,327	1,394,375.00		6.00
7.00	Total overhead cost (see instructions)	16,050,449	160,448	16,210,897	643,354.00		7.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet S-3 Part III Date/Time Prepared: 5/25/2012 12:22 pm
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		Average Hourly Wage (col. 4 ÷ col. 5)	
		6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>			
1.00	Net salaries (see instructions)	32.27	1.00
2.00	Excluded area salaries (see instructions)	37.37	2.00
3.00	Subtotal salaries (line 1 minus line 2)	30.38	3.00
4.00	Subtotal other wages & related costs (see inst.)	180.64	4.00
5.00	Subtotal wage-related costs (see inst.)	22.82	5.00
6.00	Total (sum of lines 3 thru 5)	37.57	6.00
7.00	Total overhead cost (see instructions)	25.20	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 150059

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

Worksheet S-3  
Part IV  
Date/Time Prepared:  
5/25/2012 12:22 pm

		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
1.00	401K Employer Contributions	1,316,927	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	0	3.00
4.00	Prior Year Pension Service Cost	0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
5.00	401K/TSA Plan Administration Fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
<b>HEALTH AND INSURANCE COST</b>			
8.00	Health Insurance (Purchased or Self Funded)	5,988,943	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	101,524	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	31,031	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)	186,125	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	221,377	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	4,129,274	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	105,160	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
<b>OTHER</b>			
21.00	Executive Deferred Compensation	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	87,334	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	12,167,695	24.00
<b>Part B - Other than Core Related Cost</b>			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150059

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

Worksheet S-3  
Part V  
Date/Time Prepared:  
5/25/2012 12:22 pm

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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 150059

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

Worksheet S-7

Date/Time Prepared:  
5/25/2012 12:22 pm

		1.00	2.00		
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.				1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.				2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	0 3.00
4.00		RUL	20	0	20 4.00
5.00		RVX	0	0	0 5.00
6.00		RVL	20	0	20 6.00
7.00		RHX	2	0	2 7.00
8.00		RHL	81	0	81 8.00
9.00		RMX	15	0	15 9.00
10.00		RML	8	0	8 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	81	0	81 12.00
13.00		RUB	113	0	113 13.00
14.00		RUA	168	0	168 14.00
15.00		RVC	181	0	181 15.00
16.00		RVB	400	0	400 16.00
17.00		RVA	356	0	356 17.00
18.00		RHC	276	0	276 18.00
19.00		RHB	705	0	705 19.00
20.00		RHA	844	0	844 20.00
21.00		RMC	83	0	83 21.00
22.00		RMB	148	0	148 22.00
23.00		RMA	139	0	139 23.00
24.00		RLB	0	0	0 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	0	0	0 27.00
28.00		ES1	0	0	0 28.00
29.00		HE2	0	0	0 29.00
30.00		HE1	0	0	0 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	2	0	2 32.00
33.00		HC2	0	0	0 33.00
34.00		HC1	0	0	0 34.00
35.00		HB2	7	0	7 35.00
36.00		HB1	12	0	12 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	0	0	0 38.00
39.00		LD2	0	0	0 39.00
40.00		LD1	0	0	0 40.00
41.00		LC2	0	0	0 41.00
42.00		LC1	0	0	0 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	1	0	1 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	0	0	0 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	4	0	4 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	14	0	14 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	15	0	15 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	4	0	4 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	4	0	4 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 150059

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

Worksheet S-7

Date/Time Prepared:  
5/25/2012 12:22 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	4	0	4	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	3	0	3	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		3,710	0	3,710	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
SNF SERVICES						
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).					201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		2,588,250			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet S-10 Date/Time Prepared: 5/25/2012 12: 22 pm
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				1.00		
<b>Uncompensated and indigent care cost computation</b>						
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)		0.333304		1.00	
<b>Medicaid (see instructions for each line)</b>						
2.00	Net revenue from Medicaid		3,353,894		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		4,049,754		5.00	
6.00	Medicaid charges		19,617,190		6.00	
7.00	Medicaid cost (line 1 times line 6)		6,538,488		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	
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>						
9.00	Net revenue from stand-alone SCHIP		0		9.00	
10.00	Stand-alone SCHIP charges		0		10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0		11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00	
<b>Other state or local government indigent care program (see instructions for each line)</b>						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00	
<b>Uncompensated care (see instructions for each line)</b>						
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		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		6,992,681	0	6,992,681	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)		2,330,689	0	2,330,689	21.00
22.00	Partial payment by patients approved for charity care		0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		2,330,689	0	2,330,689	23.00
				1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?					24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit				0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)				11,980,311	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)				487,429	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)				11,492,882	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)				3,830,624	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)				6,161,313	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)				6,161,313	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150059

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

Worksheet A  
Date/Time Prepared:  
5/25/2012 12:22 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 NEW CAP REL COSTS-BLDG & FIXT		11,662,407	11,662,407	-75,806	11,586,601	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
4.00 EMPLOYEE BENEFITS	570,530	7,133,232	7,703,762	378,054	8,081,816	4.00
5.00 ADMINISTRATIVE & GENERAL	6,907,242	9,843,090	16,750,332	-832,207	15,918,125	5.00
7.00 OPERATION OF PLANT	1,595,941	3,578,504	5,174,445	0	5,174,445	7.00
8.00 LAUNDRY & LINEN SERVICE	78,032	380,850	458,882	0	458,882	8.00
9.00 HOUSEKEEPING	940,446	302,675	1,243,121	0	1,243,121	9.00
10.00 DIETARY	947,106	1,546,919	2,494,025	-1,774,687	719,338	10.00
11.00 CAFETERIA	0	0	0	1,619,392	1,619,392	11.00
13.00 NURSING ADMINISTRATION	756,384	82,444	838,828	0	838,828	13.00
14.00 CENTRAL SERVICES & SUPPLY	375,992	9,865,220	10,241,212	599,298	10,840,510	14.00
15.00 PHARMACY	1,793,948	4,537,860	6,331,808	0	6,331,808	15.00
16.00 MEDICAL RECORDS & LIBRARY	723,589	688,597	1,412,186	0	1,412,186	16.00
17.00 SOCIAL SERVICE	290,827	16,918	307,745	0	307,745	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	6,877,301	761,504	7,638,805	487,800	8,126,605	30.00
31.00 INTENSIVE CARE UNIT	1,922,407	194,357	2,116,764	0	2,116,764	31.00
41.00 SUBPROVIDER - IRF	1,325,612	897,929	2,223,541	0	2,223,541	41.00
43.00 NURSERY	0	0	0	0	0	43.00
44.00 SKILLED NURSING FACILITY	0	2,033,529	2,033,529	-32,356	2,001,173	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	807,242	5,746,802	6,554,044	-565,975	5,988,069	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	1,531,670	648,217	2,179,887	14,100	2,193,987	54.00
55.00 RADIOLOGY-THERAPEUTIC	416,128	477,603	893,731	-2,238	891,493	55.00
57.00 CT SCAN	232,278	221,101	453,379	0	453,379	57.00
57.01 ULTRA SOUND	158,901	74,457	233,358	0	233,358	57.01
58.00 MAGNETIC RESONANCE IMAGING (MRI)	189,930	43,338	233,268	0	233,268	58.00
59.00 CARDIAC CATHETERIZATION	749,408	210,902	960,310	132,613	1,092,923	59.00
60.00 LABORATORY	1,872,067	2,504,377	4,376,444	48,000	4,424,444	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	560,282	560,282	0	560,282	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	991,913	118,606	1,110,519	0	1,110,519	65.00
66.00 PHYSICAL THERAPY	3,658,616	1,304,988	4,963,604	0	4,963,604	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	620,627	69,427	690,054	104,680	794,734	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	1,326,789	1,326,789	0	1,326,789	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 RENAL DIALYSIS	0	246,715	246,715	0	246,715	74.00
76.00	0	0	0	0	0	76.00
76.01 CARDIAC REHAB	515,055	100,584	615,639	0	615,639	76.01
76.02 WOMEN'S CENTER	332,356	44,336	376,692	0	376,692	76.02
76.03 ENDOSCOPY	559,875	91,965	651,840	0	651,840	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 CLINIC	0	0	0	0	0	90.00
90.01 OUTPATIENT	242,590	24,662	267,252	15,000	282,252	90.01
91.00 EMERGENCY	1,906,129	674,014	2,580,143	66,500	2,646,643	91.00
91.01 SHORT STAY	0	0	0	0	0	91.01
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 AMBULANCE SERVICES	71,743	216,684	288,427	-10,315	278,112	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00 SUBTOTALS (SUM OF LINES 1-117)	39,961,885	68,231,884	108,193,769	171,853	108,365,622	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	86,271	103,896	190,167	0	190,167	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	15,891,518	9,409,095	25,300,613	-282,875	25,017,738	192.00
192.01 FOUNDATION	210,524	10,950	221,474	0	221,474	192.01
192.02 CLINICS	767,479	726,069	1,493,548	-44,273	1,449,275	192.02
192.05 PRACTICE MANAGEMENT	459,540	320,533	780,073	0	780,073	192.05
192.06 MOB - NOBLESVILLE SQUARE	0	304,546	304,546	0	304,546	192.06
192.08 RIVERVIEW MEDICAL ARTS	0	442,392	442,392	0	442,392	192.08
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 WORKMED	392,919	128,667	521,586	0	521,586	194.00
194.01 MEALS ON WHEELS	0	0	0	155,295	155,295	194.01
200.00 TOTAL (SUM OF LINES 118-199)	57,770,136	79,678,032	137,448,168	0	137,448,168	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150059

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

Worksheet A  
Date/Time Prepared:  
5/25/2012 12:22 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	NEW CAP REL COSTS-BLDG & FIXT	-1,881	11,584,720	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
4.00	EMPLOYEE BENEFITS	-145,541	7,936,275	4.00
5.00	ADMINISTRATIVE & GENERAL	-3,151,015	12,767,110	5.00
7.00	OPERATION OF PLANT	0	5,174,445	7.00
8.00	LAUNDRY & LINEN SERVICE	0	458,882	8.00
9.00	HOUSEKEEPING	0	1,243,121	9.00
10.00	DIETARY	0	719,338	10.00
11.00	CAFETERIA	-626,516	992,876	11.00
13.00	NURSING ADMINISTRATION	0	838,828	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	10,840,510	14.00
15.00	PHARMACY	-4,524	6,327,284	15.00
16.00	MEDICAL RECORDS & LIBRARY	-35,328	1,376,858	16.00
17.00	SOCIAL SERVICE	0	307,745	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	-60,738	8,065,867	30.00
31.00	INTENSIVE CARE UNIT	0	2,116,764	31.00
41.00	SUBPROVIDER - IRF	0	2,223,541	41.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	-198,095	1,803,078	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	-2,724,766	3,263,303	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	-390	2,193,597	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	891,493	55.00
57.00	CT SCAN	0	453,379	57.00
57.01	ULTRA SOUND	0	233,358	57.01
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	233,268	58.00
59.00	CARDIAC CATHETERIZATION	-151,469	941,454	59.00
60.00	LABORATORY	-41,117	4,383,327	60.00
60.01	BLOOD LABORATORY	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	560,282	63.00
64.00	INTRAVENOUS THERAPY	0	0	64.00
65.00	RESPIRATORY THERAPY	0	1,110,519	65.00
66.00	PHYSICAL THERAPY	-10	4,963,594	66.00
67.00	OCCUPATIONAL THERAPY	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	68.00
69.00	ELECTROCARDIOLOGY	-84,128	710,606	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	1,326,789	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	RENAL DIALYSIS	0	246,715	74.00
76.00		0	0	76.00
76.01	CARDIAC REHAB	0	615,639	76.01
76.02	WOMEN'S CENTER	-1,518	375,174	76.02
76.03	ENDOSCOPY	0	651,840	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	CLINIC	0	0	90.00
90.01	OUTPATIENT	-2,290	279,962	90.01
91.00	EMERGENCY	-7,632	2,639,011	91.00
91.01	SHORT STAY	0	0	91.01
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	AMBULANCE SERVICES	0	278,112	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00	SUBTOTALS (SUM OF LINES 1-117)	-7,236,958	101,128,664	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190,167	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	25,017,738	192.00
192.01	FOUNDATION	0	221,474	192.01
192.02	CLINICS	0	1,449,275	192.02
192.05	PRACTICE MANAGEMENT	0	780,073	192.05
192.06	MOB - NOBLESVILLE SQUARE	0	304,546	192.06
192.08	RIVERVIEW MEDICAL ARTS	0	442,392	192.08
193.00	NONPAID WORKERS	0	0	193.00
194.00	WORKMED	0	521,586	194.00
194.01	MEALS ON WHEELS	0	155,295	194.01
200.00	TOTAL (SUM OF LINES 118-199)	-7,236,958	130,211,210	200.00

RECLASSIFICATIONS

Provider CCN: 150059

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

Worksheet A-6

Date/Time Prepared:  
5/25/2012 12:22 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
<b>A - CAFETERIA RECLASS</b>						
1.00	CAFETERIA	11.00	614,964	1,004,428	1.00	
	TOTALS		614,964	1,004,428		
<b>B - MEALS ON WHEELS RECLASS</b>						
1.00	MEALS ON WHEELS	194.01	58,973	96,322	1.00	
	TOTALS		58,973	96,322		
<b>C - INSURANCE RECLASS</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	75,806	1.00	
	TOTALS		0	75,806		
<b>D - MED SUPPLY RECLASS</b>						
1.00	CENTRAL SERVICES & SUPPLY	14.00		379,877	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	
	TOTALS		0	379,877		
<b>E - RSMA RECLASS</b>						
1.00	EMPLOYEE BENEFITS	4.00		378,054	1.00	
2.00		14.00	219,421		2.00	
3.00		50.00	2,487,574		3.00	
	TOTALS		2,706,995	378,054		
<b>F - PHYSICIAN PROFESSIONAL FEES</b>						
1.00	ADULTS & PEDIATRICS	30.00	0	487,800	1.00	
2.00	OPERATING ROOM	50.00	0	31,500	2.00	
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	14,100	3.00	
4.00	LABORATORY	60.00	0	48,000	4.00	
5.00	ELECTROCARDIOLOGY	69.00	0	112,500	5.00	
6.00	CARDIAC CATHETERIZATION	59.00	0	132,613	6.00	
7.00	OUTPATIENT	90.01	0	15,000	7.00	
8.00	EMERGENCY	91.00	0	66,500	8.00	
	TOTALS		0	908,013		
500.00	Grand Total: Increases		3,380,932	2,842,500	500.00	

RECLASSIFICATIONS

Provider CCN: 150059

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

Worksheet A-6

Date/Time Prepared:  
5/25/2012 12:22 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - CAFETERIA RECLASS</b>							
1.00	DIETARY	10.00	614,964	1,004,428	0		1.00
	TOTALS		614,964	1,004,428			
<b>B - MEALS ON WHEELS RECLASS</b>							
1.00	DIETARY	10.00	58,973	96,322	0		1.00
	TOTALS		58,973	96,322			
<b>C - INSURANCE RECLASS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	75,806	12		1.00
	TOTALS		0	75,806			
<b>D - MED SUPPLY RECLASS</b>							
1.00		44.00		32,356	0		1.00
2.00		55.00		2,238	0		2.00
3.00		69.00		7,820	0		3.00
4.00		95.00		10,315	0		4.00
5.00		192.00		282,875	0		5.00
6.00		192.02		44,273	0		6.00
	TOTALS		0	379,877			
<b>E - RSMA RECLASS</b>							
1.00	OPERATING ROOM	50.00		378,054	0		1.00
2.00		50.00		2,706,995	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	3,085,049			
<b>F - PHYSICIAN PROFESSIONAL FEES</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	908,013	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
	TOTALS		0	908,013			
500.00	Grand Total: Decreases		673,937	5,549,495			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150059

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
5/25/2012 12:22 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	10,915,010	0	0	0	0	1.00
2.00	Land Improvements	2,189,691	71,328	0	71,328	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	88,371,639	3,068,531	0	3,068,531	0	4.00
5.00	Fixed Equipment	32,785,951	252,877	0	252,877	125,184	5.00
6.00	Movable Equipment	66,811,188	6,818,161	0	6,818,161	9,545,403	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	201,073,479	10,210,897	0	10,210,897	9,670,587	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	201,073,479	10,210,897	0	10,210,897	9,670,587	10.00
<b>SUMMARY OF CAPITAL</b>							
Cost Center Description		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	9,078,348	0	2,363,032	221,027	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	9,078,348	0	2,363,032	221,027	0	3.00
<b>COMPUTATION OF RATIOS</b>					<b>ALLOCATION OF OTHER CAPITAL</b>		
Cost Center Description		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150059

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
5/25/2012 12:22 pm

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	10,915,010	0		1.00	
2.00	Land Improvements	2,261,019	0		2.00	
3.00	Buildings and Fixtures	0	0		3.00	
4.00	Building Improvements	91,440,170	0		4.00	
5.00	Fixed Equipment	32,913,644	0		5.00	
6.00	Movable Equipment	64,083,946	0		6.00	
7.00	HIT designated Assets	0	0		7.00	
8.00	Subtotal (sum of lines 1-7)	201,613,789	0		8.00	
9.00	Reconciling Items	0	0		9.00	
10.00	Total (line 8 minus line 9)	201,613,789	0		10.00	
<b>SUMMARY OF CAPITAL</b>						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	11,662,407		1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00	
3.00	Total (sum of lines 1-2)	0	11,662,407		3.00	
<b>ALLOCATION OF OTHER CAPITAL</b>						
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	9,078,348	0
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0
3.00	Total (sum of lines 1-2)	0	0	0	9,078,348	0

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150059

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
5/25/2012 12:22 pm

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,361,151	145,221	0	0	11,584,720	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,361,151	145,221	0	0	11,584,720	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150059

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

Worksheet A-8

Date/Time Prepared:  
5/25/2012 12:22 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 #
			3.00	4.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			NEW CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			NEW CAP REL COSTS-MVBLE EQUIP	2.00 2.00
3.00 Investment income - other (chapter 2)		0		0.00 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00 7.00
8.00 Television and radio service (chapter 21)		0		0.00 8.00
9.00 Parking lot (chapter 21)		0		0.00 9.00
10.00 Provider-based physician adjustment	A-8-2	-2,598,053		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	-348,581		12.00
13.00 Laundry and linen service		0		0.00 13.00
14.00 Cafeteria-employees and guests		0		0.00 14.00
15.00 Rental of quarters to employee and others		0		0.00 15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00 16.00
17.00 Sale of drugs to other than patients		0		0.00 17.00
18.00 Sale of medical records and abstracts		0		0.00 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		ORESPIRATORY THERAPY	65.00 23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY	66.00 24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00 25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP	2.00 27.00
28.00 Non-physician Anesthetist			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		OCCUPATIONAL THERAPY	67.00 30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY	68.00 31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A		0	0.00 32.00
33.00 OTHER REV MEDICAL REPORT	B	-35,328	MEDICAL RECORDS & LIBRARY	16.00 33.00
34.00 OTHER REV CASH OVER/SHORT	B	40	ADMINISTRATIVE & GENERAL	5.00 34.00
35.00 OTHER REV RADIOLOGY FILM	B	-390	RADIOLOGY-DIAGNOSTIC	54.00 35.00
36.00 OTHER REVENUES-OTHER REV-FITNESS	B	-7,043	ADMINISTRATIVE & GENERAL	5.00 36.00
37.00 OTHER REVENUES ->PURCHASE DISCOUNTS	B	-32,650	ADMINISTRATIVE & GENERAL	5.00 37.00
38.00 OTHER REV ->VHA DIVIDENDS: OTHER	B	-61,564	ADMINISTRATIVE & GENERAL	5.00 38.00
39.00 OTHER REV ->OTHER MIS REVENUE	B	-2,054	ADMINISTRATIVE & GENERAL	5.00 39.00
40.00 NON-OPERATING REV --> MIS. INCOME	B	-71	ADMINISTRATIVE & GENERAL	5.00 40.00
41.00 NON-OP EXPENSE INVESTMENT FEES	B	134,718	ADMINISTRATIVE & GENERAL	5.00 41.00
42.00 MATERNITY CENTER ->OTHER REVENUE	B	-125	ADULTS & PEDIATRICS	30.00 42.00
43.00 PHARMACY -> OTHER REVENUE	B	-4,524	PHARMACY	15.00 43.00
44.00 WOMEN'S CTR. -OTHER REVENUE-SILVER RE	B	-1,518	WOMEN'S CENTER	76.02 44.00
45.00 LABORATORY -> OTHER REVENUE	B	-33,042	LABORATORY	60.00 45.00
45.01 HAZEL DELL REHAB ADMIN- OTHER REVENUE	B	-10	PHYSICAL THERAPY	66.00 45.01
45.02 WOC--OTHER REVENUE-NGS	B	-402	OUTPATIENT	90.01 45.02
45.03 DIETARY ->OTHER REVENUE	B	-626,516	CAFETERIA	11.00 45.03
45.04 EMPLOYEE WELLNESS- OTHER REVENUE	B	-13,884	EMPLOYEE BENEFITS	4.00 45.04
45.05 PHYSICIANS' BILLING -> BILLING FEES	B	-1,416,637	ADMINISTRATIVE & GENERAL	5.00 45.05
45.06 ORG IMPROVEMENT ->OTHER REVENUE	B	-8,860	ADMINISTRATIVE & GENERAL	5.00 45.06
45.07 205 CONNER STREET- > RENTAL INCOME	B	-21,072	ADMINISTRATIVE & GENERAL	5.00 45.07

Provider CCN: 150059  
 Period: From 01/01/2011 To 12/31/2011  
 Worksheet A-8  
 Date/Time Prepared: 5/25/2012 12:22 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	
45.08 MISCELLANEOUS INTEREST INCOME	B	-25,706	ADMINISTRATIVE & GENERAL	5.00	45.08
45.09 INTEREST INCOME - BOND FUNDS	B	-1,881	NEW CAP REL COSTS-BLDG & FI XT	1.00	45.09
45.10 RENTAL INCOME - TCU	B	-110,403	SKILLED NURSING FACILITY	44.00	45.10
45.11 RENTAL INCOME - BRADFORD BICHEY	B	-6,020	ADMINISTRATIVE & GENERAL	5.00	45.11
45.12 RENTAL INCOME - INFECTIOUS DISEASES	B	-1,200	OUTPATIENT	90.01	45.12
45.13 COMMUNITY RELATIONS	A	-1,188,055	ADMINISTRATIVE & GENERAL	5.00	45.13
45.14 COMMUNITY RELATIONS BENEFITS	A	-32,218	EMPLOYEE BENEFITS	4.00	45.14
45.15 CRNA	A	-666,229	OPERATING ROOM	50.00	45.15
45.18 CRNA BENEFITS	A	-99,439	EMPLOYEE BENEFITS	4.00	45.18
45.19 PHYSICIAN RECRUITMENT	A	-24,966	ADMINISTRATIVE & GENERAL	5.00	45.19
45.20 IHA LOBBYING EXPENSE	A	-3,275	ADMINISTRATIVE & GENERAL	5.00	45.20
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,236,958			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150059

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

Worksheet A-8

Date/Time Prepared:  
5/25/2012 12:22 pm

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	OTHER REV MEDICAL REPORT	0	33.00
34.00	OTHER REV CASH OVER/SHORT	0	34.00
35.00	OTHER REV RADIOLOGY FILM	0	35.00
36.00	OTHER REVENUES-OTHER REV-FITNESS	0	36.00
37.00	OTHER REVENUES -->PURCHASE DISCOUNTS	0	37.00
38.00	OTHER REV -->VHA DIVIDENDS: OTHER	0	38.00
39.00	OTHER REV -->OTHER MISC REVENUE	0	39.00
40.00	NON-OPERATING REV --> MISC. INCOME	0	40.00
41.00	NON-OP EXPENSE INVESTMENT FEES	0	41.00
42.00	MATERNITY CENTER -->OTHER REVENUE	0	42.00
43.00	PHARMACY --> OTHER REVENUE	0	43.00
44.00	WOMEN'S CTR. -OTHER REVENUE-SILVER RE	0	44.00
45.00	LABORATORY --> OTHER REVENUE	0	45.00
45.01	HAZEL DELL REHAB ADMIN- OTHER REVENUE	0	45.01
45.02	WOC--OTHER REVENUE-NGS	0	45.02
45.03	DIETARY -->OTHER REVENUE	0	45.03
45.04	EMPLOYEE WELLNESS- OTHER REVENUE	0	45.04
45.05	PHYSICIANS' BILLING --> BILLING FEES	0	45.05
45.06	ORG IMPROVEMENT -->OTHER REVENUE	0	45.06
45.07	205 CONNER STREET- > RENTAL INCOME	0	45.07
45.08	MISCELLANEOUS INTEREST INCOME	0	45.08
45.09	INTEREST INCOME - BOND FUNDS	11	45.09
45.10	RENTAL INCOME - TCU	0	45.10
45.11	RENTAL INCOME - BRADFORD BICHEY	0	45.11
45.12	RENTAL INCOME - INFECTIOUS DISEASES	0	45.12
45.13	COMMUNITY RELATIONS	0	45.13
45.14	COMMUNITY RELATIONS BENEFITS	0	45.14
45.15	CRNA	0	45.15

ADJUSTMENTS TO EXPENSES

Provider CCN: 150059

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

Worksheet A-8

Date/Time Prepared:  
5/25/2012 12:22 pm

Cost Center Description		Wkst.	A-7 Ref.	
		5.00		
45.18	CRNA BENEFITS		0	45.18
45.19	PHYSICIAN RECRUITMENT		0	45.19
45.20	IHA LOBBYING EXPENSE		0	45.20
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: 150059

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

Worksheet A-8-1

Date/Time Prepared:  
5/25/2012 12:22 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	50.00	OPERATING ROOM	OPERATING ROOM	1.00
2.00	0.00			2.00
3.00	0.00			3.00
4.00	0.00			4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5.00

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

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

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

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

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

(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: 150059

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

Worksheet A-8-1

Date/Time Prepared: 5/25/2012 12:22 pm

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	3,271,333	3,619,914	-348,581	0	1.00
2.00	0	0	0	0	2.00
3.00	0	0	0	0	3.00
4.00	0	0	0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	3,271,333	3,619,914	-348,581	5.00

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

Related Organization(s) and/or Home Office			
Name	Percentage of Ownership	Type of Business	
4.00	5.00	6.00	
<b>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>			

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150059

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

Worksheet A-8-2

Date/Time Prepared:  
5/25/2012 12:22 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00		5.00ADMINISTRATIVE & GENERAL	487,800	487,800	1.00
2.00		30.00ADULTS & PEDIATRICS	60,613	60,613	2.00
3.00		50.00OPERATING ROOM	31,500	31,500	3.00
4.00		54.00RADIOLOGY-DIAGNOSTIC	14,100	0	4.00
5.00		59.00CARDIAC CATHETERIZATION	72,000	0	5.00
6.00		60.00LABORATORY	48,000	0	6.00
7.00		69.00ELECTROCARDIOLOGY	105,000	0	7.00
8.00		69.00ELECTROCARDIOLOGY	7,500	0	8.00
9.00		90.01OUTPATIENT	15,000	0	9.00
10.00		91.00EMERGENCY	66,500	0	10.00
11.00		50.00OPERATING ROOM	1,678,456	1,678,456	11.00
12.00		59.00CARDIAC CATHETERIZATION	100,000	100,000	12.00
13.00		44.00SKILLED NURSING FACILITY	120,065	0	13.00
200.00			2,806,534	2,358,369	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150059

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

Worksheet A-8-2

Date/Time Prepared:  
5/25/2012 12:22 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	208,000	0	0	0	3.00
4.00	14,100	225,300	190	20,580	1,029	4.00
5.00	72,000	177,200	241	20,531	1,027	5.00
6.00	48,000	215,700	385	39,925	1,996	6.00
7.00	105,000	177,200	245	20,872	1,044	7.00
8.00	7,500	177,200	119	10,138	507	8.00
9.00	15,000	177,200	168	14,312	716	9.00
10.00	66,500	177,200	691	58,868	2,943	10.00
11.00	0	177,200	0	0	0	11.00
12.00	0	177,200	0	0	0	12.00
13.00	120,065	177,200	380	32,373	1,619	13.00
200.00	448,165		2,419	217,599	10,881	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150059

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

Worksheet A-8-2

Date/Time Prepared:  
5/25/2012 12:22 pm

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 16.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	20,580	4.00
5.00	0	0	0	0	20,531	5.00
6.00	0	0	0	0	39,925	6.00
7.00	0	0	0	0	20,872	7.00
8.00	0	0	0	0	10,138	8.00
9.00	0	0	0	0	14,312	9.00
10.00	0	0	0	0	58,868	10.00
11.00	0	0	0	0	0	11.00
12.00	0	0	0	0	0	12.00
13.00	0	0	0	0	32,373	13.00
200.00	0	0	0	0	217,599	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150059

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

Worksheet A-8-2

Date/Time Prepared:  
5/25/2012 12:22 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	487,800	1.00
2.00	0	60,613	2.00
3.00	0	31,500	3.00
4.00	0	0	4.00
5.00	51,469	51,469	5.00
6.00	8,075	8,075	6.00
7.00	84,128	84,128	7.00
8.00	0	0	8.00
9.00	688	688	9.00
10.00	7,632	7,632	10.00
11.00	0	1,678,456	11.00
12.00	0	100,000	12.00
13.00	87,692	87,692	13.00
200.00	239,684	2,598,053	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150059

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/25/2012 12:22 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 NEW CAP REL COSTS-BLDG & FIXT	11,584,720	11,584,720				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0		0			2.00
4.00 EMPLOYEE BENEFITS	7,936,275	58,584	0	7,994,859		4.00
5.00 ADMINISTRATIVE & GENERAL	12,767,110	870,988	0	921,806	14,559,904	5.00
7.00 OPERATION OF PLANT	5,174,445	4,576,345	0	212,986	9,963,776	7.00
8.00 LAUNDRY & LINEN SERVICE	458,882	47,283	0	10,414	516,579	8.00
9.00 HOUSEKEEPING	1,243,121	27,094	0	125,507	1,395,722	9.00
10.00 DIETARY	719,338	76,718	0	36,456	832,512	10.00
11.00 CAFETERIA	992,876	142,469	0	82,070	1,217,415	11.00
13.00 NURSING ADMINISTRATION	838,828	0	0	100,943	939,771	13.00
14.00 CENTRAL SERVICES & SUPPLY	10,840,510	88,998	0	79,461	11,008,969	14.00
15.00 PHARMACY	6,327,284	77,936	0	239,411	6,644,631	15.00
16.00 MEDICAL RECORDS & LIBRARY	1,376,858	96,357	0	96,567	1,569,782	16.00
17.00 SOCIAL SERVICE	307,745	0	0	38,812	346,557	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	8,065,867	1,917,415	0	917,810	10,901,092	30.00
31.00 INTENSIVE CARE UNIT	2,116,764	132,482	0	256,555	2,505,801	31.00
41.00 SUBPROVIDER - IRF	2,223,541	320,465	0	176,910	2,720,916	41.00
43.00 NURSERY	0	0	0	0	0	43.00
44.00 SKILLED NURSING FACILITY	1,803,078	221,122	0	0	2,024,200	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	3,263,303	744,144	0	439,710	4,447,157	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	2,193,597	335,469	0	204,409	2,733,475	54.00
55.00 RADIOLOGY-THERAPEUTIC	891,493	169,658	0	55,534	1,116,685	55.00
57.00 CT SCAN	453,379	0	0	30,999	484,378	57.00
57.01 ULTRA SOUND	233,358	0	0	21,206	254,564	57.01
58.00 MAGNETIC RESONANCE IMAGING (MRI)	233,268	0	0	25,347	258,615	58.00
59.00 CARDIAC CATHETERIZATION	941,454	68,785	0	100,012	1,110,251	59.00
60.00 LABORATORY	4,383,327	178,474	0	249,837	4,811,638	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	560,282	87,541	0	0	647,823	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	1,110,519	24,824	0	132,376	1,267,719	65.00
66.00 PHYSICAL THERAPY	4,963,594	0	0	488,261	5,451,855	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	710,606	438,182	0	82,826	1,231,614	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	1,326,789	0	0	0	1,326,789	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 RENAL DIALYSIS	246,715	12,687	0	0	259,402	74.00
76.00	0	0	0	0	0	76.00
76.01 CARDIAC REHAB	615,639	0	0	68,737	684,376	76.01
76.02 WOMEN'S CENTER	375,174	194,410	0	44,355	613,939	76.02
76.03 ENDOSCOPY	651,840	169,013	0	74,718	895,571	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 CLINIC	0	0	0	0	0	90.00
90.01 OUTPATIENT	279,962	26,090	0	32,375	338,427	90.01
91.00 EMERGENCY	2,639,011	382,226	0	254,382	3,275,619	91.00
91.01 SHORT STAY	0	0	0	0	0	91.01
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 AMBULANCE SERVICES	278,112	0	0	9,574	287,686	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00 SUBTOTALS (SUM OF LINES 1-117)	101,128,664	11,485,759	0	5,610,366	98,645,210	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	190,167	98,961	0	11,513	300,641	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	25,017,738	0	0	2,120,826	27,138,564	192.00
192.01 FOUNDATION	221,474	0	0	28,095	249,569	192.01
192.02 CLINICS	1,449,275	0	0	102,424	1,551,699	192.02
192.05 PRACTICE MANAGEMENT	780,073	0	0	61,328	841,401	192.05
192.06 MOB - NOBLESVILLE SQUARE	304,546	0	0	0	304,546	192.06
192.08 RIVERVIEW MEDICAL ARTS	442,392	0	0	0	442,392	192.08
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 WORKMED	521,586	0	0	52,437	574,023	194.00
194.01 MEALS ON WHEELS	155,295	0	0	7,870	163,165	194.01
200.00 Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150059

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/25/2012 12:22 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
201.00 Negative Cost Centers		0	0	0		201.00
202.00 TOTAL (sum lines 118-201)	130,211,210	11,584,720	0	7,994,859	130,211,210	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150059

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/25/2012 12:22 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	14,559,904					5.00
7.00	OPERATION OF PLANT	1,254,390	11,218,166				7.00
8.00	LAUNDRY & LINEN SERVICE	65,035	87,258	668,872			8.00
9.00	HOUSEKEEPING	175,714	50,000	0	1,621,436		9.00
10.00	DIETARY	104,809	141,579	0	4,546	1,083,446	10.00
11.00	CAFETERIA	153,266	262,920	0	31,823	0	11.00
13.00	NURSING ADMINISTRATION	118,312	0	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	1,385,974	164,242	5,027	45,461	0	14.00
15.00	PHARMACY	836,526	143,828	0	15,154	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	197,628	177,823	0	7,577	0	16.00
17.00	SOCIAL SERVICE	43,630	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	1,372,393	3,538,506	209,655	527,344	555,063	30.00
31.00	INTENSIVE CARE UNIT	315,468	244,490	48,876	69,707	81,857	31.00
41.00	SUBPROVIDER - IRF	342,550	591,404	52,258	101,529	235,081	41.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	254,837	408,070	48,510	89,406	211,445	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	559,875	1,373,286	35,083	228,819	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	344,131	619,094	39,169	66,676	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	140,585	313,096	5,411	15,154	0	55.00
57.00	CT SCAN	60,981	0	0	0	0	57.00
57.01	ULTRA SOUND	32,048	0	0	0	0	57.01
58.00	MAGNETIC RESONANCE IMAGING (MRI)	32,558	0	0	6,061	0	58.00
59.00	CARDIAC CATHETERIZATION	139,775	126,941	17,258	0	0	59.00
60.00	LABORATORY	605,761	329,366	0	28,792	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	81,558	161,553	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	159,599	45,811	0	10,608	0	65.00
66.00	PHYSICAL THERAPY	686,361	0	5,640	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	155,054	808,645	5,740	48,492	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	167,036	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	32,657	23,413	0	0	0	74.00
76.00		0	0	0	0	0	76.00
76.01	CARDIAC REHAB	86,160	0	494	54,553	0	76.01
76.02	WOMEN'S CENTER	77,292	358,776	3,336	15,154	0	76.02
76.03	ENDOSCOPY	112,748	311,906	29,836	30,307	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0	0	0	0	0	90.00
90.01	OUTPATIENT	42,606	48,148	18,172	12,123	0	90.01
91.00	EMERGENCY	412,384	705,382	90,284	136,382	0	91.00
91.01	SHORT STAY	0	0	0	0	0	91.01
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	AMBULANCE SERVICES	36,218	0	0	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	10,585,919	11,035,537	614,749	1,545,668	1,083,446	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	37,849	182,629	0	6,061	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	3,416,593	0	52,761	0	0	192.00
192.01	FOUNDATION	31,419	0	0	0	0	192.01
192.02	CLINICS	195,351	0	585	69,707	0	192.02
192.05	PRACTICE MANAGEMENT	105,928	0	219	0	0	192.05
192.06	MOB - NOBLESVILLE SQUARE	38,341	0	0	0	0	192.06
192.08	RIVERVIEW MEDICAL ARTS	55,695	0	0	0	0	192.08
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	WORKMED	72,267	0	558	0	0	194.00
194.01	MEALS ON WHEELS	20,542	0	0	0	0	194.01
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	14,559,904	11,218,166	668,872	1,621,436	1,083,446	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150059

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/25/2012 12:22 pm

Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA	1,665,424					11.00
13.00 NURSING ADMINISTRATION	26,024	1,084,107				13.00
14.00 CENTRAL SERVICES & SUPPLY	28,468	0	12,638,141			14.00
15.00 PHARMACY	69,534	0	0	7,709,673		15.00
16.00 MEDICAL RECORDS & LIBRARY	44,162	0	0	0	1,996,972	16.00
17.00 SOCIAL SERVICE	9,553	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	388,341	558,964	0	0	536,735	30.00
31.00 INTENSIVE CARE UNIT	128,955	185,612	0	0	142,077	31.00
41.00 SUBPROVIDER - IRF	112,558	162,011	0	0	15,786	41.00
43.00 NURSERY	0	0	0	0	0	43.00
44.00 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	85,635	0	0	0	536,736	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	105,367	0	0	0	15,786	54.00
55.00 RADIOLOGY-THERAPEUTIC	20,220	0	0	0	31,573	55.00
57.00 CT SCAN	10,404	0	0	0	0	57.00
57.01 ULTRA SOUND	10,426	0	0	0	0	57.01
58.00 MAGNETIC RESONANCE IMAGING (MRI)	8,053	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	42,397	0	0	0	0	59.00
60.00 LABORATORY	116,274	0	0	0	23,680	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	56,664	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	135,104	0	0	0	268,368	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	38,517	0	0	0	55,252	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	12,638,141	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	7,709,673	0	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	0	0	0	0	0	76.00
76.01 CARDIAC REHAB	18,226	0	0	0	0	76.01
76.02 WOMEN'S CENTER	16,010	0	0	0	0	76.02
76.03 ENDOSCOPY	26,815	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 CLINIC	0	0	0	0	0	90.00
90.01 OUTPATIENT	7,906	0	0	0	0	90.01
91.00 EMERGENCY	123,332	177,520	0	0	363,086	91.00
91.01 SHORT STAY	0	0	0	0	0	91.01
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 AMBULANCE SERVICES	2,851	0	0	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00 SUBTOTALS (SUM OF LINES 1-117)	1,631,796	1,084,107	12,638,141	7,709,673	1,989,079	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,590	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 FOUNDATION	8,200	0	0	0	0	192.01
192.02 CLINICS	0	0	0	0	7,893	192.02
192.05 PRACTICE MANAGEMENT	0	0	0	0	0	192.05
192.06 MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.08 RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 WORKMED	14,509	0	0	0	0	194.00
194.01 MEALS ON WHEELS	6,329	0	0	0	0	194.01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	1,665,424	1,084,107	12,638,141	7,709,673	1,996,972	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150059

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/25/2012 12:22 pm

Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	17.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 EMPLOYEE BENEFITS					4.00
5.00 ADMINISTRATIVE & GENERAL					5.00
7.00 OPERATION OF PLANT					7.00
8.00 LAUNDRY & LINEN SERVICE					8.00
9.00 HOUSEKEEPING					9.00
10.00 DIETARY					10.00
11.00 CAFETERIA					11.00
13.00 NURSING ADMINISTRATION					13.00
14.00 CENTRAL SERVICES & SUPPLY					14.00
15.00 PHARMACY					15.00
16.00 MEDICAL RECORDS & LIBRARY					16.00
17.00 SOCIAL SERVICE	399,740				17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00 ADULTS & PEDIATRICS	308,233	18,896,326	0	18,896,326	30.00
31.00 INTENSIVE CARE UNIT	30,352	3,753,195	0	3,753,195	31.00
41.00 SUBPROVIDER - IRF	30,287	4,364,380	0	4,364,380	41.00
43.00 NURSERY	0	0	0	0	43.00
44.00 SKILLED NURSING FACILITY	30,868	3,067,336	0	3,067,336	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 OPERATING ROOM	0	7,266,591	0	7,266,591	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	3,923,698	0	3,923,698	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	1,642,724	0	1,642,724	55.00
57.00 CT SCAN	0	555,763	0	555,763	57.00
57.01 ULTRA SOUND	0	297,038	0	297,038	57.01
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	305,287	0	305,287	58.00
59.00 CARDIAC CATHETERIZATION	0	1,436,622	0	1,436,622	59.00
60.00 LABORATORY	0	5,915,511	0	5,915,511	60.00
60.01 BLOOD LABORATORY	0	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	890,934	0	890,934	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	1,540,401	0	1,540,401	65.00
66.00 PHYSICAL THERAPY	0	6,547,328	0	6,547,328	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	2,343,314	0	2,343,314	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,638,141	0	12,638,141	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	1,493,825	0	1,493,825	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	7,709,673	0	7,709,673	73.00
74.00 RENAL DIALYSIS	0	315,472	0	315,472	74.00
76.00	0	0	0	0	76.00
76.01 CARDIAC REHAB	0	843,809	0	843,809	76.01
76.02 WOMEN'S CENTER	0	1,084,507	0	1,084,507	76.02
76.03 ENDOSCOPY	0	1,407,183	0	1,407,183	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 CLINIC	0	0	0	0	90.00
90.01 OUTPATIENT	0	467,382	0	467,382	90.01
91.00 EMERGENCY	0	5,283,989	0	5,283,989	91.00
91.01 SHORT STAY	0	0	0	0	91.01
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00 AMBULANCE SERVICES	0	326,755	0	326,755	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00 SUBTOTALS (SUM OF LINES 1-117)	399,740	94,317,184	0	94,317,184	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	531,770	0	531,770	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	30,607,918	0	30,607,918	192.00
192.01 FOUNDATION	0	289,188	0	289,188	192.01
192.02 CLINICS	0	1,825,235	0	1,825,235	192.02
192.05 PRACTICE MANAGEMENT	0	947,548	0	947,548	192.05
192.06 MOB - NOBLESVILLE SQUARE	0	342,887	0	342,887	192.06
192.08 RIVERVIEW MEDICAL ARTS	0	498,087	0	498,087	192.08
193.00 NONPAID WORKERS	0	0	0	0	193.00
194.00 WORKMED	0	661,357	0	661,357	194.00
194.01 MEALS ON WHEELS	0	190,036	0	190,036	194.01
200.00 Cross Foot Adjustments	0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	399,740	130,211,210	0	130,211,210	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150059

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/25/2012 12:22 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	0	58,584	0	58,584	4.00
5.00	ADMINISTRATIVE & GENERAL	0	870,988	0	870,988	5.00
7.00	OPERATION OF PLANT	0	4,576,345	0	4,576,345	7.00
8.00	LAUNDRY & LINEN SERVICE	0	47,283	0	47,283	8.00
9.00	HOUSEKEEPING	0	27,094	0	27,094	9.00
10.00	DIETARY	0	76,718	0	76,718	10.00
11.00	CAFETERIA	0	142,469	0	142,469	11.00
13.00	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	88,998	0	88,998	14.00
15.00	PHARMACY	0	77,936	0	77,936	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	96,357	0	96,357	16.00
17.00	SOCIAL SERVICE	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS	0	1,917,415	0	1,917,415	30.00
31.00	INTENSIVE CARE UNIT	0	132,482	0	132,482	31.00
41.00	SUBPROVIDER - IRF	0	320,465	0	320,465	41.00
43.00	NURSERY	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	221,122	0	221,122	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	0	744,144	0	744,144	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	335,469	0	335,469	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	169,658	0	169,658	55.00
57.00	CT SCAN	0	0	0	0	57.00
57.01	ULTRA SOUND	0	0	0	0	57.01
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	68,785	0	68,785	59.00
60.00	LABORATORY	0	178,474	0	178,474	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	87,541	0	87,541	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	24,824	0	24,824	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	438,182	0	438,182	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	12,687	0	12,687	74.00
76.00		0	0	0	0	76.00
76.01	CARDIAC REHAB	0	0	0	0	76.01
76.02	WOMEN'S CENTER	0	194,410	0	194,410	76.02
76.03	ENDOSCOPY	0	169,013	0	169,013	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	CLINIC	0	0	0	0	90.00
90.01	OUTPATIENT	0	26,090	0	26,090	90.01
91.00	EMERGENCY	0	382,226	0	382,226	91.00
91.01	SHORT STAY	0	0	0	0	91.01
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	AMBULANCE SERVICES	0	0	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	11,485,759	0	11,485,759	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	98,961	0	98,961	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	FOUNDATION	0	0	0	0	192.01
192.02	CLINICS	0	0	0	0	192.02
192.05	PRACTICE MANAGEMENT	0	0	0	0	192.05
192.06	MOB - NOBLESVILLE SQUARE	0	0	0	0	192.06
192.08	RIVERVIEW MEDICAL ARTS	0	0	0	0	192.08
193.00	NONPAID WORKERS	0	0	0	0	193.00
194.00	WORKMED	0	0	0	0	194.00
194.01	MEALS ON WHEELS	0	0	0	0	194.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150059		Period: From 01/01/2011 To 12/31/2011		Worksheet B Part II Date/Time Prepared: 5/25/2012 12:22 pm	
Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS		
		NEW BLDG & FIXT	NEW MVBLE EQUIP				
	0	1.00	2.00	2A	4.00		
202.00 TOTAL (sum lines 118-201)	0	11,584,720	0	11,584,720	58,584	202.00	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150059

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/25/2012 12:22 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	877,743					5.00
7.00	OPERATION OF PLANT	75,625	4,653,531				7.00
8.00	LAUNDRY & LINEN SERVICE	3,921	36,196	87,476			8.00
9.00	HOUSEKEEPING	10,594	20,741	0	59,349		9.00
10.00	DIETARY	6,319	58,730	0	166	142,200	10.00
11.00	CAFETERIA	9,240	109,065	0	1,165	0	11.00
13.00	NURSING ADMINISTRATION	7,133	0	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	83,558	68,131	657	1,664	0	14.00
15.00	PHARMACY	50,433	59,663	0	555	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	11,915	73,765	0	277	0	16.00
17.00	SOCIAL SERVICE	2,630	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	82,739	1,467,847	27,418	19,302	72,850	30.00
31.00	INTENSIVE CARE UNIT	19,019	101,419	6,392	2,551	10,744	31.00
41.00	SUBPROVIDER - IRF	20,652	245,327	6,834	3,716	30,854	41.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	15,364	169,276	6,344	3,273	27,752	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	33,754	569,668	4,588	8,375	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	20,747	256,813	5,123	2,441	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	8,476	129,879	708	555	0	55.00
57.00	CT SCAN	3,676	0	0	0	0	57.00
57.01	ULTRA SOUND	1,932	0	0	0	0	57.01
58.00	MAGNETIC RESONANCE IMAGING (MRI)	1,963	0	0	222	0	58.00
59.00	CARDIAC CATHETERIZATION	8,427	52,658	2,257	0	0	59.00
60.00	LABORATORY	36,520	136,628	0	1,054	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	4,917	67,015	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	9,622	19,004	0	388	0	65.00
66.00	PHYSICAL THERAPY	41,380	0	738	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	9,348	335,443	751	1,775	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	10,070	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	1,969	9,712	0	0	0	74.00
76.00		0	0	0	0	0	76.00
76.01	CARDIAC REHAB	5,194	0	65	1,997	0	76.01
76.02	WOMEN'S CENTER	4,660	148,828	436	555	0	76.02
76.03	ENDOSCOPY	6,797	129,385	3,902	1,109	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0	0	0	0	0	90.00
90.01	OUTPATIENT	2,569	19,973	2,377	444	0	90.01
91.00	EMERGENCY	24,862	292,607	11,807	4,992	0	91.00
91.01	SHORT STAY	0	0	0	0	0	91.01
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	AMBULANCE SERVICES	2,184	0	0	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	638,209	4,577,773	80,397	56,576	142,200	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,282	75,758	0	222	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	205,930	0	6,900	0	0	192.00
192.01	FOUNDATION	1,894	0	0	0	0	192.01
192.02	CLINICS	11,777	0	77	2,551	0	192.02
192.05	PRACTICE MANAGEMENT	6,386	0	29	0	0	192.05
192.06	MOB - NOBLESVILLE SQUARE	2,312	0	0	0	0	192.06
192.08	RIVERVIEW MEDICAL ARTS	3,358	0	0	0	0	192.08
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	WORKMED	4,357	0	73	0	0	194.00
194.01	MEALS ON WHEELS	1,238	0	0	0	0	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	877,743	4,653,531	87,476	59,349	142,200	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150059		Period: From 01/01/2011 To 12/31/2011		Worksheet B Part II Date/Time Prepared: 5/25/2012 12:22 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	262,540					11.00
13.00	NURSING ADMINISTRATION	4,102	11,975				13.00
14.00	CENTRAL SERVICES & SUPPLY	4,488	0	248,078			14.00
15.00	PHARMACY	10,961	0	0	201,302		15.00
16.00	MEDICAL RECORDS & LIBRARY	6,962	0	0	0	189,984	16.00
17.00	SOCIAL SERVICE	1,506	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	61,217	6,174	0	0	51,062	30.00
31.00	INTENSIVE CARE UNIT	20,329	2,050	0	0	13,517	31.00
41.00	SUBPROVIDER - IRF	17,744	1,790	0	0	1,502	41.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	13,500	0	0	0	51,063	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	16,610	0	0	0	1,502	54.00
55.00	RADIOLOGY-THERAPEUTIC	3,187	0	0	0	3,004	55.00
57.00	CT SCAN	1,640	0	0	0	0	57.00
57.01	ULTRA SOUND	1,644	0	0	0	0	57.01
58.00	MAGNETIC RESONANCE IMAGING (MRI)	1,270	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	6,684	0	0	0	0	59.00
60.00	LABORATORY	18,330	0	0	0	2,253	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	8,933	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	21,298	0	0	0	25,531	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	6,072	0	0	0	5,256	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	248,078	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	201,302	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00		0	0	0	0	0	76.00
76.01	CARDIAC REHAB	2,873	0	0	0	0	76.01
76.02	WOMEN'S CENTER	2,524	0	0	0	0	76.02
76.03	ENDOSCOPY	4,227	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0	0	0	0	0	90.00
90.01	OUTPATIENT	1,246	0	0	0	0	90.01
91.00	EMERGENCY	19,442	1,961	0	0	34,543	91.00
91.01	SHORT STAY	0	0	0	0	0	91.01
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	AMBULANCE SERVICES	449	0	0	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	257,238	11,975	248,078	201,302	189,233	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	724	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	FOUNDATION	1,293	0	0	0	0	192.01
192.02	CLINICS	0	0	0	0	751	192.02
192.05	PRACTICE MANAGEMENT	0	0	0	0	0	192.05
192.06	MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.08	RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	WORKMED	2,287	0	0	0	0	194.00
194.01	MEALS ON WHEELS	998	0	0	0	0	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	262,540	11,975	248,078	201,302	189,984	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150059

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/25/2012 12:22 pm

Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	17.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 EMPLOYEE BENEFITS					4.00
5.00 ADMINISTRATIVE & GENERAL					5.00
7.00 OPERATION OF PLANT					7.00
8.00 LAUNDRY & LINEN SERVICE					8.00
9.00 HOUSEKEEPING					9.00
10.00 DIETARY					10.00
11.00 CAFETERIA					11.00
13.00 NURSING ADMINISTRATION					13.00
14.00 CENTRAL SERVICES & SUPPLY					14.00
15.00 PHARMACY					15.00
16.00 MEDICAL RECORDS & LIBRARY					16.00
17.00 SOCIAL SERVICE	4,420				17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00 ADULTS & PEDIATRICS	3,408	3,716,158	0	3,716,158	30.00
31.00 INTENSIVE CARE UNIT	336	310,719	0	310,719	31.00
41.00 SUBPROVIDER - IRF	335	650,515	0	650,515	41.00
43.00 NURSERY	0	0	0	0	43.00
44.00 SKILLED NURSING FACILITY	341	443,472	0	443,472	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 OPERATING ROOM	0	1,428,314	0	1,428,314	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	640,203	0	640,203	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	315,874	0	315,874	55.00
57.00 CT SCAN	0	5,543	0	5,543	57.00
57.01 ULTRA SOUND	0	3,731	0	3,731	57.01
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	3,641	0	3,641	58.00
59.00 CARDIAC CATHETERIZATION	0	139,544	0	139,544	59.00
60.00 LABORATORY	0	375,090	0	375,090	60.00
60.01 BLOOD LABORATORY	0	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	159,473	0	159,473	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	63,741	0	63,741	65.00
66.00 PHYSICAL THERAPY	0	92,525	0	92,525	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	797,434	0	797,434	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	248,078	0	248,078	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	10,070	0	10,070	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	201,302	0	201,302	73.00
74.00 RENAL DIALYSIS	0	24,368	0	24,368	74.00
76.00	0	0	0	0	76.00
76.01 CARDIAC REHAB	0	10,633	0	10,633	76.01
76.02 WOMEN'S CENTER	0	351,738	0	351,738	76.02
76.03 ENDOSCOPY	0	314,981	0	314,981	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 CLINIC	0	0	0	0	90.00
90.01 OUTPATIENT	0	52,936	0	52,936	90.01
91.00 EMERGENCY	0	774,304	0	774,304	91.00
91.01 SHORT STAY	0	0	0	0	91.01
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00 AMBULANCE SERVICES	0	2,703	0	2,703	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00 SUBTOTALS (SUM OF LINES 1-117)	4,420	11,137,090	0	11,137,090	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	178,031	0	178,031	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	228,370	0	228,370	192.00
192.01 FOUNDATION	0	3,393	0	3,393	192.01
192.02 CLINICS	0	15,907	0	15,907	192.02
192.05 PRACTICE MANAGEMENT	0	6,864	0	6,864	192.05
192.06 MOB - NOBLESVILLE SQUARE	0	2,312	0	2,312	192.06
192.08 RIVERVIEW MEDICAL ARTS	0	3,358	0	3,358	192.08
193.00 NONPAID WORKERS	0	0	0	0	193.00
194.00 WORKMED	0	7,101	0	7,101	194.00
194.01 MEALS ON WHEELS	0	2,294	0	2,294	194.01
200.00 Cross Foot Adjustments	0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	4,420	11,584,720	0	11,584,720	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150059

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

Worksheet B-1  
Date/Time Prepared:  
5/25/2012 12:22 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 NEW CAP REL COSTS-BLDG & FIXT	484,876						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		5,071,723					2.00
4.00 EMPLOYEE BENEFITS	2,452	7,641	59,906,601				4.00
5.00 ADMINISTRATIVE & GENERAL	36,455	2,180,842	6,907,242	-14,559,904	115,651,306		5.00
7.00 OPERATION OF PLANT	191,542	155,167	1,595,941	0	9,963,776		7.00
8.00 LAUNDRY & LINEN SERVICE	1,979	1,568	78,032	0	516,579		8.00
9.00 HOUSEKEEPING	1,134	13,757	940,446	0	1,395,722		9.00
10.00 DIETARY	3,211	17,381	273,169	0	832,512		10.00
11.00 CAFETERIA	5,963	0	614,964	0	1,217,415		11.00
13.00 NURSING ADMINISTRATION	0	237	756,384	0	939,771		13.00
14.00 CENTRAL SERVICES & SUPPLY	3,725	82,738	595,413	0	11,008,969		14.00
15.00 PHARMACY	3,262	7,899	1,793,948	0	6,644,631		15.00
16.00 MEDICAL RECORDS & LIBRARY	4,033	22,187	723,589	0	1,569,782		16.00
17.00 SOCIAL SERVICE	0	617	290,827	0	346,557		17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 ADULTS & PEDIATRICS	80,253	251,722	6,877,301	0	10,901,092		30.00
31.00 INTENSIVE CARE UNIT	5,545	145,880	1,922,407	0	2,505,801		31.00
41.00 SUBPROVIDER - IRF	13,413	9,994	1,325,612	0	2,720,916		41.00
43.00 NURSERY	0	0	0	0	0		43.00
44.00 SKILLED NURSING FACILITY	9,255	13,469	0	0	2,024,200		44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 OPERATING ROOM	31,146	338,967	3,294,816	0	4,447,157		50.00
52.00 DELIVERY ROOM & LABOR ROOM		0	0	0	0		52.00
54.00 RADIOLOGY-DIAGNOSTIC	14,041	32,947	1,531,670	0	2,733,475		54.00
55.00 RADIOLOGY-THERAPEUTIC	7,101	265,681	416,128	0	1,116,685		55.00
57.00 CT SCAN	0	39,718	232,278	0	484,378		57.00
57.01 ULTRA SOUND	0	1,051	158,901	0	254,564		57.01
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	18,257	189,930	0	258,615		58.00
59.00 CARDIAC CATHETERIZATION	2,879	220,005	749,408	0	1,110,251		59.00
60.00 LABORATORY	7,470	213,093	1,872,067	0	4,811,638		60.00
60.01 BLOOD LABORATORY	0	0	0	0	0		60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	3,664	4,194	0	0	647,823		63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0		64.00
65.00 RESPIRATORY THERAPY	1,039	37,228	991,913	0	1,267,719		65.00
66.00 PHYSICAL THERAPY	0	76,754	3,658,616	0	5,451,855		66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	18,340	323,338	620,627	0	1,231,614		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,326,789		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0		73.00
74.00 RENAL DIALYSIS	531	85	0	0	259,402		74.00
76.00	0	0	0	0	0		76.00
76.01 CARDIAC REHAB	0	7,961	515,055	0	684,376		76.01
76.02 WOMEN'S CENTER	8,137	221,045	332,356	0	613,939		76.02
76.03 ENDOSCOPY	7,074	177,198	559,875	0	895,571		76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 CLINIC	0	0	0	0	0		90.00
90.01 OUTPATIENT	1,092	7,473	242,590	0	338,427		90.01
91.00 EMERGENCY	15,998	161,471	1,906,129	0	3,275,619		91.00
91.01 SHORT STAY	0	3,721	0	0	0		91.01
92.00 OBSERVATION BEDS (NON-DISTINCT PART)							92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00 AMBULANCE SERVICES	0	0	71,743	0	287,686		95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00 SUBTOTALS (SUM OF LINES 1-117)	480,734	5,061,286	42,039,377	-14,559,904	84,085,306		118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,142	8,757	86,271	0	300,641		190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	15,891,518	0	27,138,564		192.00
192.01 FOUNDATION	0	1,680	210,524	0	249,569		192.01
192.02 CLINICS	0	0	767,479	0	1,551,699		192.02
192.05 PRACTICE MANAGEMENT	0	0	459,540	0	841,401		192.05
192.06 MOB - NOBLESVILLE SQUARE	0	0	0	0	304,546		192.06
192.08 RIVERVIEW MEDICAL ARTS	0	0	0	0	442,392		192.08
193.00 NONPAID WORKERS	0	0	0	0	0		193.00
194.00 WORKMED	0	0	392,919	0	574,023		194.00
194.01 MEALS ON WHEELS	0	0	58,973	0	163,165		194.01
200.00 Cross Foot Adjustments							200.00
201.00 Negative Cost Centers							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150059

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

Worksheet B-1  
Date/Time Prepared:  
5/25/2012 12:22 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
202.00 Cost to be allocated (per Wkst. B, Part I)	11,584,720	0	7,994,859	5A	14,559,904	202.00	
203.00 Unit cost multiplier (Wkst. B, Part I)	23.892129	0.000000	0.133455		0.125895	203.00	
204.00 Cost to be allocated (per Wkst. B, Part II)			58,584		877,743	204.00	
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000978		0.007590	205.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150059

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

Worksheet B-1  
Date/Time Prepared:  
5/25/2012 12:22 pm

Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	
	7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT	254,427					7.00
8.00 LAUNDRY & LINEN SERVICE	1,979	73,174				8.00
9.00 HOUSEKEEPING	1,134	0	1,070			9.00
10.00 DIETARY	3,211	0	3	91,817		10.00
11.00 CAFETERIA	5,963	0	21	0	1,602,263	11.00
13.00 NURSING ADMINISTRATION	0	0	0	0	25,037	13.00
14.00 CENTRAL SERVICES & SUPPLY	3,725	550	30	0	27,388	14.00
15.00 PHARMACY	3,262	0	10	0	66,897	15.00
16.00 MEDICAL RECORDS & LIBRARY	4,033	0	5	0	42,487	16.00
17.00 SOCIAL SERVICE	0	0	0	0	9,191	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	80,253	22,936	348	47,039	373,614	30.00
31.00 INTENSIVE CARE UNIT	5,545	5,347	46	6,937	124,064	31.00
41.00 SUBPROVIDER - IRF	13,413	5,717	67	19,922	108,289	41.00
43.00 NURSERY	0	0	0	0	0	43.00
44.00 SKILLED NURSING FACILITY	9,255	5,307	59	17,919	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	31,146	3,838	151	0	82,387	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	14,041	4,285	44	0	101,371	54.00
55.00 RADIOLOGY-THERAPEUTIC	7,101	592	10	0	19,453	55.00
57.00 CT SCAN	0	0	0	0	10,009	57.00
57.01 ULTRA SOUND	0	0	0	0	10,031	57.01
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	4	0	7,748	58.00
59.00 CARDIAC CATHETERIZATION	2,879	1,888	0	0	40,789	59.00
60.00 LABORATORY	7,470	0	19	0	111,864	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	3,664	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	1,039	0	7	0	54,515	65.00
66.00 PHYSICAL THERAPY	0	617	0	0	129,980	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	18,340	628	32	0	37,056	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 RENAL DIALYSIS	531	0	0	0	0	74.00
76.00	0	0	0	0	0	76.00
76.01 CARDIAC REHAB	0	54	36	0	17,535	76.01
76.02 WOMEN'S CENTER	8,137	365	10	0	15,403	76.02
76.03 ENDOSCOPY	7,074	3,264	20	0	25,798	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 CLINIC	0	0	0	0	0	90.00
90.01 OUTPATIENT	1,092	1,988	8	0	7,606	90.01
91.00 EMERGENCY	15,998	9,877	90	0	118,655	91.00
91.01 SHORT STAY	0	0	0	0	0	91.01
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 AMBULANCE SERVICES	0	0	0	0	2,743	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00 SUBTOTALS (SUM OF LINES 1-117)	250,285	67,253	1,020	91,817	1,569,910	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,142	0	4	0	4,416	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	5,772	0	0	0	192.00
192.01 FOUNDATION	0	0	0	0	7,889	192.01
192.02 CLINICS	0	64	46	0	0	192.02
192.05 PRACTICE MANAGEMENT	0	24	0	0	0	192.05
192.06 MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.08 RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 WORKMED	0	61	0	0	13,959	194.00
194.01 MEALS ON WHEELS	0	0	0	0	6,089	194.01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	11,218,166	668,872	1,621,436	1,083,446	1,665,424	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	44.091885	9.140842	1,515.360748	11.800059	1.039420	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150059

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

Worksheet B-1

Date/Time Prepared:  
5/25/2012 12:22 pm

Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	
	7.00	8.00	9.00	10.00	11.00	
204.00 Cost to be allocated (per Wkst. B, Part II)	4,653,531	87,476	59,349	142,200	262,540	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	18.290240	1.195452	55.466355	1.548733	0.163856	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150059

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

Worksheet B-1  
Date/Time Prepared:  
5/25/2012 12:22 pm

Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
	(DIRECT NRSING HRS)	(COSTED REQUIS.)		(TIME SPENT)		
	13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA						11.00
13.00 NURSING ADMINISTRATION	724,622					13.00
14.00 CENTRAL SERVICES & SUPPLY	0	1,000				14.00
15.00 PHARMACY	0	0	1,000			15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	0	506		16.00
17.00 SOCIAL SERVICE	0	0	0	0	6,190	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	373,614	0	0	136	4,773	30.00
31.00 INTENSIVE CARE UNIT	124,064	0	0	36	470	31.00
41.00 SUBPROVIDER - IRF	108,289	0	0	4	469	41.00
43.00 NURSERY	0	0	0	0	0	43.00
44.00 SKILLED NURSING FACILITY	0	0	0	0	478	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	0	0	0	136	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	4	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	8	0	55.00
57.00 CT SCAN	0	0	0	0	0	57.00
57.01 ULTRA SOUND	0	0	0	0	0	57.01
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	6	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	68	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	14	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,000	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	1,000	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	0	0	0	0	0	76.00
76.01 CARDIAC REHAB	0	0	0	0	0	76.01
76.02 WOMEN'S CENTER	0	0	0	0	0	76.02
76.03 ENDOSCOPY	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 CLINIC	0	0	0	0	0	90.00
90.01 OUTPATIENT	0	0	0	0	0	90.01
91.00 EMERGENCY	118,655	0	0	92	0	91.00
91.01 SHORT STAY	0	0	0	0	0	91.01
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 AMBULANCE SERVICES	0	0	0	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00 SUBTOTALS (SUM OF LINES 1-117)	724,622	1,000	1,000	504	6,190	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 FOUNDATION	0	0	0	0	0	192.01
192.02 CLINICS	0	0	0	2	0	192.02
192.05 PRACTICE MANAGEMENT	0	0	0	0	0	192.05
192.06 MOB - NOBLESVILLE SQUARE	0	0	0	0	0	192.06
192.08 RIVERVIEW MEDICAL ARTS	0	0	0	0	0	192.08
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 WORKMED	0	0	0	0	0	194.00
194.01 MEALS ON WHEELS	0	0	0	0	0	194.01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	1,084,107	12,638,141	7,709,673	1,996,972	399,740	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150059

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

Worksheet B-1

Date/Time Prepared:  
5/25/2012 12:22 pm

Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	(DIRECT NURSING HRS)	(COSTED REQUIS.)		(TIME SPENT)	(TIME SPENT)	
	13.00	14.00	15.00	16.00	17.00	
203.00 Unit cost multiplier (Wkst. B, Part I)	1.496100	12,638.141000	7,709.673000	3,946.584980	64.578352	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	11,975	248,078	201,302	189,984	4,420	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.016526	248.078000	201.302000	375.462451	0.714055	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150059

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/25/2012 12:22 pm

		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	18,896,326		18,896,326	0	18,896,326	30.00
31.00	INTENSIVE CARE UNIT	3,753,195		3,753,195	0	3,753,195	31.00
41.00	SUBPROVIDER - IRF	4,364,380		4,364,380	0	4,364,380	41.00
43.00	NURSERY	0		0	0	0	43.00
44.00	SKILLED NURSING FACILITY	3,067,336		3,067,336	87,692	3,155,028	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	7,266,591		7,266,591	0	7,266,591	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	3,923,698		3,923,698	0	3,923,698	54.00
55.00	RADIOLOGY-THERAPEUTIC	1,642,724		1,642,724	0	1,642,724	55.00
57.00	CT SCAN	555,763		555,763	0	555,763	57.00
57.01	ULTRA SOUND	297,038		297,038	0	297,038	57.01
58.00	MAGNETIC RESONANCE IMAGING (MRI)	305,287		305,287	0	305,287	58.00
59.00	CARDIAC CATHETERIZATION	1,436,622		1,436,622	51,469	1,488,091	59.00
60.00	LABORATORY	5,915,511		5,915,511	8,075	5,923,586	60.00
60.01	BLOOD LABORATORY	0		0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	890,934		890,934	0	890,934	63.00
64.00	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	RESPIRATORY THERAPY	1,540,401	0	1,540,401	0	1,540,401	65.00
66.00	PHYSICAL THERAPY	6,547,328	0	6,547,328	0	6,547,328	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	2,343,314		2,343,314	84,128	2,427,442	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,638,141		12,638,141	0	12,638,141	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	1,493,825		1,493,825	0	1,493,825	72.00
73.00	DRUGS CHARGED TO PATIENTS	7,709,673		7,709,673	0	7,709,673	73.00
74.00	RENAL DIALYSIS	315,472		315,472	0	315,472	74.00
76.00		0		0	0	0	76.00
76.01	CARDIAC REHAB	843,809		843,809	0	843,809	76.01
76.02	WOMEN'S CENTER	1,084,507		1,084,507	0	1,084,507	76.02
76.03	ENDOSCOPY	1,407,183		1,407,183	0	1,407,183	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0		0	0	0	90.00
90.01	OUTPATIENT	467,382		467,382	688	468,070	90.01
91.00	EMERGENCY	5,283,989		5,283,989	7,632	5,291,621	91.00
91.01	SHORT STAY	0		0	0	0	91.01
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1,936,635		1,936,635	0	1,936,635	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	AMBULANCE SERVICES	326,755		326,755	0	326,755	95.00
200.00	Subtotal (see instructions)	96,253,819	0	96,253,819	239,684	96,493,503	200.00
201.00	Less Observation Beds	1,936,635		1,936,635	0	1,936,635	201.00
202.00	Total (see instructions)	94,317,184	0	94,317,184	239,684	94,556,868	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150059

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/25/2012 12:22 pm

		Title XVII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	23,458,216		23,458,216			30.00
31.00	INTENSIVE CARE UNIT	5,906,577		5,906,577			31.00
41.00	SUBPROVIDER - IRF	5,918,946		5,918,946			41.00
43.00	NURSERY	0		0			43.00
44.00	SKILLED NURSING FACILITY	2,588,250		2,588,250			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	16,153,426	18,438,648	34,592,074	0.210065	0.000000	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
54.00	RADIOLOGY-DIAGNOSTIC	1,850,699	10,119,551	11,970,250	0.327787	0.000000	54.00
55.00	RADIOLOGY-THERAPEUTIC	120,065	6,032,198	6,152,263	0.267011	0.000000	55.00
57.00	CT SCAN	3,364,061	12,003,568	15,367,629	0.036165	0.000000	57.00
57.01	ULTRA SOUND	342,034	2,121,767	2,463,801	0.120561	0.000000	57.01
58.00	MAGNETIC RESONANCE IMAGING (MRI)	845,606	5,512,821	6,358,427	0.048013	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	3,973,033	5,975,309	9,948,342	0.144408	0.000000	59.00
60.00	LABORATORY	10,158,815	19,639,831	29,798,646	0.198516	0.000000	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	1,282,722	577,574	1,860,296	0.478921	0.000000	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	RESPIRATORY THERAPY	3,237,368	565,797	3,803,165	0.405031	0.000000	65.00
66.00	PHYSICAL THERAPY	6,787,862	8,755,162	15,543,024	0.421239	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	ELECTROCARDIOLOGY	2,218,601	6,579,708	8,798,309	0.266337	0.000000	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,761,741	19,091,950	44,853,691	0.281764	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	1,867,303	3,640,440	5,507,743	0.271223	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	11,797,929	8,406,253	20,204,182	0.381588	0.000000	73.00
74.00	RENAL DIALYSIS	380,107	0	380,107	0.829956	0.000000	74.00
76.00		0	0	0	0.000000	0.000000	76.00
76.01	CARDIAC REHAB	268,948	1,510,047	1,778,995	0.474318	0.000000	76.01
76.02	WOMEN'S CENTER	14,760	3,365,655	3,380,415	0.320821	0.000000	76.02
76.03	ENDOSCOPY	578,842	4,844,206	5,423,048	0.259482	0.000000	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	OUTPATIENT	190,744	591,110	781,854	0.597787	0.000000	90.01
91.00	EMERGENCY	3,427,817	13,994,404	17,422,221	0.303290	0.000000	91.00
91.01	SHORT STAY	0	0	0	0.000000	0.000000	91.01
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,789,690	3,789,690	0.511027	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	AMBULANCE SERVICES	0	736,774	736,774	0.443494	0.000000	95.00
200.00	Subtotal (see instructions)	132,494,472	156,292,463	288,786,935			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	132,494,472	156,292,463	288,786,935			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150059

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/25/2012 12:22 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS				30.00
31.00	INTENSIVE CARE UNIT				31.00
41.00	SUBPROVIDER - IRF				41.00
43.00	NURSERY				43.00
44.00	SKILLED NURSING FACILITY				44.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.210065			50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.327787			54.00
55.00	RADIOLOGY-THERAPEUTIC	0.267011			55.00
57.00	CT SCAN	0.036165			57.00
57.01	ULTRA SOUND	0.120561			57.01
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.048013			58.00
59.00	CARDIAC CATHETERIZATION	0.149582			59.00
60.00	LABORATORY	0.198787			60.00
60.01	BLOOD LABORATORY	0.000000			60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0.478921			63.00
64.00	INTRAVENOUS THERAPY	0.000000			64.00
65.00	RESPIRATORY THERAPY	0.405031			65.00
66.00	PHYSICAL THERAPY	0.421239			66.00
67.00	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	SPEECH PATHOLOGY	0.000000			68.00
69.00	ELECTROCARDIOLOGY	0.275899			69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.281764			71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.271223			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.381588			73.00
74.00	RENAL DIALYSIS	0.829956			74.00
76.00		0.000000			76.00
76.01	CARDIAC REHAB	0.474318			76.01
76.02	WOMEN'S CENTER	0.320821			76.02
76.03	ENDOSCOPY	0.259482			76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	CLINIC	0.000000			90.00
90.01	OUTPATIENT	0.598667			90.01
91.00	EMERGENCY	0.303728			91.00
91.01	SHORT STAY	0.000000			91.01
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.511027			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	AMBULANCE SERVICES	0.443494			95.00
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: 150059

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/25/2012 12:22 pm

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	18,896,326		18,896,326	0	0	30.00
31.00	INTENSIVE CARE UNIT	3,753,195		3,753,195	0	0	31.00
41.00	SUBPROVIDER - IRF	4,364,380		4,364,380	0	0	41.00
43.00	NURSERY	0		0	0	0	43.00
44.00	SKILLED NURSING FACILITY	3,067,336		3,067,336	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	7,266,591		7,266,591	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	3,923,698		3,923,698	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	1,642,724		1,642,724	0	0	55.00
57.00	CT SCAN	555,763		555,763	0	0	57.00
57.01	ULTRA SOUND	297,038		297,038	0	0	57.01
58.00	MAGNETIC RESONANCE IMAGING (MRI)	305,287		305,287	0	0	58.00
59.00	CARDIAC CATHETERIZATION	1,436,622		1,436,622	0	0	59.00
60.00	LABORATORY	5,915,511		5,915,511	0	0	60.00
60.01	BLOOD LABORATORY	0		0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	890,934		890,934	0	0	63.00
64.00	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	RESPIRATORY THERAPY	1,540,401	0	1,540,401	0	0	65.00
66.00	PHYSICAL THERAPY	6,547,328	0	6,547,328	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	2,343,314		2,343,314	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,638,141		12,638,141	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	1,493,825		1,493,825	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	7,709,673		7,709,673	0	0	73.00
74.00	RENAL DIALYSIS	315,472		315,472	0	0	74.00
76.00		0		0	0	0	76.00
76.01	CARDIAC REHAB	843,809		843,809	0	0	76.01
76.02	WOMEN'S CENTER	1,084,507		1,084,507	0	0	76.02
76.03	ENDOSCOPY	1,407,183		1,407,183	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0		0	0	0	90.00
90.01	OUTPATIENT	467,382		467,382	0	0	90.01
91.00	EMERGENCY	5,283,989		5,283,989	0	0	91.00
91.01	SHORT STAY	0		0	0	0	91.01
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1,936,635		1,936,635	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	AMBULANCE SERVICES	326,755		326,755	0	0	95.00
200.00	Subtotal (see instructions)	96,253,819	0	96,253,819	0	0	200.00
201.00	Less Observation Beds	1,936,635		1,936,635	0	0	201.00
202.00	Total (see instructions)	94,317,184	0	94,317,184	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150059

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/25/2012 12:22 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	23,458,216		23,458,216			30.00
31.00	INTENSIVE CARE UNIT	5,906,577		5,906,577			31.00
41.00	SUBPROVIDER - IRF	5,918,946		5,918,946			41.00
43.00	NURSERY	0		0			43.00
44.00	SKILLED NURSING FACILITY	2,588,250		2,588,250			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	16,153,426	18,438,648	34,592,074	0.210065	0.000000	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
54.00	RADIOLOGY-DIAGNOSTIC	1,850,699	10,119,551	11,970,250	0.327787	0.000000	54.00
55.00	RADIOLOGY-THERAPEUTIC	120,065	6,032,198	6,152,263	0.267011	0.000000	55.00
57.00	CT SCAN	3,364,061	12,003,568	15,367,629	0.036165	0.000000	57.00
57.01	ULTRA SOUND	342,034	2,121,767	2,463,801	0.120561	0.000000	57.01
58.00	MAGNETIC RESONANCE IMAGING (MRI)	845,606	5,512,821	6,358,427	0.048013	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	3,973,033	5,975,309	9,948,342	0.144408	0.000000	59.00
60.00	LABORATORY	10,158,815	19,639,831	29,798,646	0.198516	0.000000	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	1,282,722	577,574	1,860,296	0.478921	0.000000	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	RESPIRATORY THERAPY	3,237,368	565,797	3,803,165	0.405031	0.000000	65.00
66.00	PHYSICAL THERAPY	6,787,862	8,755,162	15,543,024	0.421239	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	ELECTROCARDIOLOGY	2,218,601	6,579,708	8,798,309	0.266337	0.000000	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,761,741	19,091,950	44,853,691	0.281764	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	1,867,303	3,640,440	5,507,743	0.271223	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	11,797,929	8,406,253	20,204,182	0.381588	0.000000	73.00
74.00	RENAL DIALYSIS	380,107	0	380,107	0.829956	0.000000	74.00
76.00		0	0	0	0.000000	0.000000	76.00
76.01	CARDIAC REHAB	268,948	1,510,047	1,778,995	0.474318	0.000000	76.01
76.02	WOMEN'S CENTER	14,760	3,365,655	3,380,415	0.320821	0.000000	76.02
76.03	ENDOSCOPY	578,842	4,844,206	5,423,048	0.259482	0.000000	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	OUTPATIENT	190,744	591,110	781,854	0.597787	0.000000	90.01
91.00	EMERGENCY	3,427,817	13,994,404	17,422,221	0.303290	0.000000	91.00
91.01	SHORT STAY	0	0	0	0.000000	0.000000	91.01
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,789,690	3,789,690	0.511027	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	AMBULANCE SERVICES	0	736,774	736,774	0.443494	0.000000	95.00
200.00	Subtotal (see instructions)	132,494,472	156,292,463	288,786,935			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	132,494,472	156,292,463	288,786,935			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150059

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/25/2012 12:22 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
INPATIENT ROUTINE SERVICE COST CENTERS		11.00			
30.00	ADULTS & PEDIATRICS				30.00
31.00	INTENSIVE CARE UNIT				31.00
41.00	SUBPROVIDER - IRF				41.00
43.00	NURSERY				43.00
44.00	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000			50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	RADIOLOGY-THERAPEUTIC	0.000000			55.00
57.00	CT SCAN	0.000000			57.00
57.01	ULTRA SOUND	0.000000			57.01
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	LABORATORY	0.000000			60.00
60.01	BLOOD LABORATORY	0.000000			60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
64.00	INTRAVENOUS THERAPY	0.000000			64.00
65.00	RESPIRATORY THERAPY	0.000000			65.00
66.00	PHYSICAL THERAPY	0.000000			66.00
67.00	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	SPEECH PATHOLOGY	0.000000			68.00
69.00	ELECTROCARDIOLOGY	0.000000			69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	RENAL DIALYSIS	0.000000			74.00
76.00		0.000000			76.00
76.01	CARDIAC REHAB	0.000000			76.01
76.02	WOMEN'S CENTER	0.000000			76.02
76.03	ENDOSCOPY	0.000000			76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0.000000			90.00
90.01	OUTPATIENT	0.000000			90.01
91.00	EMERGENCY	0.000000			91.00
91.01	SHORT STAY	0.000000			91.01
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES	0.000000			95.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150059		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part I Date/Time Prepared: 5/25/2012 12:22 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,716,158	0	3,716,158	17,807	208.69	30.00
31.00	INTENSIVE CARE UNIT	310,719	0	310,719	2,993	103.82	31.00
41.00	SUBPROVIDER - IRF	650,515	0	650,515	6,195	105.01	41.00
43.00	NURSERY	0	0	0	0	0.00	43.00
44.00	SKILLED NURSING FACILITY	443,472	0	443,472	5,330	83.20	44.00
200.00	Total (Lines 30-199)	5,120,864	0	5,120,864	32,325		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150059		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part I Date/Time Prepared: 5/25/2012 12:22 pm	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Title XVIII	Hospital	PPS	
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	6,769	1,412,623				30.00
31.00	INTENSIVE CARE UNIT	1,372	142,441				31.00
41.00	SUBPROVIDER - IRF	4,335	455,218				41.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	3,710	308,672				44.00
200.00	Total (Lines 30-199)	16,186	2,318,954				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part II Date/Time Prepared: 5/25/2012 12:22 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	1,428,314	34,592,074	0.041290	8,151,851	336,590	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	640,203	11,970,250	0.053483	1,386,935	74,177	54.00
55.00	RADIOLOGY-THERAPEUTIC	315,874	6,152,263	0.051343	66,277	3,403	55.00
57.00	CT SCAN	5,543	15,367,629	0.000361	1,699,175	613	57.00
57.01	ULTRA SOUND	3,731	2,463,801	0.001514	126,620	192	57.01
58.00	MAGNETIC RESONANCE IMAGING (MRI)	3,641	6,358,427	0.000573	405,903	233	58.00
59.00	CARDIAC CATHETERIZATION	139,544	9,948,342	0.014027	1,314,551	18,439	59.00
60.00	LABORATORY	375,090	29,798,646	0.012587	4,658,730	58,639	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	159,473	1,860,296	0.085725	361,979	31,031	63.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	63,741	3,803,165	0.016760	951,991	15,955	65.00
66.00	PHYSICAL THERAPY	92,525	15,543,024	0.005953	812,894	4,839	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	797,434	8,798,309	0.090635	1,019,948	92,443	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	248,078	44,853,691	0.005531	12,201,060	67,484	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	10,070	5,507,743	0.001828	916,768	1,676	72.00
73.00	DRUGS CHARGED TO PATIENTS	201,302	20,204,182	0.009963	4,878,956	48,609	73.00
74.00	RENAL DIALYSIS	24,368	380,107	0.064108	198,577	12,730	74.00
76.00		0	0	0.000000	0	0	76.00
76.01	CARDIAC REHAB	10,633	1,778,995	0.005977	84,733	506	76.01
76.02	WOMEN'S CENTER	351,738	3,380,415	0.104052	0	0	76.02
76.03	ENDOSCOPY	314,981	5,423,048	0.058082	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0	0	0.000000	0	0	90.00
90.01	OUTPATIENT	52,936	781,854	0.067706	1,040	70	90.01
91.00	EMERGENCY	774,304	17,422,221	0.044443	1,324,485	58,864	91.00
91.01	SHORT STAY	0	0	0.000000	0	0	91.01
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	380,859	3,789,690	0.100499	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	6,394,382	250,178,172		40,562,473	826,493	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150059		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part III Date/Time Prepared: 5/25/2012 12:22 pm	
Cost Center Description		Title XVIII		Hospital		PPS	
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	NURSERY	0	0	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00	Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150059		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part III Date/Time Prepared: 5/25/2012 12:22 pm	
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)	PPS	
		6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	17,807	0.00	6,769	0	30.00	
31.00	INTENSIVE CARE UNIT	2,993	0.00	1,372	0	31.00	
41.00	SUBPROVIDER - IRF	6,195	0.00	4,335	0	41.00	
43.00	NURSERY	0	0.00	0	0	43.00	
44.00	SKILLED NURSING FACILITY	5,330	0.00	3,710	0	44.00	
200.00	Total (Lines 30-199)	32,325		16,186	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150059

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/25/2012 12:22 pm

Cost Center Description		Title XVIII				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	CT SCAN	0	0	0	0	0	57.00
57.01	ULTRA SOUND	0	0	0	0	0	57.01
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00		0	0	0	0	0	76.00
76.01	CARDIAC REHAB	0	0	0	0	0	76.01
76.02	WOMEN'S CENTER	0	0	0	0	0	76.02
76.03	ENDOSCOPY	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0	0	0	0	0	90.00
90.01	OUTPATIENT	0	0	0	0	0	90.01
91.00	EMERGENCY	0	0	0	0	0	91.00
91.01	SHORT STAY	0	0	0	0	0	91.01
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	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: 150059

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/25/2012 12:22 pm

Cost Center Description		Title XVIII			Hospital		PPS
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0	34,592,074	0.000000	0.000000	8,151,851	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	11,970,250	0.000000	0.000000	1,386,935	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	6,152,263	0.000000	0.000000	66,277	55.00
57.00	CT SCAN	0	15,367,629	0.000000	0.000000	1,699,175	57.00
57.01	ULTRA SOUND	0	2,463,801	0.000000	0.000000	126,620	57.01
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	6,358,427	0.000000	0.000000	405,903	58.00
59.00	CARDIAC CATHETERIZATION	0	9,948,342	0.000000	0.000000	1,314,551	59.00
60.00	LABORATORY	0	29,798,646	0.000000	0.000000	4,658,730	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	1,860,296	0.000000	0.000000	361,979	63.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	RESPIRATORY THERAPY	0	3,803,165	0.000000	0.000000	951,991	65.00
66.00	PHYSICAL THERAPY	0	15,543,024	0.000000	0.000000	812,894	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	ELECTROCARDIOLOGY	0	8,798,309	0.000000	0.000000	1,019,948	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	44,853,691	0.000000	0.000000	12,201,060	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	5,507,743	0.000000	0.000000	916,768	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	20,204,182	0.000000	0.000000	4,878,956	73.00
74.00	RENAL DIALYSIS	0	380,107	0.000000	0.000000	198,577	74.00
76.00		0	0	0.000000	0.000000	0	76.00
76.01	CARDIAC REHAB	0	1,778,995	0.000000	0.000000	84,733	76.01
76.02	WOMEN'S CENTER	0	3,380,415	0.000000	0.000000	0	76.02
76.03	ENDOSCOPY	0	5,423,048	0.000000	0.000000	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	OUTPATIENT	0	781,854	0.000000	0.000000	1,040	90.01
91.00	EMERGENCY	0	17,422,221	0.000000	0.000000	1,324,485	91.00
91.01	SHORT STAY	0	0	0.000000	0.000000	0	91.01
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,789,690	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	0	250,178,172			40,562,473	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150059

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

Worksheet D  
Part IV  
Date/Time Prepared:  
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0	7,336,392	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	3,781,007	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	2,957,414	0	55.00
57.00	CT SCAN	0	4,013,632	0	57.00
57.01	ULTRA SOUND	0	414,256	0	57.01
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	1,657,066	0	58.00
59.00	CARDIAC CATHETERIZATION	0	1,635,130	0	59.00
60.00	LABORATORY	0	40,700	0	60.00
60.01	BLOOD LABORATORY	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	169,762	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	168,712	0	65.00
66.00	PHYSICAL THERAPY	0	221	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	1,489,657	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,611,978	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	1,574,122	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	4,617,099	0	73.00
74.00	RENAL DIALYSIS	0	0	0	74.00
76.00		0	0	0	76.00
76.01	CARDIAC REHAB	0	666,331	0	76.01
76.02	WOMEN'S CENTER	0	0	0	76.02
76.03	ENDOSCOPY	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	CLINIC	0	0	0	90.00
90.01	OUTPATIENT	0	0	0	90.01
91.00	EMERGENCY	0	1,959,611	0	91.00
91.01	SHORT STAY	0	0	0	91.01
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,199,271	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (Lines 50-199)	0	38,292,361	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/25/2012 12:22 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
	1.00	2.00	3.00	4.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	0.210065	7,336,392	0	0		50.00
52.00 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0		52.00
54.00 RADIOLOGY-DIAGNOSTIC	0.327787	3,781,007	0	0		54.00
55.00 RADIOLOGY-THERAPEUTIC	0.267011	2,957,414	0	0		55.00
57.00 CT SCAN	0.036165	4,013,632	0	0		57.00
57.01 ULTRA SOUND	0.120561	414,256	0	0		57.01
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.048013	1,657,066	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0.144408	1,635,130	0	0		59.00
60.00 LABORATORY	0.198516	40,700	0	0		60.00
60.01 BLOOD LABORATORY	0.000000	0	0	0		60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0.478921	169,762	0	0		63.00
64.00 INTRAVENOUS THERAPY	0.000000	0	0	0		64.00
65.00 RESPIRATORY THERAPY	0.405031	168,712	0	0		65.00
66.00 PHYSICAL THERAPY	0.421239	221	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0.000000	0	0	0		67.00
68.00 SPEECH PATHOLOGY	0.000000	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	0.266337	1,489,657	0	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.281764	4,611,978	126	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.271223	1,574,122	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.381588	4,617,099	115	5,637		73.00
74.00 RENAL DIALYSIS	0.829956	0	0	0		74.00
76.00	0.000000	0	0	0		76.00
76.01 CARDIAC REHAB	0.474318	666,331	0	0		76.01
76.02 WOMEN'S CENTER	0.320821	0	0	0		76.02
76.03 ENDOSCOPY	0.259482	0	0	0		76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 CLINIC	0.000000	0	0	0		90.00
90.01 OUTPATIENT	0.597787	0	0	0		90.01
91.00 EMERGENCY	0.303290	1,959,611	0	0		91.00
91.01 SHORT STAY	0.000000	0	0	0		91.01
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.511027	1,199,271	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 AMBULANCE SERVICES	0.443494		0			95.00
200.00 Subtotal (see instructions)		38,292,361	241	5,637		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00 Net Charges (line 200 +/- line 201)		38,292,361	241	5,637		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/25/2012 12:22 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 OPERATING ROOM	1,541,119	0	0		50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00 RADIOLOGY-DIAGNOSTIC	1,239,365	0	0		54.00
55.00 RADIOLOGY-THERAPEUTIC	789,662	0	0		55.00
57.00 CT SCAN	145,153	0	0		57.00
57.01 ULTRA SOUND	49,943	0	0		57.01
58.00 MAGNETIC RESONANCE IMAGING (MRI)	79,561	0	0		58.00
59.00 CARDIAC CATHETERIZATION	236,126	0	0		59.00
60.00 LABORATORY	8,080	0	0		60.00
60.01 BLOOD LABORATORY	0	0	0		60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	81,303	0	0		63.00
64.00 INTRAVENOUS THERAPY	0	0	0		64.00
65.00 RESPIRATORY THERAPY	68,334	0	0		65.00
66.00 PHYSICAL THERAPY	93	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	396,751	0	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,299,489	36	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	426,938	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	1,761,830	44	2,151		73.00
74.00 RENAL DIALYSIS	0	0	0		74.00
76.00	0	0	0		76.00
76.01 CARDIAC REHAB	316,053	0	0		76.01
76.02 WOMEN'S CENTER	0	0	0		76.02
76.03 ENDOSCOPY	0	0	0		76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 CLINIC	0	0	0		90.00
90.01 OUTPATIENT	0	0	0		90.01
91.00 EMERGENCY	594,330	0	0		91.00
91.01 SHORT STAY	0	0	0		91.01
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	612,860	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00 AMBULANCE SERVICES		0			95.00
200.00 Subtotal (see instructions)	9,646,990	80	2,151		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	9,646,990	80	2,151		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150059 Component CCN: 15T059		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part II Date/Time Prepared: 5/25/2012 12:22 pm	
		Title XVIIII		Subprovider - IRF		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	1,428,314	34,592,074	0.041290	123,590	5,103	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	640,203	11,970,250	0.053483	87,608	4,686	54.00
55.00	RADIOLOGY-THERAPEUTIC	315,874	6,152,263	0.051343	1,312	67	55.00
57.00	CT SCAN	5,543	15,367,629	0.000361	67,096	24	57.00
57.01	ULTRA SOUND	3,731	2,463,801	0.001514	3,288	5	57.01
58.00	MAGNETIC RESONANCE IMAGING (MRI)	3,641	6,358,427	0.000573	12,150	7	58.00
59.00	CARDIAC CATHETERIZATION	139,544	9,948,342	0.014027	21,810	306	59.00
60.00	LABORATORY	375,090	29,798,646	0.012587	554,265	6,977	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	159,473	1,860,296	0.085725	11,560	991	63.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	63,741	3,803,165	0.016760	148,987	2,497	65.00
66.00	PHYSICAL THERAPY	92,525	15,543,024	0.005953	3,116,214	18,551	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	797,434	8,798,309	0.090635	20,263	1,837	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	248,078	44,853,691	0.005531	562,529	3,111	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	10,070	5,507,743	0.001828	5,962	11	72.00
73.00	DRUGS CHARGED TO PATIENTS	201,302	20,204,182	0.009963	774,062	7,712	73.00
74.00	RENAL DIALYSIS	24,368	380,107	0.064108	66,945	4,292	74.00
76.00		0	0	0.000000	0	0	76.00
76.01	CARDIAC REHAB	10,633	1,778,995	0.005977	0	0	76.01
76.02	WOMEN'S CENTER	351,738	3,380,415	0.104052	0	0	76.02
76.03	ENDOSCOPY	314,981	5,423,048	0.058082	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0	0	0.000000	0	0	90.00
90.01	OUTPATIENT	52,936	781,854	0.067706	120	8	90.01
91.00	EMERGENCY	774,304	17,422,221	0.044443	18,175	808	91.00
91.01	SHORT STAY	0	0	0.000000	0	0	91.01
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	380,859	3,789,690	0.100499	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	6,394,382	250,178,172		5,595,936	56,993	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150059  
Component CCN: 15T059

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/25/2012 12:22 pm

Title XVIII

Subprovider -  
IRF

PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00 CT SCAN	0	0	0	0	0	57.00
57.01 ULTRA SOUND	0	0	0	0	0	57.01
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	0	0	0	0	0	76.00
76.01 CARDIAC REHAB	0	0	0	0	0	76.01
76.02 WOMEN'S CENTER	0	0	0	0	0	76.02
76.03 ENDOSCOPY	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 CLINIC	0	0	0	0	0	90.00
90.01 OUTPATIENT	0	0	0	0	0	90.01
91.00 EMERGENCY	0	0	0	0	0	91.00
91.01 SHORT STAY	0	0	0	0	0	91.01
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 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: 150059 Component CCN: 15T059	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/25/2012 12:22 pm
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	0	34,592,074	0.000000	0.000000	123,590	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	11,970,250	0.000000	0.000000	87,608	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	6,152,263	0.000000	0.000000	1,312	55.00
57.00 CT SCAN	0	15,367,629	0.000000	0.000000	67,096	57.00
57.01 ULTRA SOUND	0	2,463,801	0.000000	0.000000	3,288	57.01
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	6,358,427	0.000000	0.000000	12,150	58.00
59.00 CARDIAC CATHETERIZATION	0	9,948,342	0.000000	0.000000	21,810	59.00
60.00 LABORATORY	0	29,798,646	0.000000	0.000000	554,265	60.00
60.01 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	1,860,296	0.000000	0.000000	11,560	63.00
64.00 INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00 RESPIRATORY THERAPY	0	3,803,165	0.000000	0.000000	148,987	65.00
66.00 PHYSICAL THERAPY	0	15,543,024	0.000000	0.000000	3,116,214	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00 ELECTROCARDIOLOGY	0	8,798,309	0.000000	0.000000	20,263	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	44,853,691	0.000000	0.000000	562,529	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	5,507,743	0.000000	0.000000	5,962	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	20,204,182	0.000000	0.000000	774,062	73.00
74.00 RENAL DIALYSIS	0	380,107	0.000000	0.000000	66,945	74.00
76.00	0	0	0.000000	0.000000	0	76.00
76.01 CARDIAC REHAB	0	1,778,995	0.000000	0.000000	0	76.01
76.02 WOMEN'S CENTER	0	3,380,415	0.000000	0.000000	0	76.02
76.03 ENDOSCOPY	0	5,423,048	0.000000	0.000000	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 CLINIC	0	0	0.000000	0.000000	0	90.00
90.01 OUTPATIENT	0	781,854	0.000000	0.000000	120	90.01
91.00 EMERGENCY	0	17,422,221	0.000000	0.000000	18,175	91.00
91.01 SHORT STAY	0	0	0.000000	0.000000	0	91.01
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	3,789,690	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 AMBULANCE SERVICES						95.00
200.00 Total (Lines 50-199)	0	250,178,172			5,595,936	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150059 Component CCN: 15T059	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/25/2012 12:22 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 OPERATING ROOM	0	0	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
57.00 CT SCAN	0	0	0	57.00
57.01 ULTRA SOUND	0	0	0	57.01
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 LABORATORY	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	74.00
76.00	0	0	0	76.00
76.01 CARDIAC REHAB	0	0	0	76.01
76.02 WOMEN'S CENTER	0	0	0	76.02
76.03 ENDOSCOPY	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 CLINIC	0	0	0	90.00
90.01 OUTPATIENT	0	0	0	90.01
91.00 EMERGENCY	0	0	0	91.00
91.01 SHORT STAY	0	0	0	91.01
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00 AMBULANCE SERVICES				95.00
200.00 Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150059  
Component CCN: 155669

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/25/2012 12:22 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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00 CT SCAN	0	0	0	0	0	57.00
57.01 ULTRA SOUND	0	0	0	0	0	57.01
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	0	0	0	0	0	76.00
76.01 CARDIAC REHAB	0	0	0	0	0	76.01
76.02 WOMEN'S CENTER	0	0	0	0	0	76.02
76.03 ENDOSCOPY	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 CLINIC	0	0	0	0	0	90.00
90.01 OUTPATIENT	0	0	0	0	0	90.01
91.00 EMERGENCY	0	0	0	0	0	91.00
91.01 SHORT STAY	0	0	0	0	0	91.01
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 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: 150059 Component CCN: 155669	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/25/2012 12:22 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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	0	34,592,074	0.000000	0.000000	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	11,970,250	0.000000	0.000000	50,353	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	6,152,263	0.000000	0.000000	0	55.00
57.00 CT SCAN	0	15,367,629	0.000000	0.000000	0	57.00
57.01 ULTRA SOUND	0	2,463,801	0.000000	0.000000	0	57.01
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	6,358,427	0.000000	0.000000	2,544	58.00
59.00 CARDIAC CATHETERIZATION	0	9,948,342	0.000000	0.000000	0	59.00
60.00 LABORATORY	0	29,798,646	0.000000	0.000000	465,552	60.00
60.01 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	1,860,296	0.000000	0.000000	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00 RESPIRATORY THERAPY	0	3,803,165	0.000000	0.000000	16,736	65.00
66.00 PHYSICAL THERAPY	0	15,543,024	0.000000	0.000000	741,305	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00 ELECTROCARDIOLOGY	0	8,798,309	0.000000	0.000000	4,285	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	44,853,691	0.000000	0.000000	244,205	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	5,507,743	0.000000	0.000000	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	20,204,182	0.000000	0.000000	632,535	73.00
74.00 RENAL DIALYSIS	0	380,107	0.000000	0.000000	0	74.00
76.00	0	0	0.000000	0.000000	0	76.00
76.01 CARDIAC REHAB	0	1,778,995	0.000000	0.000000	0	76.01
76.02 WOMEN'S CENTER	0	3,380,415	0.000000	0.000000	0	76.02
76.03 ENDOSCOPY	0	5,423,048	0.000000	0.000000	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 CLINIC	0	0	0.000000	0.000000	0	90.00
90.01 OUTPATIENT	0	781,854	0.000000	0.000000	0	90.01
91.00 EMERGENCY	0	17,422,221	0.000000	0.000000	0	91.00
91.01 SHORT STAY	0	0	0.000000	0.000000	0	91.01
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	3,789,690	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 AMBULANCE SERVICES						95.00
200.00 Total (Lines 50-199)	0	250,178,172			2,157,515	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150059  
Component CCN: 155669

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/25/2012 12:22 pm  
PPS

Title XVIII

Skilled Nursing Facility

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 OPERATING ROOM	0	0	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
57.00 CT SCAN	0	0	0	57.00
57.01 ULTRA SOUND	0	0	0	57.01
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 LABORATORY	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	74.00
76.00	0	0	0	76.00
76.01 CARDIAC REHAB	0	0	0	76.01
76.02 WOMEN'S CENTER	0	0	0	76.02
76.03 ENDOSCOPY	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 CLINIC	0	0	0	90.00
90.01 OUTPATIENT	0	0	0	90.01
91.00 EMERGENCY	0	0	0	91.00
91.01 SHORT STAY	0	0	0	91.01
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00 AMBULANCE SERVICES				95.00
200.00 Total (lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/25/2012 12:22 pm
Cost Center Description		PPS		
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		17,807	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		17,807	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		17,807	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)		6,769	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		18,896,326	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)		18,896,326	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		23,458,216	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		23,458,216	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.805531	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,317.36	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)		18,896,326	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,061.17	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		7,183,060	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)		7,183,060	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/25/2012 12: 22 pm		
Cost Center Description			Title XVIII		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	3,753,195	2,993	1,253.99	1,372	1,720,474	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)					10,742,564	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					19,646,098	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)					1,555,064	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					826,493	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,381,557	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					17,264,541	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)					1,825	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,061.17	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,936,635	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 5/25/2012 12:22 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,716,158	18,896,326	0.196660	1,936,635	380,859	90.00
91.00	Nursing School cost	0	18,896,326	0.000000	1,936,635	0	91.00
92.00	Allied health cost	0	18,896,326	0.000000	1,936,635	0	92.00
93.00	All other Medical Education	0	18,896,326	0.000000	1,936,635	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Component CCN: 15T059		Date/Time Prepared: 5/25/2012 12:22 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,195	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,195	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		6,195	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)		4,335	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,364,380	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)		4,364,380	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		5,918,946	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		5,918,946	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.737358	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)		955.44	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)		4,364,380	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		704.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,054,008	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)		3,054,008	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1	
		Component CCN: 15T059				Date/Time Prepared: 5/25/2012 12:22 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,072,663		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,126,671		49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					455,218		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					56,993		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					512,211		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					4,614,460		53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Component CCN: 15T059		Date/Time Prepared: 5/25/2012 12:22 pm
		Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	650,515	4,364,380	0.149051	0	0	90.00
91.00 Nursing School cost	0	4,364,380	0.000000	0	0	91.00
92.00 Allied health cost	0	4,364,380	0.000000	0	0	92.00
93.00 All other Medical Education	0	4,364,380	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Component CCN: 155669		Date/Time Prepared: 5/25/2012 12:22 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,330	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,330	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,330	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		3,710	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,155,028	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)		3,155,028	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,588,250	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,588,250	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.218981	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)		485.60	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)		3,155,028	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			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: 150059		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1	
		Component CCN: 155669				Date/Time Prepared: 5/25/2012 12:22 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)					3,155,028	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					591.94	71.00
72.00	Program routine service cost (line 9 x line 71)					2,196,097	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)					2,196,097	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)					2,196,097	83.00
84.00	Program inpatient ancillary services (see instructions)					739,410	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)					2,935,507	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: 150059 Component CCN: 155669		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 5/25/2012 12:22 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: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/25/2012 12:22 pm
Cost Center Description		Cost		
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		17,807	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		17,807	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		17,807	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,315	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		18,896,326	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)		18,896,326	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		23,458,216	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		23,458,216	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.805531	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,317.36	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)		18,896,326	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,061.17	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,395,439	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)		1,395,439	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1	
Date/Time Prepared: 5/25/2012 12: 22 pm		Title XIX		Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	3,753,195	2,993	1,253.99	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,410,827		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,806,266		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)					1,825		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,061.17		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,936,635		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 5/25/2012 12:22 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Component CCN: 15T059		Date/Time Prepared: 5/25/2012 12:22 pm
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,195	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,195	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		6,195	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)		212	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,364,380	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)		4,364,380	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		55,918,946	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		55,918,946	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.078048	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)		9,026.46	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,364,380	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		704.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		149,354	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)		149,354	41.00

COMPUTATION OF INPATIENT OPERATING COST					Provider CCN: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
					Component CCN: 15T059		Date/Time Prepared: 5/25/2012 12:22 pm
					Title XIX	Subprovider - IRF	Cost
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
<b>Cost Center Description</b>							
						1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						82,277	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						231,631	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						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
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1	
		Component CCN: 15T059				Date/Time Prepared: 5/25/2012 12:22 pm	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Component CCN: 155669		Date/Time Prepared: 5/25/2012 12:22 pm
		Title XIX	Skilled Nursing Facility	
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,330	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,330	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,330	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,067,336	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)		3,067,336	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,588,250	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,588,250	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.185100	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)		485.60	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)		3,067,336	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			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: 150059		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1	
		Component CCN: 155669		Date/Time Prepared: 5/25/2012 12:22 pm			
		Title XIX		Skilled Nursing Facility			
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)					3,067,336	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					575.49	71.00
72.00	Program routine service cost (line 9 x line 71)					0	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					443,472	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					83.20	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					0	83.00
84.00	Program inpatient ancillary services (see instructions)					0	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)					0	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: 150059 Component CCN: 155669		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 5/25/2012 12:22 pm	
		Title XIX		Skilled Nursing Facility			
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/25/2012 12:22 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS		8,183,994		30.00
31.00	INTENSIVE CARE UNIT		2,758,589		31.00
41.00	SUBPROVIDER - IRF		0		41.00
43.00	NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.210065	8,151,851	1,712,419	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.327787	1,386,935	454,619	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.267011	66,277	17,697	55.00
57.00	CT SCAN	0.036165	1,699,175	61,451	57.00
57.01	ULTRA SOUND	0.120561	126,620	15,265	57.01
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.048013	405,903	19,489	58.00
59.00	CARDIAC CATHETERIZATION	0.149582	1,314,551	196,633	59.00
60.00	LABORATORY	0.198787	4,658,730	926,095	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0.478921	361,979	173,359	63.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	0.405031	951,991	385,586	65.00
66.00	PHYSICAL THERAPY	0.421239	812,894	342,423	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.275899	1,019,948	281,403	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.281764	12,201,060	3,437,819	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.271223	916,768	248,649	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.381588	4,878,956	1,861,751	73.00
74.00	RENAL DIALYSIS	0.829956	198,577	164,810	74.00
76.00		0.000000	0	0	76.00
76.01	CARDIAC REHAB	0.474318	84,733	40,190	76.01
76.02	WOMEN'S CENTER	0.320821	0	0	76.02
76.03	ENDOSCOPY	0.259482	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	CLINIC	0.000000	0	0	90.00
90.01	OUTPATIENT	0.598667	1,040	623	90.01
91.00	EMERGENCY	0.303728	1,324,485	402,283	91.00
91.01	SHORT STAY	0.000000	0	0	91.01
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.511027	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		40,562,473	10,742,564	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		40,562,473		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3	
		Component CCN: 15T059		Date/Time Prepared: 5/25/2012 12:22 pm	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
41.00	SUBPROVIDER - IRF		4,229,142		41.00
43.00	NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.210065	123,590	25,962	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.327787	87,608	28,717	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.267011	1,312	350	55.00
57.00	CT SCAN	0.036165	67,096	2,427	57.00
57.01	ULTRA SOUND	0.120561	3,288	396	57.01
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.048013	12,150	583	58.00
59.00	CARDIAC CATHETERIZATION	0.149582	21,810	3,262	59.00
60.00	LABORATORY	0.198787	554,265	110,181	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0.478921	11,560	5,536	63.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	0.405031	148,987	60,344	65.00
66.00	PHYSICAL THERAPY	0.421239	3,116,214	1,312,671	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.275899	20,263	5,591	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.281764	562,529	158,500	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.271223	5,962	1,617	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.381588	774,062	295,373	73.00
74.00	RENAL DIALYSIS	0.829956	66,945	55,561	74.00
76.00		0.000000	0	0	76.00
76.01	CARDIAC REHAB	0.474318	0	0	76.01
76.02	WOMEN'S CENTER	0.320821	0	0	76.02
76.03	ENDOSCOPY	0.259482	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	CLINIC	0.000000	0	0	90.00
90.01	OUTPATIENT	0.598667	120	72	90.01
91.00	EMERGENCY	0.303728	18,175	5,520	91.00
91.01	SHORT STAY	0.000000	0	0	91.01
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.511027	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		5,595,936	2,072,663	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)		5,595,936		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3	
		Component CCN: 155669		Date/Time Prepared: 5/25/2012 12:22 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
41.00	SUBPROVIDER - IRF		0		41.00
43.00	NURSERY		0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.210065	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.327787	50,353	16,505	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.267011	0	0	55.00
57.00	CT SCAN	0.036165	0	0	57.00
57.01	ULTRA SOUND	0.120561	0	0	57.01
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.048013	2,544	122	58.00
59.00	CARDIAC CATHETERIZATION	0.144408	0	0	59.00
60.00	LABORATORY	0.198516	465,552	92,420	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0.478921	0	0	63.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	0.405031	16,736	6,779	65.00
66.00	PHYSICAL THERAPY	0.421239	741,305	312,267	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.266337	4,285	1,141	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.281764	244,205	68,808	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.271223	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.381588	632,535	241,368	73.00
74.00	RENAL DIALYSIS	0.829956	0	0	74.00
76.00		0.000000	0	0	76.00
76.01	CARDIAC REHAB	0.474318	0	0	76.01
76.02	WOMEN'S CENTER	0.320821	0	0	76.02
76.03	ENDOSCOPY	0.259482	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	CLINIC	0.000000	0	0	90.00
90.01	OUTPATIENT	0.597787	0	0	90.01
91.00	EMERGENCY	0.303290	0	0	91.00
91.01	SHORT STAY	0.000000	0	0	91.01
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.511027	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		2,157,515	739,410	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)		2,157,515		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/25/2012 12:22 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS		1,690,694		30.00
31.00	INTENSIVE CARE UNIT		402,090		31.00
41.00	SUBPROVIDER - IRF		0		41.00
43.00	NURSERY		0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.210065	750,910	157,740	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.327787	105,265	34,504	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.267011	52,216	13,942	55.00
57.00	CT SCAN	0.036165	233,258	8,436	57.00
57.01	ULTRA SOUND	0.120561	28,810	3,473	57.01
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.048013	62,775	3,014	58.00
59.00	CARDIAC CATHETERIZATION	0.144408	302,799	43,727	59.00
60.00	LABORATORY	0.198516	736,066	146,121	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0.478921	26,669	12,772	63.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	0.405031	212,677	86,141	65.00
66.00	PHYSICAL THERAPY	0.421239	55,833	23,519	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.266337	115,793	30,840	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.281764	1,384,456	390,090	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.271223	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.381588	871,164	332,426	73.00
74.00	RENAL DIALYSIS	0.829956	40,756	33,826	74.00
76.00		0.000000	0	0	76.00
76.01	CARDIAC REHAB	0.474318	0	0	76.01
76.02	WOMEN'S CENTER	0.320821	0	0	76.02
76.03	ENDOSCOPY	0.259482	39,467	10,241	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	CLINIC	0.000000	0	0	90.00
90.01	OUTPATIENT	0.597787	13,863	8,287	90.01
91.00	EMERGENCY	0.303290	236,500	71,728	91.00
91.01	SHORT STAY	0.000000	0	0	91.01
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.511027	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		5,269,277	1,410,827	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		5,269,277		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3	
		Component CCN: 15T059		Date/Time Prepared: 5/25/2012 12:22 pm	
		Title XIX	Subprovider - IRF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
41.00	SUBPROVIDER - IRF		148,958		41.00
43.00	NURSERY		0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.210065	6,301	1,324	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.327787	2,060	675	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.267011	0	0	55.00
57.00	CT SCAN	0.036165	1,795	65	57.00
57.01	ULTRA SOUND	0.120561	0	0	57.01
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.048013	9,260	445	58.00
59.00	CARDIAC CATHETERIZATION	0.144408	2,230	322	59.00
60.00	LABORATORY	0.198516	29,005	5,758	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0.478921	0	0	63.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	0.405031	1,571	636	65.00
66.00	PHYSICAL THERAPY	0.421239	116,590	49,112	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.266337	1,664	443	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.281764	19,453	5,481	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.271223	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.381588	36,563	13,952	73.00
74.00	RENAL DIALYSIS	0.829956	4,264	3,539	74.00
76.00		0.000000	0	0	76.00
76.01	CARDIAC REHAB	0.474318	0	0	76.01
76.02	WOMEN'S CENTER	0.320821	0	0	76.02
76.03	ENDOSCOPY	0.259482	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	CLINIC	0.000000	0	0	90.00
90.01	OUTPATIENT	0.597787	451	270	90.01
91.00	EMERGENCY	0.303290	841	255	91.00
91.01	SHORT STAY	0.000000	0	0	91.01
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.511027	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		232,048	82,277	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)		232,048		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part A Date/Time Prepared: 5/25/2012 12:22 pm
		Title VIII	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER PPS</b>				
1.00	DRG Amounts Other than Outlier Payments		13,323,966	1.00
2.00	Outlier payments for discharges. (see instructions)		209,817	2.00
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		100.00	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		1.35	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		16.95	31.00
32.00	Sum of lines 30 and 31		18.30	32.00
33.00	Allowable disproportionate share percentage (see instructions)		4.65	33.00
34.00	Disproportionate share adjustment (see instructions)		619,564	34.00
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0	46.00
47.00	Subtotal (see instructions)		14,153,347	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		14,153,347	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		1,166,070	50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0	56.00
57.00	Routine service other pass through costs		0	57.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part A Date/Time Prepared: 5/25/2012 12:22 pm
		Title XVIII	Hospital	PPS
		1.00		
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)			0 58.00
59.00	Total (sum of amounts on lines 49 through 58)			15,319,417 59.00
60.00	Primary payer payments			23,009 60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			15,296,408 61.00
62.00	Deductibles billed to program beneficiaries			1,504,696 62.00
63.00	Coinsurance billed to program beneficiaries			9,056 63.00
64.00	Allowable bad debts (see instructions)			355,331 64.00
65.00	Adjusted reimbursable bad debts (see instructions)			248,732 65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			154,131 66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			14,031,388 67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)			0 68.00
69.00	Outlier payments reconciliation			0 69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 70.00
70.95	Recovery of Accelerated Depreciation			0 70.95
70.96	Low Volume Payment-1			0 70.96
70.97	Low Volume Payment-2			0 70.97
70.98	Low Volume Payment-3			0 70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			14,031,388 71.00
72.00	Interim payments			13,948,459 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)			82,929 74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			100,000 75.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Operating outlier amount from Worksheet E, Part A line 2			0 90.00
91.00	Capital outlier from Worksheet L, Part I, line 2			0 91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0 92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0 93.00
94.00	The rate used to calculate the Time Value of Money			0.00 94.00
95.00	Time Value of Money for operating expenses(see instructions)			0 95.00
96.00	Time Value of Money for capital related expenses (see instructions)			0 96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/25/2012 12:22 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		2,231	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		9,646,990	2.00
3.00	PPS payments		8,445,483	3.00
4.00	Outlier payment (see instructions)		23,114	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)		2,231	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		5,878	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)		5,878	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		5,878	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		3,647	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)		2,231	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)		8,468,597	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		25	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,970,054	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)		6,500,749	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)		6,500,749	30.00
31.00	Primary payer payments		3,951	31.00
32.00	Subtotal (line 30 minus line 31)		6,496,798	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		338,744	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		237,121	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		147,866	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		6,733,919	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-259	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)		6,734,178	40.00
41.00	Interim payments		6,632,036	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)		102,142	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/25/2012 12:22 pm
		Component CCN: 15T059	Title VIII	Subprovider - IRF PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		0	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		0	40.00
41.00	Interim payments		0	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/25/2012 12:22 pm
		Component CCN: 155669	Title XVIII	Skilled Nursing Facility
		PPS		
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		0	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R			38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		0	40.00
41.00	Interim payments		0	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150059

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/25/2012 12:22 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		13,799,606		6,496,264	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	09/09/2011	38,364	09/09/2011	26,075	3.01
3.02		01/01/2011	110,489	01/01/2011	109,697	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)		148,853		135,772	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)		13,948,459		6,632,036	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		82,929		102,142	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		14,031,388		6,734,178	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: 150059  
Component CCN: 15T059

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/25/2012 12:22 pm  
PPS

Title XVIII

Subprovider -  
IRF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		5,235,818		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	09/09/2011	34,352		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)		34,352		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)		5,270,170		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		66,991		0	6.02
7.00	Total Medicare program liability (see instructions)		5,203,179		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150059  
Component CCN: 155669

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/25/2012 12:22 pm  
PPS

Title XVIII

Skilled Nursing  
Facility

		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				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		1,486,694		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)		1,486,694		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,486,694		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: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part III Date/Time Prepared: 5/25/2012 12:22 pm
		Component CCN: 15T059	Title XVIII	Subprovider - IRF
		PPS		
		1.00		
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)		5,137,274	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0150	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		115,137	3.00
4.00	Outlier Payments		47,644	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)		16.972603	10.00
11.00	Medical Education Adjustment Factor $\{((1 + (\text{line } 9/\text{line } 10)) \text{ raised to the power of } .6876 - 1)\}$ .		0.000000	11.00
12.00	Medical Education Adjustment (line 1 multiplied by line 11).		0	12.00
13.00	Total PPS Payment (sum of lines 1, 3, 4 and 12)		5,300,055	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)		5,300,055	17.00
18.00	Primary payer payments		0	18.00
19.00	Subtotal (line 17 less line 18).		5,300,055	19.00
20.00	Deductibles		82,604	20.00
21.00	Subtotal (line 19 minus line 20)		5,217,451	21.00
22.00	Coinsurance		15,848	22.00
23.00	Subtotal (line 21 minus line 22)		5,201,603	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		2,252	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		1,576	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)		5,203,179	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)		5,203,179	32.00
33.00	Interim payments		5,270,170	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)		-66,991	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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: 150059 Component CCN: 155669	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part VI Date/Time Prepared: 5/25/2012 12:22 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		1,582,065	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,582,065	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		95,371	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Allowable reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)		1,486,694	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14)		1,486,694	15.00
16.00	Interim payments		1,486,694	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus the sum of lines 16 and 17)		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2		0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part VII Date/Time Prepared: 5/25/2012 12:22 pm
		Title XIX	Hospital	Cost
				1.00
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>				
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient hospital/SNF/NF services		2,806,266	1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		2,806,266	4.00
5.00	Inpatient primary payer payments		0	5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		2,806,266	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable Charges</b>				
8.00	Routine service charges		2,092,784	8.00
9.00	Ancillary service charges		5,269,277	9.00
10.00	Organ acquisition charges, net of revenue		0	10.00
11.00	Incentive from target amount computation		0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		7,362,061	12.00
<b>CUSTOMARY CHRGES</b>				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		7,362,061	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		4,555,795	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		2,806,266	21.00
<b>PROSPECTIVE PAYMENT AMOUNT</b>				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		0	23.00
24.00	Program capital payments		0	24.00
25.00	Capital exception payments (see instructions)		0	25.00
26.00	Routine and Ancillary service other pass through costs		0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX enter the sum of lines 27 and 21.		2,806,266	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		2,806,266	31.00
32.00	Deductibles		0	32.00
33.00	Coinsurance		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Utilization review		0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		2,806,266	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		2,806,266	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		2,806,266	40.00
41.00	Interim payments		1,390,850	41.00
42.00	Balance due provider/program (line 40 minus 41)		1,415,416	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part VII Date/Time Prepared: 5/25/2012 12:22 pm
		Title XIX	Subprovider - IRF	Cost
				1.00
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>				
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient hospital/SNF/NF services		231,631	1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		231,631	4.00
5.00	Inpatient primary payer payments		0	5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		231,631	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable Charges</b>				
8.00	Routine service charges		0	8.00
9.00	Ancillary service charges		232,048	9.00
10.00	Organ acquisition charges, net of revenue		0	10.00
11.00	Incentive from target amount computation		0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		232,048	12.00
<b>CUSTOMARY CHRGES</b>				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		232,048	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		417	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		231,631	21.00
<b>PROSPECTIVE PAYMENT AMOUNT</b>				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		0	23.00
24.00	Program capital payments		0	24.00
25.00	Capital exception payments (see instructions)		0	25.00
26.00	Routine and Ancillary service other pass through costs		0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX enter the sum of lines 27 and 21.		231,631	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		231,631	31.00
32.00	Deductibles		0	32.00
33.00	Coinurance		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Utilization review		0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		231,631	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		231,631	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		231,631	40.00
41.00	Interim payments		92,425	41.00
42.00	Balance due provider/program (line 40 minus 41)		139,206	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)      Provider CCN: 150059      Period: From 01/01/2011 To 12/31/2011      Worksheet G  
 Date/Time Prepared: 5/25/2012 12:22 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	12,038,016	0	0	0	1.00
2.00	Temporary investments	2,835,607	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	19,221,202	0	0	0	4.00
5.00	Other receivable	442,990	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,229,958	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	9,442,787	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)	45,210,560	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	10,915,010	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	187,030,219	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	3,666,763	0	0	0	17.00
18.00	Accumulated depreciation	-113,455,282	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	88,156,710	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	41,106,768	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	41,106,768	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	174,474,038	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	4,677,215	0	0	0	37.00
38.00	Salaries, wages, and fees payable	6,739,810	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,601,953	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	873,731	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	15,892,709	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	44,689,448	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	44,689,448	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	60,582,157	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	113,891,881	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	113,891,881	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	174,474,038	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150059

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

Worksheet G-1

Date/Time Prepared:  
5/25/2012 12:22 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		111,742,859	
2.00	Net income (loss) (From Wkst. G-3, line 29)		2,149,022			2.00
3.00	Total (sum of line 1 and line 2)		113,891,881		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)		113,891,881		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		113,891,881		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150059

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

Worksheet G-1

Date/Time Prepared:  
5/25/2012 12:22 pm

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150059

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

Worksheet G-2 Parts

Date/Time Prepared:  
5/25/2012 12:22 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	23,458,216		23,458,216	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	5,918,946		5,918,946	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	2,588,250		2,588,250	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	31,965,412		31,965,412	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,906,577		5,906,577	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)	5,906,577		5,906,577	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	37,871,989		37,871,989	17.00
18.00	Ancillary services	92,283,290	137,190,421	229,473,711	18.00
19.00	Outpatient services	3,618,561	19,111,978	22,730,539	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN OFFICES	23,781	40,150,121	40,173,902	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	133,797,621	196,452,520	330,250,141	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		137,448,168		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)		137,448,168		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150059

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

Worksheet G-3

Date/Time Prepared:  
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	330,250,141	1.00
2.00	Less contractual allowances and discounts on patients' accounts	196,878,572	2.00
3.00	Net patient revenues (line 1 minus line 2)	133,371,569	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	137,448,168	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,076,599	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING	5,946,290	24.00
24.01	TOTAL NON OPERATING	279,331	24.01
25.00	Total other income (sum of lines 6-24)	6,225,621	25.00
26.00	Total (line 5 plus line 25)	2,149,022	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,149,022	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150059	Period: From 01/01/2011 To 12/31/2011	Worksheet L Parts I-III Date/Time Prepared: 5/25/2012 12:22 pm
		Title XVII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		1,078,112	1.00
2.00	Capital DRG outlier payments		47,205	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		51.99	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)		1.35	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		16.95	8.00
9.00	Sum of lines 7 and 8		18.30	9.00
10.00	Allowable disproportionate share percentage (see instructions)		3.78	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		40,753	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		1,166,070	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00