

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: 144034	Period: From 07/01/2010 To 06/30/2011	Worksheet 5 Parts I-III Date/Time Prepared: 11/16/2011 2:07 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input type="checkbox"/> Electronically filed cost report	Date:	Time:
	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.		
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: 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 STREAMWOOD for the cost reporting period beginning 07/01/2010 and ending 06/30/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) 
Officer or Administrator of Provider(s)

Title _____
Date _____

Cost Center Description	Title XVIII					Title XIX	
	Title V	Part A	Part B	HIT			
	1.00	2.00	3.00	4.00	5.00		
PART III - SETTLEMENT SUMMARY							
1.00 Hospital	0	0	0	0	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	0	6.00
7.00 Skilled Nursing Facility	0	0	0	0	0	0	7.00
8.00 Nursing Facility	0	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	0	12.00
200.00 Total	0	0	0	0	0	0	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: 144034		Period: From 07/01/2010 To 06/30/2011		Worksheet S-2 Part I Date/Time Prepared: 11/16/2011 2:07 pm						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 1400 EAST IRVING PARK		PO Box:		Zip Code: 60107		County: COOK		1.00			
2.00	City: STREAMWOOD		State: IL						2.00			
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)					
							V	XVIII	XIX			
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		STREAMWOOD	144034	16974	4	05/01/1991	N	P	O	3.00	
4.00	Subprovider - IPF										4.00	
5.00	Subprovider - IRF										5.00	
6.00	Subprovider - (Other)										6.00	
7.00	Swing Beds - SNF							N	N	N	7.00	
8.00	Swing Beds - NF							N		N	8.00	
9.00	Hospital-Based SNF										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)					07/01/2010		06/30/2011		20.00		
21.00	Type of Control (see instructions)							4		21.00		
Inpatient PPS Information												
22.00	Does this facility qualify for and receive disproportionate share hospital payment in accordance with 42 CFR Section §412.106, or low income payment in accordance with 42 CFR Section §412.624(e)(2)? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N		N		22.00		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							3		23.00		
		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days					
		1.00	2.00	3.00	4.00	5.00	6.00					
24.00	If line 22 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.					0	0	0	0	0	0	24.00
25.00	If line 22 is "yes", and this provider is an IRF then enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.					0	0	0	0	0	0	25.00
								1.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.									1	26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period? Enter (1) for urban or (2) for rural.									1	27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.									0	35.00	
						Beginning:	Ending:					
						1.00	2.00					
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.										36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.									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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet S-2
Part I
Date/Time Prepared:
11/16/2011 2:07 pm

		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.				58.00	
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. 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		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
65.00	Enter in column 1 the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	0.00	0.00	0.000000	65.00	
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet 5-2
Part I
Date/Time Prepared:
11/16/2011 2:07 pm

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/(col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010.						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/(col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	0.00	0.00	0.000000	67.00	
		1.00	2.00	3.00	4.00	5.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.		Y		70.00	
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	71.00	
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.		N		75.00	
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00	
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.			N	80.00	
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00	
86.00	Did this facility establish a new other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N	86.00	
			V	XIX		
		1.00		2.00		
Title V or XIX Inpatient Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	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	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 144034	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 11/16/2011 2:07 pm	
			V	XIX	
			1.00	2.00	
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(C). Enter "Y" for yes or "N" for no.		N		108.00
			Physical 1.00	Occupational 2.00	
			Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				109.00
			1.00	2.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.		N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			0	118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.			0	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	399001	140.00
			1.00	2.00	3.00
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: UNIVERSAL HEALTH SERVICES		Contractor's Name: 399001		141.00
142.00	Street: 367 SOUTH GULPH ROAD		PO Box:		142.00
143.00	City: KING OF PRUSSIA		State: PA		143.00
			Zip Code: 19406		
			1.00		
144.00	Are provider based physicians' costs included in worksheet A?		Y		144.00
145.00	If costs for renal services are claimed on worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N		145.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 144034	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 11/16/2011 2:07 pm
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		1.00	2.00					
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00				
147.00	was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00				
148.00	was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00				
149.00	was the change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00				
		Part A	Part B					
		1.00	2.00					
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	155.00				
156.00	Subprovider - IPF	N	N	156.00				
157.00	Subprovider - IRF	N	N	157.00				
158.00	Subprovider - Other	N	N	158.00				
159.00	SNF	N	N	159.00				
160.00	HHA	N	N	160.00				
161.00	CMHC		N	161.00				
			1.00					
	Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.		N	165.00				
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							0168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
11/16/2011 2:07 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	
	Line Number				
	1.00	2.00	3.00	4.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	172	62,780	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)		172	62,780	0.00	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)		172	62,780	0.00	14.00
15.00 CAH visits					15.00
16.00 SUBPROVIDER - IPF					16.00
17.00 SUBPROVIDER - IRF					17.00
18.00 SUBPROVIDER					18.00
19.00 SKILLED NURSING FACILITY					19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE	46.00	15	5,475		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)		187			27.00
28.00 Observation Bed Days					28.00
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: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
11/16/2011 2:07 pm

Cost Center Description	I/P Days / O/P Visits / Trips				Total All Patients	
	Title V	Title XVIII	Title XIX			
	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	24	29,855	41,332		1.00
2.00 HMO		0	0			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	24	29,855	41,332		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	24	29,855	41,332		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE				5,278		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	0		28.00
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				0		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			0	0		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 144034 Period: From 07/01/2010 To 06/30/2011 Worksheet S-3 Part I Date/Time Prepared: 11/16/2011 2:07 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	2	1.00
2.00 HMO					0	2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	292.00	0.00	0	2	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	0.00	27.00	0.00			21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
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	319.00	0.00			27.00
28.00 Observation Bed Days						28.00
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: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
11/16/2011 2:07 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)	2,197	2,651		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)	2,197	2,651		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE			3	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
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 UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet S-10

Date/Time Prepared:
11/16/2011 2:07 pm

		1.00		
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)	0.350054		1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		0	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		0	6.00
7.00	Medicaid cost (line 1 times line 6)		0	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 2 plus line 5 minus line 7)		0	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone SCHIP		0	9.00
10.00	Stand-alone SCHIP charges		0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 9 minus line 11)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 13 minus line 15)		0	16.00
Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	0	0	0
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	0	0	0
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	0	0	0
				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)		0	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		0	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		0	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		0	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		0	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		0	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet A

Date/Time Prepared:
11/16/2011 2:07 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	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT		1,734,240	1,734,240	167,176	1,901,416	1.00
2.00 CAP REL COSTS-MVBLE EQUIP		287,681	287,681	112,513	400,194	2.00
3.00 OTHER CAP REL COSTS		0	0	0	0	3.00
4.00 EMPLOYEE BENEFITS	399,072	2,390,826	2,789,898	-4,627	2,785,271	4.00
5.00 ADMINISTRATIVE & GENERAL	2,383,229	7,007,270	9,390,499	-471,927	8,918,572	5.00
7.00 OPERATION OF PLANT	0	1,046,983	1,046,983	-2,281	1,044,702	7.00
8.00 LAUNDRY & LINEN SERVICE	0	172,756	172,756	0	172,756	8.00
9.00 HOUSEKEEPING	0	526,226	526,226	0	526,226	9.00
10.00 DIETARY	299,198	422,469	721,667	0	721,667	10.00
13.00 NURSING ADMINISTRATION	1,144,792	59,878	1,204,670	-4,766	1,199,904	13.00
16.00 MEDICAL RECORDS & LIBRARY	217,832	252,583	470,415	-2,838	467,577	16.00
17.00 SOCIAL SERVICE	903,176	41,406	944,582	-944,970	-388	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	6,940,561	1,989,795	8,930,356	1,052,769	9,983,125	30.00
46.00 OTHER LONG TERM CARE	831,690	69,123	900,813	100,615	1,001,428	46.00
ANCILLARY SERVICE COST CENTERS						
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00 LABORATORY	0	96,469	96,469	0	96,469	60.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00 ELECTROCARDIOLOGY	45,040	107,676	152,716	0	152,716	69.00
70.00 ELECTROENCEPHALOGRAPHY	77,200	69,543	146,743	0	146,743	70.00
73.00 DRUGS CHARGED TO PATIENTS	0	870,418	870,418	0	870,418	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	1,192,768	250,237	1,443,005	258	1,443,263	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	14,434,558	17,395,579	31,830,137	1,922	31,832,059	118.00
NONREIMBURSABLE COST CENTERS						
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 EDUCATION	431,734	23,723	455,457	-1,779	453,678	194.01
194.02 MARKETING	239,204	72,864	312,068	-143	311,925	194.02
200.00 TOTAL (SUM OF LINES 118-199)	15,105,496	17,492,166	32,597,662	0	32,597,662	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 144034 Period: From 07/01/2010 To 06/30/2011 worksheet A
 Date/Time Prepared: 11/16/2011 2:07 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	-15,252	1,886,164	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	143,881	544,075	2.00
3.00	OTHER CAP REL COSTS	0	0	3.00
4.00	EMPLOYEE BENEFITS	-426,583	2,358,688	4.00
5.00	ADMINISTRATIVE & GENERAL	-4,335,079	4,583,493	5.00
7.00	OPERATION OF PLANT	0	1,044,702	7.00
8.00	LAUNDRY & LINEN SERVICE	0	172,756	8.00
9.00	HOUSEKEEPING	0	526,226	9.00
10.00	DIETARY	-9,097	712,570	10.00
13.00	NURSING ADMINISTRATION	0	1,199,904	13.00
16.00	MEDICAL RECORDS & LIBRARY	-17,750	449,827	16.00
17.00	SOCIAL SERVICE	0	-388	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-2,237,525	7,745,600	30.00
46.00	OTHER LONG TERM CARE	-4,387	997,041	46.00
ANCILLARY SERVICE COST CENTERS				
54.00	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	LABORATORY	0	96,469	60.00
67.00	OCCUPATIONAL THERAPY	0	0	67.00
69.00	ELECTROCARDIOLOGY	0	152,716	69.00
70.00	ELECTROENCEPHALOGRAPHY	-56,277	90,466	70.00
73.00	DRUGS CHARGED TO PATIENTS	0	870,418	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	-1,399,440	43,823	90.00
91.00	EMERGENCY	0	0	91.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	-8,357,509	23,474,550	118.00
NONREIMBURSABLE COST CENTERS				
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	EDUCATION	0	453,678	194.01
194.02	MARKETING	-9,657	302,268	194.02
200.00	TOTAL (SUM OF LINES 118-199)	-8,367,166	24,230,496	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - OUTREACH THERAPY					
1.00	ADULTS & PEDIATRICS	30.00	33,777	10,285	1.00
	TOTALS		33,777	10,285	
B - RENT LEASE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	167,176	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	112,513	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
	TOTALS		0	279,689	
C - RECREATION THERAPY					
1.00	ADULTS & PEDIATRICS	30.00	177,145	11,252	1.00
2.00	OTHER LONG TERM CARE	46.00	22,623	1,437	2.00
	TOTALS		199,768	12,689	
D - TRANSPORTATION					
1.00	OTHER LONG TERM CARE	46.00	14,434	2,627	1.00
2.00	CLINIC	90.00	2,195	400	2.00
	TOTALS		16,629	3,027	
E - THERAPY					
1.00	ADULTS & PEDIATRICS	30.00	797,868	35,142	1.00
2.00	OTHER LONG TERM CARE	46.00	101,893	4,488	2.00
	TOTALS		899,761	39,630	
500.00	Grand Total: Increases		1,149,935	345,320	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - OUTREACH THERAPY							
1.00	OTHER LONG TERM CARE	46.00	33,777	10,285	0		1.00
	TOTALS		33,777	10,285			
B - RENT LEASE							
1.00	EMPLOYEE BENEFITS	4.00	0	4,627	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	239,814	10		2.00
3.00	OPERATION OF PLANT	7.00	0	2,281	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	4,766	0		4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,838	0		5.00
6.00	SOCIAL SERVICE	17.00	0	5,579	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	12,700	0		7.00
8.00	OTHER LONG TERM CARE	46.00	0	2,825	0		8.00
9.00	CLINIC	90.00	0	2,337	0		9.00
10.00	EDUCATION	194.01	0	1,779	0		10.00
11.00	MARKETING	194.02	0	143	0		11.00
	TOTALS		0	279,689			
C - RECREATION THERAPY							
1.00	ADMINISTRATIVE & GENERAL	5.00	199,768	12,689	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		199,768	12,689			
D - TRANSPORTATION							
1.00	ADMINISTRATIVE & GENERAL	5.00	16,629	3,027	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		16,629	3,027			
E - THERAPY							
1.00	SOCIAL SERVICE	17.00	899,761	39,630	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		899,761	39,630			
500.00	Grand Total: Decreases		1,149,935	345,320			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/16/2011 2:07 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	0	0	0	0	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	0	0	0	0	10.00
SUMMARY OF CAPITAL						
Cost Center Description		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)
		9.00	10.00	11.00	12.00	13.00
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	3.00
COMPUTATION OF RATIOS						
Cost Center Description		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance
		1.00	2.00	3.00	4.00	5.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
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		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0		1.00		
2.00	Land Improvements	0	0		2.00		
3.00	Buildings and Fixtures	0	0		3.00		
4.00	Building Improvements	0	0		4.00		
5.00	Fixed Equipment	0	0		5.00		
6.00	Movable Equipment	0	0		6.00		
7.00	HIT designated Assets	0	0		7.00		
8.00	Subtotal (sum of lines 1-7)	0	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	0	0		10.00		
SUMMARY OF CAPITAL							
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0		1.00		
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00		
3.00	Total (sum of lines 1-2)	0	0		3.00		
ALLOCATION OF OTHER CAPITAL							
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	-15,252	167,176	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	143,881	112,513	2.00
3.00	Total (sum of lines 1-2)	0	0	0	128,629	279,689	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
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Cost Center Description		SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
		11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	151,924	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	256,394	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	408,318	3.00

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8

Date/Time Prepared:
11/16/2011 2:07 pm

		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
1.00	Investment income - buildings and fixtures (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00	Investment income - movable equipment (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00 2.00
3.00	Investment income - other (chapter 2)		0		0.00 3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00 4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00 5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00 6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		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	-3,561,505		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	-3,516,822		12.00
13.00	Laundry and linen service		0		0.00 13.00
14.00	Cafeteria-employees and guests	A	-9,097	DIETARY	10.00 14.00
15.00	Rental of quarters to employee and others		0		0.00 15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00 16.00
17.00	Sale of drugs to other than patients		0		0.00 17.00
18.00	Sale of medical records and abstracts	A	-17,750	MEDICAL RECORDS & LIBRARY	16.00 18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00 19.00
20.00	Vending machines		0		0.00 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00 23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	66.00 24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00 25.00
26.00	Depreciation - buildings and fixtures	B	-15,252	CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00	Depreciation - movable equipment	B	143,881	CAP REL COSTS-MVBLE EQUIP	2.00 27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00 28.00
29.00	Physicians' assistant		0		0.00 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00 30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00 31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00 32.00
33.00	PHYSICIAN COSTS	B	-36,001	ADULTS & PEDIATRICS	30.00 33.00
34.00	PHYSICIAN COSTS	B	-47,606	CLINIC	90.00 34.00
35.00	PHYSICIAN COSTS	B	-178,569	EMPLOYEE BENEFITS	4.00 35.00
36.00	MISC REVENUE	A	-5,773	ADMINISTRATIVE & GENERAL	5.00 36.00
37.00	PT TRANSPORTATION	B	-33,769	ADMINISTRATIVE & GENERAL	5.00 37.00
38.00	PT TRANSPORTATION	B	-7,470	ADULTS & PEDIATRICS	30.00 38.00
39.00	PT TRANSPORTATION	B	-4,287	OTHER LONG TERM CARE	46.00 39.00
40.00	PT TRANSPORTATION	B	-2,973	CLINIC	90.00 40.00
41.00	WORKERS COMP INSURANCE	B	-107,694	EMPLOYEE BENEFITS	4.00 41.00
42.00	MEDICAL INSURANCE	B	-140,320	EMPLOYEE BENEFITS	4.00 42.00
43.00	LIABILITY INSURANCE	B	-102,223	ADMINISTRATIVE & GENERAL	5.00 43.00
44.00	MISC NON ALLOWABLE	B	-146,417	ADMINISTRATIVE & GENERAL	5.00 44.00
45.00	MISC NON ALLOWABLE	B	-692	ADULTS & PEDIATRICS	30.00 45.00
46.00	MISC NON ALLOWABLE	B	-9,657	MARKETING	194.02 46.00
47.00	MISC NON ALLOWABLE	B	-100	OTHER LONG TERM CARE	46.00 47.00
48.00	BAD DEBT	B	-530,075	ADMINISTRATIVE & GENERAL	5.00 48.00
49.00	BAD DEBT	B	-36,995	ADULTS & PEDIATRICS	30.00 49.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-8,367,166		50.00

		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - buildings and fixtures (chapter 2)	0	1.00
2.00	Investment income - movable equipment (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	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)	0	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	0	24.00
25.00	Utilization review - physicians' compensation (chapter 21)	0	25.00
26.00	Depreciation - buildings and fixtures	9	26.00
27.00	Depreciation - movable equipment	9	27.00
28.00	Non-physician Anesthetist	0	28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	0	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	0	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	PHYSICIAN COSTS	0	33.00
34.00	PHYSICIAN COSTS	0	34.00
35.00	PHYSICIAN COSTS	0	35.00
36.00	MISC REVENUE	0	36.00
37.00	PT TRANSPORTATION	0	37.00
38.00	PT TRANSPORTATION	0	38.00
39.00	PT TRANSPORTATION	0	39.00
40.00	PT TRANSPORTATION	0	40.00
41.00	WORKERS COMP INSURANCE	0	41.00
42.00	MEDICAL INSURANCE	0	42.00
43.00	LIABILITY INSURANCE	0	43.00
44.00	MISC NON ALLOWABLE	0	44.00
45.00	MISC NON ALLOWABLE	0	45.00
46.00	MISC NON ALLOWABLE	0	46.00
47.00	MISC NON ALLOWABLE	0	47.00
48.00	BAD DEBT	0	48.00
49.00	BAD DEBT	0	49.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)	0	50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS
 Provider CCN: 144034
 Period: From 07/01/2010 To 06/30/2011
 Worksheet A-8-1
 Date/Time Prepared: 11/16/2011 2:07 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	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEE	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	INTERCOMPANY INTEREST	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			0.00	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:			100.00

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

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

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

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8-1

Date/Time Prepared:
11/16/2011 2:07 pm

	Amount of Allowable Cost	Amount Included in wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	wkst. A-7 Ref.	
	4.00	5.00	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1,172,747	900,071	272,676	0	1.00
2.00	0	3,789,498	-3,789,498	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.	1,172,747	4,689,569	-3,516,822	5.00

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

Related Organization(s) and/or Home Office			
Name	Percentage of Ownership	Type of Business	
4.00	5.00	6.00	

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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	UNIVERSAL HEALT	100.00	HOSPITAL	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: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8-2

Date/Time Prepared:
11/16/2011 2:07 pm

	1.00	2.00	3.00	4.00	
	30.00	AGGREGATE	2,156,367	2,156,367	1.00
1.00	70.00	AGGREGATE	56,277	56,277	2.00
2.00	90.00	AGGREGATE	1,348,861	1,348,861	3.00
3.00	0.00		0	0	4.00
4.00	0.00		0	0	5.00
5.00	0.00		0	0	6.00
6.00	0.00		0	0	7.00
7.00	0.00		0	0	8.00
8.00	0.00		0	0	9.00
9.00	0.00		0	0	10.00
10.00	0.00		0	0	10.00
200.00	TOTAL (lines 1.00 through 199.00)		3,561,505	3,561,505	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8-2

Date/Time Prepared:
11/16/2011 2:07 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	0	0	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8-2

Date/Time Prepared:
11/16/2011 2:07 pm

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8-2

Date/Time Prepared:
11/16/2011 2:07 pm

	RCE Disallowance	Adjustment	
	17.00	18.00	
1.00	0	2,156,367	1.00
2.00	0	56,277	2.00
3.00	0	1,348,861	3.00
4.00	0	0	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	3,561,505	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet B
Part I
Date/Time Prepared:
11/16/2011 2:07 pm

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,886,164	1,886,164			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	544,075		544,075		2.00
4.00	EMPLOYEE BENEFITS	2,358,688	0	0	2,358,688	4.00
5.00	ADMINISTRATIVE & GENERAL	4,583,493	392,211	113,136	347,527	5.00
7.00	OPERATION OF PLANT	1,044,702	126,992	36,632	0	7.00
8.00	LAUNDRY & LINEN SERVICE	172,756	26,145	7,542	0	8.00
9.00	HOUSEKEEPING	526,226	12,485	3,601	0	9.00
10.00	DIETARY	712,570	103,784	29,937	47,987	10.00
13.00	NURSING ADMINISTRATION	1,199,904	15,138	4,367	183,607	13.00
16.00	MEDICAL RECORDS & LIBRARY	449,827	14,531	4,192	34,937	16.00
17.00	SOCIAL SERVICE	-388	0	0	548	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	7,745,600	1,029,748	297,036	1,274,954	30.00
46.00	OTHER LONG TERM CARE	997,041	67,863	19,575	150,259	46.00
ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	LABORATORY	96,469	0	0	0	60.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	67.00
69.00	ELECTROCARDIOLOGY	152,716	5,002	1,443	7,224	69.00
70.00	ELECTROENCEPHALOGRAPHY	90,466	0	0	12,382	70.00
73.00	DRUGS CHARGED TO PATIENTS	870,418	11,254	3,246	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	43,823	69,606	20,078	191,654	90.00
91.00	EMERGENCY	0	0	0	0	91.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	23,474,550	1,874,759	540,785	2,251,079	118.00
NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	EDUCATION	453,678	10,401	3,000	69,244	194.01
194.02	MARKETING	302,268	1,004	290	38,365	194.02
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	24,230,496	1,886,164	544,075	2,358,688	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet B
Part I
Date/Time Prepared:
11/16/2011 2:07 pm

Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
4.00						4.00
5.00	5,436,367					5.00
7.00	349,519	1,557,845				7.00
8.00	59,715	29,796	295,954			8.00
9.00	156,869	14,229	0	713,410		9.00
10.00	258,678	118,276	0	55,739	1,326,971	10.00
13.00	405,835	17,251	0	8,130	0	13.00
16.00	145,638	16,560	0	7,804	0	16.00
17.00	46	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	2,993,058	1,173,544	262,441	553,052	1,176,708	30.00
46.00	357,159	77,340	33,513	36,447	150,263	46.00
ANCILLARY SERVICE COST CENTERS						
54.00	0	0	0	0	0	54.00
60.00	27,905	0	0	0	0	60.00
67.00	0	0	0	0	0	67.00
69.00	48,128	5,700	0	2,686	0	69.00
70.00	29,750	0	0	0	0	70.00
73.00	255,970	12,825	0	6,044	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	94,056	79,326	0	37,383	0	90.00
91.00	0	0	0	0	0	91.00
SPECIAL PURPOSE COST CENTERS						
118.00	5,182,326	1,544,847	295,954	707,285	1,326,971	118.00
NONREIMBURSABLE COST CENTERS						
192.00	0	0	0	0	0	192.00
194.00	0	0	0	0	0	194.00
194.01	155,136	11,854	0	5,586	0	194.01
194.02	98,905	1,144	0	539	0	194.02
200.00						200.00
201.00	0	0	0	0	0	201.00
202.00	5,436,367	1,557,845	295,954	713,410	1,326,971	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet B
Part I
Date/Time Prepared:
11/16/2011 2:07 pm

Cost Center Description	NURSING	MEDICAL	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	ADMINISTRATION	RECORDS & LIBRARY				
	13.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
4.00						4.00
5.00						5.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
10.00						10.00
13.00	1,834,232					13.00
16.00	0	673,489				16.00
17.00	0	0	206			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	1,626,528	597,225	183	18,730,077	0	30.00
46.00	207,704	76,264	23	2,173,451	0	46.00
ANCILLARY SERVICE COST CENTERS						
54.00	0	0	0	0	0	54.00
60.00	0	0	0	124,374	0	60.00
67.00	0	0	0	0	0	67.00
69.00	0	0	0	222,899	0	69.00
70.00	0	0	0	132,598	0	70.00
73.00	0	0	0	1,159,757	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	0	0	0	535,926	0	90.00
91.00	0	0	0	0	0	91.00
SPECIAL PURPOSE COST CENTERS						
118.00	1,834,232	673,489	206	23,079,082	0	118.00
NONREIMBURSABLE COST CENTERS						
192.00	0	0	0	0	0	192.00
194.00	0	0	0	0	0	194.00
194.01	0	0	0	708,899	0	194.01
194.02	0	0	0	442,515	0	194.02
200.00	0	0	0	0	0	200.00
201.00	0	0	0	0	0	201.00
202.00	1,834,232	673,489	206	24,230,496	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet B
Part I
Date/Time Prepared:
11/16/2011 2:07 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT		1.00
2.00	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
13.00	NURSING ADMINISTRATION		13.00
16.00	MEDICAL RECORDS & LIBRARY		16.00
17.00	SOCIAL SERVICE		17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	18,730,077	30.00
46.00	OTHER LONG TERM CARE	2,173,451	46.00
ANCILLARY SERVICE COST CENTERS			
54.00	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	LABORATORY	124,374	60.00
67.00	OCCUPATIONAL THERAPY	0	67.00
69.00	ELECTROCARDIOLOGY	222,899	69.00
70.00	ELECTROENCEPHALOGRAPHY	132,598	70.00
73.00	DRUGS CHARGED TO PATIENTS	1,159,757	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	535,926	90.00
91.00	EMERGENCY	0	91.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	23,079,082	118.00
NONREIMBURSABLE COST CENTERS			
192.00	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	194.00
194.01	EDUCATION	708,899	194.01
194.02	MARKETING	442,515	194.02
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	24,230,496	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	0	0	0	0	4.00
5.00	ADMINISTRATIVE & GENERAL	86,698	392,211	113,136	592,045	5.00
7.00	OPERATION OF PLANT	0	126,992	36,632	163,624	7.00
8.00	LAUNDRY & LINEN SERVICE	0	26,145	7,542	33,687	8.00
9.00	HOUSEKEEPING	0	12,485	3,601	16,086	9.00
10.00	DIETARY	0	103,784	29,937	133,721	10.00
13.00	NURSING ADMINISTRATION	0	15,138	4,367	19,505	13.00
16.00	MEDICAL RECORDS & LIBRARY	0	14,531	4,192	18,723	16.00
17.00	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	1,029,748	297,036	1,326,784	30.00
46.00	OTHER LONG TERM CARE	0	67,863	19,575	87,438	46.00
ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	60.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	67.00
69.00	ELECTROCARDIOLOGY	0	5,002	1,443	6,445	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	0	11,254	3,246	14,500	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	69,606	20,078	89,684	90.00
91.00	EMERGENCY	0	0	0	0	91.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	86,698	1,874,759	540,785	2,502,242	118.00
NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	EDUCATION	0	10,401	3,000	13,401	194.01
194.02	MARKETING	0	1,004	290	1,294	194.02
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	86,698	1,886,164	544,075	2,516,937	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet B
Part II
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	592,045					5.00
7.00	OPERATION OF PLANT	38,065	201,689				7.00
8.00	LAUNDRY & LINEN SERVICE	6,503	3,858	44,048			8.00
9.00	HOUSEKEEPING	17,084	1,842	0	35,012		9.00
10.00	DIETARY	28,172	15,313	0	2,736	179,942	10.00
13.00	NURSING ADMINISTRATION	44,198	2,233	0	399	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	15,861	2,144	0	383	0	16.00
17.00	SOCIAL SERVICE	5	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	325,954	151,935	39,060	27,141	159,566	30.00
46.00	OTHER LONG TERM CARE	38,897	10,013	4,988	1,789	20,376	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	3,039	0	0	0	0	60.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	ELECTROCARDIOLOGY	5,241	738	0	132	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	3,240	0	0	0	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	27,877	1,660	0	297	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	10,243	10,270	0	1,835	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	564,379	200,006	44,048	34,712	179,942	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	EDUCATION	16,895	1,535	0	274	0	194.01
194.02	MARKETING	10,771	148	0	26	0	194.02
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)	592,045	201,689	44,048	35,012	179,942	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

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Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	13.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
4.00						4.00
5.00						5.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
13.00	66,335					13.00
16.00	0	37,111				16.00
17.00	0	0	2			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	58,823	32,909	2	2,122,174	0	30.00
46.00	7,512	4,202	0	175,215	0	46.00
ANCILLARY SERVICE COST CENTERS						
54.00	0	0	0	0	0	54.00
60.00	0	0	0	3,039	0	60.00
67.00	0	0	0	0	0	67.00
69.00	0	0	0	12,556	0	69.00
70.00	0	0	0	3,240	0	70.00
73.00	0	0	0	44,334	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	0	0	0	112,032	0	90.00
91.00	0	0	0	0	0	91.00
SPECIAL PURPOSE COST CENTERS						
118.00	66,335	37,111	2	2,472,590	0	118.00
NONREIMBURSABLE COST CENTERS						
192.00	0	0	0	0	0	192.00
194.00	0	0	0	0	0	194.00
194.01	0	0	0	32,105	0	194.01
194.02	0	0	0	12,239	0	194.02
200.00	0	0	0	0	0	200.00
201.00	0	0	3	3	0	201.00
202.00	66,335	37,111	5	2,516,937	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT		1.00
2.00	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
13.00	NURSING ADMINISTRATION		13.00
16.00	MEDICAL RECORDS & LIBRARY		16.00
17.00	SOCIAL SERVICE		17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	2,122,174	30.00
46.00	OTHER LONG TERM CARE	175,215	46.00
ANCILLARY SERVICE COST CENTERS			
54.00	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	LABORATORY	3,039	60.00
67.00	OCCUPATIONAL THERAPY	0	67.00
69.00	ELECTROCARDIOLOGY	12,556	69.00
70.00	ELECTROENCEPHALOGRAPHY	3,240	70.00
73.00	DRUGS CHARGED TO PATIENTS	44,334	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	112,032	90.00
91.00	EMERGENCY	0	91.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,472,590	118.00
NONREIMBURSABLE COST CENTERS			
192.00	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	194.00
194.01	EDUCATION	32,105	194.01
194.02	MARKETING	12,239	194.02
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	3	201.00
202.00	TOTAL (sum lines 118-201)	2,516,937	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet B-1

Date/Time Prepared:
11/16/2011 2:07 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00	99,557					1.00
2.00		99,557				2.00
4.00	0	0	14,706,424			4.00
5.00	20,702	20,702	2,166,832	-5,436,367	18,794,129	5.00
7.00	6,703	6,703	0	0	1,208,326	7.00
8.00	1,380	1,380	0	0	206,443	8.00
9.00	659	659	0	0	542,312	9.00
10.00	5,478	5,478	299,198	0	894,278	10.00
13.00	799	799	1,144,792	0	1,403,016	13.00
16.00	767	767	217,832	0	503,487	16.00
17.00	0	0	3,415	0	160	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	54,353	54,353	7,949,351	0	10,347,338	30.00
46.00	3,582	3,582	936,863	0	1,234,738	46.00
ANCILLARY SERVICE COST CENTERS						
54.00	0	0	0	0	0	54.00
60.00	0	0	0	0	96,469	60.00
67.00	0	0	0	0	0	67.00
69.00	264	264	45,040	0	166,385	69.00
70.00	0	0	77,200	0	102,848	70.00
73.00	594	594	0	0	884,918	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	3,674	3,674	1,194,963	0	325,161	90.00
91.00	0	0	0	0	0	91.00
SPECIAL PURPOSE COST CENTERS						
118.00	98,955	98,955	14,035,486	-5,436,367	17,915,879	118.00
NONREIMBURSABLE COST CENTERS						
192.00	0	0	0	0	0	192.00
194.00	0	0	0	0	0	194.00
194.01	549	549	431,734	0	536,323	194.01
194.02	53	53	239,204	0	341,927	194.02
200.00						200.00
201.00						201.00
202.00	1,886,164	544,075	2,358,688		5,436,367	202.00
203.00	18.945569	5.464960	0.160385		0.289259	203.00
204.00			0		592,045	204.00
205.00			0.000000		0.031502	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet B-1

Date/Time Prepared:
11/16/2011 2:07 pm

Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (PATIENT DAYS)	
	7.00	8.00	9.00	10.00	13.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
4.00						4.00
5.00						5.00
7.00	72,152					7.00
8.00	1,380	46,610				8.00
9.00	659	0	70,113			9.00
10.00	5,478	0	5,478	139,830		10.00
13.00	799	0	799	0	46,610	13.00
16.00	767	0	767	0	0	16.00
17.00	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	54,353	41,332	54,353	123,996	41,332	30.00
46.00	3,582	5,278	3,582	15,834	5,278	46.00
ANCILLARY SERVICE COST CENTERS						
54.00	0	0	0	0	0	54.00
60.00	0	0	0	0	0	60.00
67.00	0	0	0	0	0	67.00
69.00	264	0	264	0	0	69.00
70.00	0	0	0	0	0	70.00
73.00	594	0	594	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	3,674	0	3,674	0	0	90.00
91.00	0	0	0	0	0	91.00
SPECIAL PURPOSE COST CENTERS						
118.00	71,550	46,610	69,511	139,830	46,610	118.00
NONREIMBURSABLE COST CENTERS						
192.00	0	0	0	0	0	192.00
194.00	0	0	0	0	0	194.00
194.01	549	0	549	0	0	194.01
194.02	53	0	53	0	0	194.02
200.00						200.00
201.00						201.00
202.00	1,557,845	295,954	713,410	1,326,971	1,834,232	202.00
203.00	21.591155	6.349582	10.175146	9.489888	39.352757	203.00
204.00	201,689	44,048	35,012	179,942	66,335	204.00
205.00	2.795335	0.945033	0.499365	1.286863	1.423192	205.00

Cost Center Description		MEDICAL RECORDS & LIBRARY (PATIENT DAYS) 16.00	SOCIAL SERVICE (PATIENT DAYS) 17.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT			1.00
2.00	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
13.00	NURSING ADMINISTRATION			13.00
16.00	MEDICAL RECORDS & LIBRARY	46,610		16.00
17.00	SOCIAL SERVICE	0	46,610	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	41,332	41,332	30.00
46.00	OTHER LONG TERM CARE	5,278	5,278	46.00
ANCILLARY SERVICE COST CENTERS				
54.00	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	LABORATORY	0	0	60.00
67.00	OCCUPATIONAL THERAPY	0	0	67.00
69.00	ELECTROCARDIOLOGY	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0	0	90.00
91.00	EMERGENCY	0	0	91.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	46,610	46,610	118.00
NONREIMBURSABLE COST CENTERS				
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	EDUCATION	0	0	194.01
194.02	MARKETING	0	0	194.02
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)	673,489	206	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	14.449453	0.004420	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	37,111	5	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	0.796203	0.000043	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

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Part I
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Title XVIII

Hospital

PPS

Cost Center Description	Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	18,730,077		18,730,077	0	18,730,077	30.00
46.00 OTHER LONG TERM CARE	2,173,451		2,173,451	0	2,173,451	46.00
ANCILLARY SERVICE COST CENTERS						
54.00 RADIOLOGY-DIAGNOSTIC	0		0	0	0	54.00
60.00 LABORATORY	124,374		124,374	0	124,374	60.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00 ELECTROCARDIOLOGY	222,899		222,899	0	222,899	69.00
70.00 ELECTROENCEPHALOGRAPHY	132,598		132,598	0	132,598	70.00
73.00 DRUGS CHARGED TO PATIENTS	1,159,757		1,159,757	0	1,159,757	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	535,926		535,926	0	535,926	90.00
91.00 EMERGENCY	0		0	0	0	91.00
200.00 Subtotal (see instructions)	23,079,082	0	23,079,082	0	23,079,082	200.00
201.00 Less observation Beds	0		0	0	0	201.00
202.00 Total (see instructions)	23,079,082	0	23,079,082	0	23,079,082	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

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		Title XVIII			Hospital	PPS
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	57,528,579		57,528,579		30.00
46.00	OTHER LONG TERM CARE	2,772,466		2,772,466		46.00
ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	54.00
60.00	LABORATORY	151,988	0	151,988	0.818315	60.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
69.00	ELECTROCARDIOLOGY	275,730	0	275,730	0.808396	69.00
70.00	ELECTROENCEPHALOGRAPHY	88,000	0	88,000	1.506795	70.00
73.00	DRUGS CHARGED TO PATIENTS	1,663,866	0	1,663,866	0.697025	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	3,449,494	3,449,494	0.155364	90.00
91.00	EMERGENCY	0	0	0	0.000000	91.00
200.00	Subtotal (see instructions)	62,480,629	3,449,494	65,930,123		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	62,480,629	3,449,494	65,930,123		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144034

Period:
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To 06/30/2011

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Title XVIII

Hospital

PPS

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS		30.00
46.00	OTHER LONG TERM CARE		46.00
ANCILLARY SERVICE COST CENTERS			
54.00	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	LABORATORY	0.818315	60.00
67.00	OCCUPATIONAL THERAPY	0.000000	67.00
69.00	ELECTROCARDIOLOGY	0.808396	69.00
70.00	ELECTROENCEPHALOGRAPHY	1.506795	70.00
73.00	DRUGS CHARGED TO PATIENTS	0.697025	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	0.155364	90.00
91.00	EMERGENCY	0.000000	91.00
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: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet C
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		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (From Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	18,730,077		18,730,077	0	0 30.00
46.00	OTHER LONG TERM CARE	2,173,451		2,173,451	0	0 46.00
ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0		0	0	0 54.00
60.00	LABORATORY	124,374		124,374	0	0 60.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
69.00	ELECTROCARDIOLOGY	222,899		222,899	0	0 69.00
70.00	ELECTROENCEPHALOGRAPHY	132,598		132,598	0	0 70.00
73.00	DRUGS CHARGED TO PATIENTS	1,159,757		1,159,757	0	0 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	535,926		535,926	0	0 90.00
91.00	EMERGENCY	0		0	0	0 91.00
200.00	Subtotal (see instructions)	23,079,082	0	23,079,082	0	0 200.00
201.00	Less observation Beds	0		0	0	0 201.00
202.00	Total (see instructions)	23,079,082	0	23,079,082	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144034

Period:
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Cost Center Description	Title XIX			Hospital	Cost	TEFRA Inpatient Ratio	
	Charges			Cost or Other Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	57,528,579		57,528,579			30.00
46.00	OTHER LONG TERM CARE	2,772,466		2,772,466			46.00
ANCILLARY SERVICE COST CENTERS							
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
60.00	LABORATORY	151,988	0	151,988	0.818315	0.000000	60.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
69.00	ELECTROCARDIOLOGY	275,730	0	275,730	0.808396	0.000000	69.00
70.00	ELECTROENCEPHALOGRAPHY	88,000	0	88,000	1.506795	0.000000	70.00
73.00	DRUGS CHARGED TO PATIENTS	1,663,866	0	1,663,866	0.697025	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	0	3,449,494	3,449,494	0.155364	0.000000	90.00
91.00	EMERGENCY	0	0	0	0.000000	0.000000	91.00
200.00	Subtotal (see instructions)	62,480,629	3,449,494	65,930,123			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	62,480,629	3,449,494	65,930,123			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144034

Period:
From 07/01/2010
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Title XIX

Hospital

Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS			30.00
46.00	OTHER LONG TERM CARE			46.00
ANCILLARY SERVICE COST CENTERS				
54.00	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	LABORATORY	0.000000		60.00
67.00	OCCUPATIONAL THERAPY	0.000000		67.00
69.00	ELECTROCARDIOLOGY	0.000000		69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000		70.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0.000000		90.00
91.00	EMERGENCY	0.000000		91.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 144034	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part II Date/Time Prepared: 11/16/2011 2:07 pm
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Cost Center Description	Title XVIII			Hospital	PPS		
	Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0	0	54.00
60.00	LABORATORY	3,039	151,988	0.019995	0	0	60.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
69.00	ELECTROCARDIOLOGY	12,556	275,730	0.045537	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	3,240	88,000	0.036818	0	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	44,334	1,663,866	0.026645	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	112,032	3,449,494	0.032478	0	0	90.00
91.00	EMERGENCY	0	0	0.000000	0	0	91.00
200.00	Total (lines 50-199)	175,201	5,629,078		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144034

Period:
From 07/01/2010
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Worksheet D
Part IV
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Cost Center Description	Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS								
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	0	60.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	CLINIC	0	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	0	91.00
200.00	Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

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Part IV
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Cost Center Description		Title XVIII			Hospital		PPS
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0.000000	0	54.00
60.00	LABORATORY	0	151,988	0.000000	0.000000	0	60.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
69.00	ELECTROCARDIOLOGY	0	275,730	0.000000	0.000000	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	88,000	0.000000	0.000000	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,663,866	0.000000	0.000000	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	0	3,449,494	0.000000	0.000000	0	90.00
91.00	EMERGENCY	0	0	0.000000	0.000000	0	91.00
200.00	Total (lines 50-199)	0	5,629,078			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144034

Period:
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Cost Center Description		Title XVIII			Hospital		
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	60.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
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: 144034

Period:
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Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
54.00	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	LABORATORY	0	0	60.00
67.00	OCCUPATIONAL THERAPY	0	0	67.00
69.00	ELECTROCARDIOLOGY	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0	0	90.00
91.00	EMERGENCY	0	0	91.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 144034		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part I Date/Time Prepared: 11/16/2011 2:07 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)	Hospital Total Patient Days	Cost Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,122,174	0	2,122,174	41,332	51.34	
200.00	Total (lines 30-199)	2,122,174		2,122,174	41,332	200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 144034	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part I Date/Time Prepared: 11/16/2011 2:07 pm
	Title XIX	Hospital	Cost

Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
	6.00	7.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS	29,855	1,532,756	30.00
200.00 Total (lines 30-199)	29,855	1,532,756	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 144034	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part II Date/Time Prepared: 11/16/2011 2:07 pm
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Cost Center Description	Title XIX			Hospital	Cost	
	Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0	54.00
60.00	LABORATORY	3,039	151,988	0.019995	101,211	60.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0	67.00
69.00	ELECTROCARDIOLOGY	12,556	275,730	0.045537	273,744	69.00
70.00	ELECTROENCEPHALOGRAPHY	3,240	88,000	0.036818	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	44,334	1,663,866	0.026645	1,227,141	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	112,032	3,449,494	0.032478	0	90.00
91.00	EMERGENCY	0	0	0.000000	0	91.00
200.00	Total (lines 50-199)	175,201	5,629,078		1,602,096	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 144034	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part III Date/Time Prepared: 11/16/2011 2:07 pm
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Cost Center Description	Title XIX				Hospital	Total Costs (sum of cols. 1 through 3, minus col. 4)
	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Cost	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	0	0	0	0	0	0 30.00
200.00 Total (lines 30-199)	0	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 144034		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part III Date/Time Prepared: 11/16/2011 2:07 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)	PSA Adj. Nursing School Cost	
		6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	41,332	0.00	29,855	0	0	30.00
200.00	Total (lines 30-199)	41,332		29,855	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 144034	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part III Date/Time Prepared: 11/16/2011 2:07 pm
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Cost Center Description	Title XIX		Hospital	Cost
	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS	0	0		30.00
200.00 Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144034

Period:
From 07/01/2010
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Cost Center Description	Title XIX				Hospital	Total Cost (sum of col 1 through col. 4)	Cost
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	60.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
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: 144034

Period:
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Cost Center Description	Title XIX		Hospital		Inpatient Program Charges	
	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, part 1, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)		
ANCILLARY SERVICE COST CENTERS						
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0.000000	0	54.00
60.00 LABORATORY	0	151,988	0.000000	0.000000	101,211	60.00
67.00 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
69.00 ELECTROCARDIOLOGY	0	275,730	0.000000	0.000000	273,744	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	88,000	0.000000	0.000000	0	70.00
73.00 DRUGS CHARGED TO PATIENTS	0	1,663,866	0.000000	0.000000	1,227,141	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	3,449,494	0.000000	0.000000	0	90.00
91.00 EMERGENCY	0	0	0.000000	0.000000	0	91.00
200.00 Total (lines 50-199)	0	5,629,078			1,602,096	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet D
Part IV
Date/Time Prepared:
11/16/2011 2:07 pm

Cost Center Description	Title XIX			Hospital	Cost	
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS						
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00 LABORATORY	0	0	0	0	0	60.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
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: 144034	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 11/16/2011 2:07 pm
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Cost Center Description	Title XIX		Hospital	Cost
	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
	23.00	24.00		
ANCILLARY SERVICE COST CENTERS				
54.00 RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00 LABORATORY	0	0		60.00
67.00 OCCUPATIONAL THERAPY	0	0		67.00
69.00 ELECTROCARDIOLOGY	0	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0		70.00
73.00 DRUGS CHARGED TO PATIENTS	0	0		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 CLINIC	0	0		90.00
91.00 EMERGENCY	0	0		91.00
200.00 Total (lines 50-199)	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 144034	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 11/16/2011 2:07 pm
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Cost Center Description		Title XVIII	Hospital	PPS		
				1.00		
PART I - ALL PROVIDER COMPONENTS						
INPATIENT DAYS						
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			41,332 1.00		
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			41,332 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)			41,332 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)			24 9.00		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00		
15.00	Total nursery days (title V or XIX only)			0 15.00		
16.00	Nursery days (title V or XIX only)			0 16.00		
SWING BED ADJUSTMENT						
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00		
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00		
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00		
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00		
21.00	Total general inpatient routine service cost (see instructions)			18,730,077 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)			18,730,077 27.00		
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT						
28.00	General inpatient routine service charges (excluding swing-bed charges)			57,528,579 28.00		
29.00	Private room charges (excluding swing-bed charges)			0 29.00		
30.00	Semi-private room charges (excluding swing-bed charges)			57,528,579 30.00		
31.00	General inpatient routine service cost/charge ratio (line 27 + line 28)			0.325579 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)			1,391.87 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)			18,730,077 37.00		
PART II - HOSPITAL AND SUBPROVIDERS ONLY						
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS						
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			453.16 38.00		
39.00	Program general inpatient routine service cost (line 9 x line 38)			10,876 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)			10,876 41.00		
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

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet D-1

Date/Time Prepared:
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		Title XVIII			Hospital	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 + col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						1.00
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)				0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				10,876	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)				10,876	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges				0	54.00
55.00	Target amount per discharge				0.00	55.00
56.00	Target amount (line 54 x line 55)				0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0	57.00
58.00	Bonus payment (see instructions)				0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0	61.00
62.00	Relief payment (see instructions)				0	62.00
63.00	Allowable inpatient cost plus incentive payment (see instructions)				0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)				0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0	89.00
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	18,730,077	0.000000	0	90.00
91.00	Nursing School cost	0	18,730,077	0.000000	0	91.00
92.00	Allied health cost	0	18,730,077	0.000000	0	92.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

worksheet D-1

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Cost Center Description	Cost	Title XVIII		Hospital	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		Routine Cost (from line 27)	column 1 + column 2				
	1.00	2.00	3.00	4.00	5.00		
93.00 All other Medical Education	0	18,730,077	0.000000	0	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 144034	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 11/16/2011 2:07 pm
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Cost Center Description		Title XIX	Hospital	Cost		
PART I - ALL PROVIDER COMPONENTS						
INPATIENT DAYS						
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			41,332 1.00		
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			41,332 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)			41,332 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)			29,855 9.00		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00		
15.00	Total nursery days (title V or XIX only)			0 15.00		
16.00	Nursery days (title V or XIX only)			0 16.00		
SWING-BED ADJUSTMENT						
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00		
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00		
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00		
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00		
21.00	Total general inpatient routine service cost (see instructions)			18,730,077 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)			18,730,077 27.00		
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT						
28.00	General inpatient routine service charges (excluding swing-bed charges)			57,528,579 28.00		
29.00	Private room charges (excluding swing-bed charges)			0 29.00		
30.00	Semi-private room charges (excluding swing-bed charges)			57,528,579 30.00		
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.325579 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)			1,391.87 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)			18,730,077 37.00		
PART II - HOSPITAL AND SUBPROVIDERS ONLY						
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS						
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			453.16 38.00		
39.00	Program general inpatient routine service cost (line 9 x line 38)			13,529,092 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)			13,529,092 41.00		
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

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

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		Title XIX			Hospital	Cost
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 + col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1,159,464	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					14,688,556	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)						0 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)						0 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges						0 54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00
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

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

worksheet D-1
Date/Time Prepared:
11/16/2011 2:07 pm

Cost Center Description	Cost	Title XIX		Hospital	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	
93.00 All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 144034	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3
Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	Cost Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		34,340,402	30.00
ANCILLARY SERVICE COST CENTERS				
54.00	RADIOLOGY-DIAGNOSTIC	0.000000	0	0 54.00
60.00	LABORATORY	0.818315	101,211	82,822 60.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0 67.00
69.00	ELECTROCARDIOLOGY	0.808396	273,744	221,294 69.00
70.00	ELECTROENCEPHALOGRAPHY	1.506795	0	0 70.00
73.00	DRUGS CHARGED TO PATIENTS	0.697025	1,227,141	855,348 73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0.155364	0	0 90.00
91.00	EMERGENCY	0.000000	0	0 91.00
200.00	Total (sum of lines 50-94 and 96-98)		1,602,096	1,159,464 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net charges (line 200 minus line 201)		1,602,096	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet E-3
Part II
Date/Time Prepared:
11/16/2011 2:07 pm

		Title XVIII	Hospital	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			0 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)		113.238356	9.00
10.00	Medical Education Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$.		0.000000	10.00
11.00	Medical Education Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			0 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition			0 14.00
15.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)			0 15.00
16.00	Subtotal (see instructions)			0 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			0 18.00
19.00	Deductibles			0 19.00
20.00	Subtotal (line 18 minus line 19)			0 20.00
21.00	Coinsurance			0 21.00
22.00	Subtotal (line 20 minus line 21)			0 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			0 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			0 26.00
27.00	Direct graduate medical education payments (from worksheet E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			0 31.00
32.00	Interim payments			0 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus the sum lines 32 and 33)			0 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 144034	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part VII Date/Time Prepared: 11/16/2011 2:07 pm
		Title XIX	Hospital	Cost
				1.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		14,688,556	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)		14,688,556	4.00
5.00	Inpatient primary payer payments		1,103,234	5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		13,585,322	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		34,340,402	8.00
9.00	Ancillary service charges		1,602,096	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)		35,942,498	12.00
CUSTOMARY CHRGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		35,942,498	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 7) (see instructions)		22,357,176	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 7 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	20.00
21.00	Cost of covered services (line 7)		13,585,322	21.00
PROSPECTIVE PAYMENT AMOUNT				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		0	23.00
24.00	Program capital payments		0	24.00
25.00	Capital exception payments (see instructions)		0	25.00
26.00	Routine and Ancillary service other pass through costs		0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX PPS, lessor of lines 27 or 28; non-PPS enter amount from line 27		0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 through 21, plus line 29, minus line 30)		13,585,322	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)		13,585,322	36.00
37.00	ELIMINATE SETTLEMENT		-13,585,322	37.00
38.00	Subtotal (line 36 ± line 37)		0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	40.00
41.00	Interim payments		0	41.00
42.00	Balance due provider/program (line 40 minus 41)		0	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: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet G

Date/Time Prepared:
11/16/2011 2:07 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-142,023	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,642,905	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,526,095	0	0	0	6.00
7.00	Inventory	126,276	0	0	0	7.00
8.00	Prepaid expenses	50,756	0	0	0	8.00
9.00	Other current assets	0	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)	4,151,819	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,240,512	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	19,342,823	0	0	0	15.00
16.00	Accumulated depreciation	-501,102	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	1,744,955	0	0	0	23.00
24.00	Accumulated depreciation	-173,559	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)	22,653,629	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	61,171,309	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	61,171,309	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	87,976,757	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	477,722	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,504,537	0	0	0	38.00
39.00	Payroll taxes payable	747,778	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,730,037	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	101,039,935	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	-18,815,807	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	82,224,128	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	84,954,165	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	3,022,592	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)	3,022,592	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	87,976,757	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet G-1

Date/Time Prepared:
11/16/2011 2:07 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		49,634,388	
2.00	Net income (loss) (from Wkst. G-3, line 29)		7,074,252			2.00
3.00	Total (sum of line 1 and line 2)		56,708,640		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)		56,708,640		0	11.00
12.00	ACQUISITION ENTRIES	53,686,048		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)		53,686,048		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		3,022,592		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet G-1

Date/Time Prepared:
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	Endowment Fund		Plant Fund		
	5.00	6.00	7.00	8.00	
1.00					1.00
2.00					2.00
3.00					3.00
4.00					4.00
5.00					5.00
6.00					6.00
7.00					7.00
8.00					8.00
9.00					9.00
10.00					10.00
11.00					11.00
12.00					12.00
13.00					13.00
14.00					14.00
15.00					15.00
16.00					16.00
17.00					17.00
18.00					18.00
19.00					19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 144034

Period:
From 07/01/2010
To 06/30/2011

Worksheet G-2 Parts

Date/Time Prepared:
11/16/2011 2:07 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	57,528,579		57,528,579	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	2,772,466		2,772,466	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	60,301,045		60,301,045	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	60,301,045		60,301,045	17.00
18.00	Ancillary services	2,179,584	0	2,179,584	18.00
19.00	Outpatient services	0	3,449,494	3,449,494	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN FEES	1,414,010	0	1,414,010	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	63,894,639	3,449,494	67,344,133	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		32,597,662		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)		32,597,662		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 144034	Period: From 07/01/2010 To 06/30/2011	worksheet G-3 Date/Time Prepared: 11/16/2011 2:07 pm
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		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	67,344,133	1.00
2.00	Less contractual allowances and discounts on patients' accounts	28,409,524	2.00
3.00	Net patient revenues (line 1 minus line 2)	38,934,609	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	32,597,662	4.00
5.00	Net income from service to patients (line 3 minus line 4)	6,336,947	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	9,097	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	17,750	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	MISC REVENUE	710,458	24.00
25.00	Total other income (sum of lines 6-24)	737,305	25.00
26.00	Total (line 5 plus line 25)	7,074,252	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)	7,074,252	29.00