

**GREENE COUNTY GENERAL HOSPITAL
LINTON, INDIANA**

PROVIDER NOS. 15-1317, 15-Z317 AND AIM NO. 100269150

**HOSPITAL STATEMENTS OF REIMBURSABLE COSTS
(MEDICARE AND MEDICAID PROGRAMS)**

DECEMBER 31, 2011

GREENE COUNTY GENERAL HOSPITAL
PROVIDER NOS. 15-1317, 15-Z317 AND AIM NO. 100269150

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Accountants' disclaimer

Hospital statements of reimbursable costs



Board of Trustees
Greene County General Hospital
Linton, Indiana

We have compiled the Hospital Statements of Reimbursable Costs (Title XVIII and XIX) of Greene County General Hospital for the year ended December 31, 2011 in the accompanying prescribed form in accordance with Statements on Standards for Accounting Review Services issued by the American Institute of Certified Public Accountants.

Our compilation was limited to presenting in the form prescribed by the Centers for Medicare and Medicaid Services, information that is the representation of management. We have not audited or reviewed the financial information referred to above and, accordingly, do not express an opinion or any other form of assurance on it.

The report is presented in accordance with the requirements of the Centers for Medicare and Medicaid Services, which differ from generally accepted accounting principles. Accordingly, this information is not designed for those who are not informed about such differences.

This financial information is intended to be filed with the Centers for Medicare and Medicaid Services and should not be used for any other purpose.

Bradley Associates

May 29, 2012

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
Worksheet S
Parts I-III
Date/Time Prepared:
5/29/2012 6:41 pm

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151317	Period: From 01/01/2011 To 12/31/2011
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/29/2012 Time: 6:41 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN
		10. NPR Date: 11. Contractor's Vendor Code: 04 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 GREENE COUNTY GENERAL HOSPITAL for the cost reporting period beginning 01/01/2011 and ending 12/31/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information
ECR: Date: 5/29/2012 Time: 6:41 pm
jsF8cRq.lj7Yoyb5MM9IE9WB5.3h00
6U5mR05n5dDqUZ827f4qNwobyADpNZ
RiyM03P5hq0sv935
PI: Date: 5/29/2012 Time: 6:41 pm
LxJqCdENSRHAQLm4ClqeI625hyYpnf0
B1BvF0g.3o:rTSA2H3trDGFb:lrqgb
FHWWA5aY5R0Xikwa

(Signed) _____
Officer or Administrator of Provider(s)

Title

Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	131,620	-96,593	133,142	0 1.00
2.00	Subprovider - IPF	0	0	0	0	0 2.00
3.00	Subprovider - IRF	0	0	0	0	0 3.00
4.00	SUBPROVIDER I	0	0	0	0	0 4.00
5.00	Swing bed - SNF	0	17,130	0	0	0 5.00
6.00	Swing bed - NF	0	0	0	0	0 6.00
7.00	SKILLED NURSING FACILITY	0	0	0	0	0 7.00
8.00	NURSING FACILITY	0	0	0	0	0 8.00
9.00	HOME HEALTH AGENCY I	0	0	0	0	0 9.00
10.00	RURAL HEALTH CLINIC I	0	0	0	0	0 10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0 11.00
12.00	CMHC I	0	0	0	0	0 12.00
200.00	Total	0	148,750	-96,593	133,142	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: 151317	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/29/2012 5:55 pm
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	1.00	2.00	3.00	4.00					
Hospital and Hospital Health Care Complex Address:									
1.00	Street: R.R. 1		PO Box: 1000		1.00				
2.00	City: LINTON		State: IN	Zip Code: 47441-9457	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	GREENE COUNTY GENERAL HOSPITAL	151317	99915	1	02/01/2003	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	GREENE COUNTY GENERAL HOSPITAL	152317	99915		02/01/2003	N	O	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)	01/01/2011	12/31/2011	20.00
21.00	Type of Control (see instructions)	9		21.00

Inpatient PPS Information										
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N				22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.					0				23.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151317	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/29/2012 5:55 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	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 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00	
		Program Name 1.00	Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151317

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151317	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/29/2012 5:55 pm	
		1.00	2.00	3.00	
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	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	Y	Y	N
		1.00		2.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.	N			115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1	118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.	250,000		5,000,000	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with ≤ 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151317

Period:
From 01/01/2011
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Part I
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5/29/2012 5:55 pm

		1.00	2.00				
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.						134.00
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y				140.00
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:			141.00
142.00	Street:	PO Box:		Zip Code:			142.00
143.00	City:	State:					143.00
			1.00				
144.00	Are provider based physicians' costs included in worksheet A?		Y				144.00
145.00	If costs for renal services are claimed on worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N				145.00
			1.00	2.00			
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N				146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N				147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N				148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N				149.00
			Part A	Part B			
			1.00	2.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital		N	N			155.00
156.00	Subprovider - IPF		N	N			156.00
157.00	Subprovider - IRF		N	N			157.00
158.00	SUBPROVIDER		N	N			158.00
159.00	SNF		N	N			159.00
160.00	HOME HEALTH AGENCY		N	N			160.00
161.00	CMHC		N	N			161.00
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
							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.					Y	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)					136,932	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.00	169.00

		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on worksheet A? If yes, see instructions.	N		11.00
			Y/N	
			1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		
		Description	Y/N	Date
		0	1.00	2.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/04/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00

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

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	05/04/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151317

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2012 5:55 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	20	7,300	61,560.00	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)		20	7,300	61,560.00	7.00
8.00 INTENSIVE CARE UNIT	31.00	5	1,825	7,056.00	8.00
9.00 CORONARY CARE UNIT					9.00
10.00 BURN INTENSIVE CARE UNIT					10.00
11.00 SURGICAL INTENSIVE CARE UNIT					11.00
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00
13.00 NURSERY	43.00				13.00
14.00 Total (see instructions)		25	9,125	68,616.00	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					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)		25			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: 151317

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2012 5:55 pm

Cost Center Description	I/P Days / O/P Visits / Trips				
	Title V	Title XVIII	Title XIX	Total All Patients	
	5.00	6.00	7.00	8.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	1,891	69	2,565	1.00
2.00 HMO		0	130		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	216	0	216	5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	13	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,107	69	2,794	7.00
8.00 INTENSIVE CARE UNIT	0	263	0	294	8.00
9.00 CORONARY CARE UNIT					9.00
10.00 BURN INTENSIVE CARE UNIT					10.00
11.00 SURGICAL INTENSIVE CARE UNIT					11.00
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00
13.00 NURSERY	0		80	177	13.00
14.00 Total (see instructions)	0	2,370	149	3,265	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					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	727	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: 151317

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2012 5:55 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	582	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	208.80	0.00	0	582	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						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	208.80	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

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)	64	868		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)	64	868		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				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: 151317

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

Worksheet S-10

Date/Time Prepared:
5/29/2012 5:55 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)			0.517644	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			743,942	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			N	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			1,081,758	5.00	
6.00	Medicaid charges			5,941,507	6.00	
7.00	Medicaid cost (line 1 times line 6)			3,075,585	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			1,249,885	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone SCHIP			0	9.00	
10.00	Stand-alone SCHIP charges			0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)			0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00	
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00	
Uncompensated care (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations			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)			1,249,885	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	829,152	239,068	1,068,220	20.00	
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	429,206	123,752	552,958	21.00	
22.00	Partial payment by patients approved for charity care	0	0	0	22.00	
23.00	Cost of charity care (line 21 minus line 22)	429,206	123,752	552,958	23.00	
				1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)			1,676,392	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)			417,581	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)			1,258,811	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)			651,616	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			1,204,574	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			2,454,459	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151317

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

Worksheet A

Date/Time Prepared:
5/29/2012 5:55 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT		305,798	305,798	38,459	344,257	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		145,847	145,847	3,098	148,945	2.00
4.00 EMPLOYEE BENEFITS	0	3,611,663	3,611,663	12,446	3,624,109	4.00
5.00 ADMINISTRATIVE & GENERAL	1,062,054	2,016,756	3,078,810	382	3,079,192	5.00
7.00 OPERATION OF PLANT	371,717	813,889	1,185,606	0	1,185,606	7.00
8.00 LAUNDRY & LINEN SERVICE	0	125,157	125,157	0	125,157	8.00
9.00 HOUSEKEEPING	301,720	75,485	377,205	0	377,205	9.00
10.00 DIETARY	427,987	461,002	888,989	-783,408	105,581	10.00
11.00 CAFETERIA	0	0	0	729,023	729,023	11.00
13.00 NURSING ADMINISTRATION	531,285	54,555	585,840	0	585,840	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	7,136	7,136	0	7,136	14.00
15.00 PHARMACY	625,449	58,030	683,479	0	683,479	15.00
16.00 MEDICAL RECORDS & LIBRARY	209,720	43,935	253,655	0	253,655	16.00
17.00 SOCIAL SERVICE	105,819	0	105,819	0	105,819	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,472,446	84,117	2,556,563	-29,118	2,527,445	30.00
31.00 INTENSIVE CARE UNIT	744,546	29,839	774,385	0	774,385	31.00
43.00 NURSERY	27,423	727	28,150	0	28,150	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	357,108	120,788	477,896	0	477,896	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	2,191	2,191	29,118	31,309	52.00
53.00 ANESTHESIOLOGY	288,504	31,367	319,871	0	319,871	53.00
54.00 RADIOLOGY-DIAGNOSTIC	854,453	857,074	1,711,527	0	1,711,527	54.00
60.00 LABORATORY	786,375	1,524,676	2,311,051	0	2,311,051	60.00
65.00 RESPIRATORY THERAPY	455,860	32,692	488,552	0	488,552	65.00
66.00 PHYSICAL THERAPY	254,531	16,728	271,259	0	271,259	66.00
67.00 OCCUPATIONAL THERAPY	92,920	0	92,920	0	92,920	67.00
68.00 SPEECH PATHOLOGY	10,434	0	10,434	0	10,434	68.00
69.00 ELECTROCARDIOLOGY	28,288	76,900	105,188	0	105,188	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	283,739	283,739	-8,323	275,416	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	8,323	8,323	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	1,333,888	1,333,888	0	1,333,888	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	359,240	1,245,675	1,604,915	0	1,604,915	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	10,367,879	13,359,654	23,727,533	0	23,727,533	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 FOUNDATION/ MOBS	0	0	0	0	0	194.00
200.00 TOTAL (SUM OF LINES 118-199)	10,367,879	13,359,654	23,727,533	0	23,727,533	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151317

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

Worksheet A
Date/Time Prepared:
5/29/2012 5:55 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	-19,885	324,372	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-104	148,841	2.00
4.00	EMPLOYEE BENEFITS	-102,843	3,521,266	4.00
5.00	ADMINISTRATIVE & GENERAL	-115,272	2,963,920	5.00
7.00	OPERATION OF PLANT	0	1,185,606	7.00
8.00	LAUNDRY & LINEN SERVICE	0	125,157	8.00
9.00	HOUSEKEEPING	0	377,205	9.00
10.00	DIETARY	0	105,581	10.00
11.00	CAFETERIA	-249,067	479,956	11.00
13.00	NURSING ADMINISTRATION	0	585,840	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	7,136	14.00
15.00	PHARMACY	-140	683,339	15.00
16.00	MEDICAL RECORDS & LIBRARY	-10,241	243,414	16.00
17.00	SOCIAL SERVICE	0	105,819	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	2,527,445	30.00
31.00	INTENSIVE CARE UNIT	0	774,385	31.00
43.00	NURSERY	0	28,150	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	477,896	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	31,309	52.00
53.00	ANESTHESIOLOGY	-288,504	31,367	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	1,711,527	54.00
60.00	LABORATORY	-40,000	2,271,051	60.00
65.00	RESPIRATORY THERAPY	0	488,552	65.00
66.00	PHYSICAL THERAPY	0	271,259	66.00
67.00	OCCUPATIONAL THERAPY	0	92,920	67.00
68.00	SPEECH PATHOLOGY	0	10,434	68.00
69.00	ELECTROCARDIOLOGY	0	105,188	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	-2,771	272,645	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	8,323	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,333,888	73.00
OUTPATIENT SERVICE COST CENTERS				
91.00	EMERGENCY	-758,185	846,730	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	-1,587,012	22,140,521	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	FOUNDATION/ MOBS	504,012	504,012	194.00
200.00	TOTAL (SUM OF LINES 118-199)	-1,083,000	22,644,533	200.00

Provider CCN: 151317

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

Worksheet A-6
Date/Time Prepared:
5/29/2012 5:55 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	38,459	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	3,098	2.00
3.00	EMPLOYEE BENEFITS	4.00	0	12,446	3.00
	TOTALS		0	54,003	
B - LABOR & DELIVERY					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	29,118	0	1.00
	TOTALS		29,118	0	
C - DIETARY/ CAFETERIA					
1.00	ADMINISTRATIVE & GENERAL	5.00	26,183	28,202	1.00
2.00	CAFETERIA	11.00	350,974	378,049	2.00
	TOTALS		377,157	406,251	
D - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	8,323	1.00
	TOTALS		0	8,323	
E - OT & ST CONTRACTED SERVICES					
1.00	OCCUPATIONAL THERAPY	67.00	0	92,920	1.00
2.00	SPEECH PATHOLOGY	68.00	0	10,434	2.00
	TOTALS		0	103,354	
500.00	Grand Total: Increases		406,275	571,931	500.00

Provider CCN: 151317

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

Worksheet A-6
Date/Time Prepared:
5/29/2012 5:55 pm

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7	Ref.	
6.00	7.00	8.00	9.00	10.00		
A - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	54,003	12	1.00
2.00		0.00	0	0	12	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		0	54,003		
B - LABOR & DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	29,118	0	0	1.00
	TOTALS		29,118	0		
C - DIETARY/ CAFETERIA						
1.00	DIETARY	10.00	377,157	406,251	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		377,157	406,251		
D - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	8,323	0	1.00
	TOTALS		0	8,323		
E - OT & ST CONTRACTED SERVICES						
1.00	OCCUPATIONAL THERAPY	67.00	92,920	0	0	1.00
2.00	SPEECH PATHOLOGY	68.00	10,434	0	0	2.00
	TOTALS		103,354	0		
500.00	Grand Total: Decreases		509,629	468,577		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151317

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/29/2012 5:55 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	759,198	0	0	0	1.00
2.00	Land Improvements	477,277	0	0	51,496	2.00
3.00	Buildings and Fixtures	7,255,971	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	759,250	90,442	0	90,442	5.00
6.00	Movable Equipment	3,323,840	0	0	27,586	6.00
7.00	HIT designated Assets	200,861	8,480	0	8,480	7.00
8.00	Subtotal (sum of lines 1-7)	12,776,397	98,922	0	98,922	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	12,776,397	98,922	0	98,922	10.00
SUMMARY OF CAPITAL						
Cost Center Description		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)
		9.00	10.00	11.00	12.00	13.00
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	305,798	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	145,847	0	0	0	2.00
3.00	Total (sum of lines 1-2)	451,645	0	0	0	3.00
COMPUTATION OF RATIOS						
Cost Center Description		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance
		1.00	2.00	3.00	4.00	5.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151317

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/29/2012 5:55 pm

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	759,198	0		1.00	
2.00	Land Improvements	425,781	0		2.00	
3.00	Buildings and Fixtures	7,255,971	0		3.00	
4.00	Building Improvements	0	0		4.00	
5.00	Fixed Equipment	849,692	0		5.00	
6.00	Movable Equipment	3,296,254	0		6.00	
7.00	HIT designated Assets	209,341	0		7.00	
8.00	Subtotal (sum of lines 1-7)	12,796,237	0		8.00	
9.00	Reconciling Items	0	0		9.00	
10.00	Total (line 8 minus line 9)	12,796,237	0		10.00	
SUMMARY OF CAPITAL						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	305,798		1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	145,847		2.00	
3.00	Total (sum of lines 1-2)	0	451,645		3.00	
ALLOCATION OF OTHER CAPITAL						
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	285,913	0
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	145,743	0
3.00	Total (sum of lines 1-2)	0	0	0	431,656	0

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151317

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/29/2012 5:55 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	38,459	0	0	324,372	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	3,098	0	0	148,841	2.00
3.00	Total (sum of lines 1-2)	0	41,557	0	0	473,213	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted			
			Cost Center	Line #		
			1.00	2.00	3.00	4.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00 Investment income - other (chapter 2)			0		0.00	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	5.00
6.00 Rental of provider space by suppliers (chapter 8)	B	-19,885	0	NEW CAP REL COSTS-BLDG & FIXT	1.00	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-14,858	0	ADMINISTRATIVE & GENERAL	5.00	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	-798,185				10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	B	-104	0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	504,012				12.00
13.00 Laundry and linen service			0		0.00	13.00
14.00 Cafeteria-employees and guests	B	-249,067	0	CAFETERIA	11.00	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	B	-2,771	0	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	16.00
17.00 Sale of drugs to other than patients			0		0.00	17.00
18.00 Sale of medical records and abstracts	B	-10,241	0	MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	19.00
20.00 Vending machines	B	-1,553	0	ADMINISTRATIVE & GENERAL	5.00	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)	A	-2,342	0	EMPLOYEE BENEFITS	4.00	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	0	RESPIRATORY THERAPY	65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	PHYSICAL THERAPY	66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00	25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00	28.00
29.00 Physicians' assistant			0		0.00	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	OCCUPATIONAL THERAPY	67.00	30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	0	SPEECH PATHOLOGY	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	0			0.00	32.00
33.00 FLU SHOTS	B	-140	0	PHARMACY	15.00	33.00
33.01 CPR TRAINING	B	-1,943	0	ADMINISTRATIVE & GENERAL	5.00	33.01
33.02 MISC INCOME	B	859	0	ADMINISTRATIVE & GENERAL	5.00	33.02
33.03 MISC NON-ALLOWABLE EXPENSE	A	-79,721	0	ADMINISTRATIVE & GENERAL	5.00	33.03
33.04 AHA DUES	A	-2,053	0	ADMINISTRATIVE & GENERAL	5.00	33.04
33.05 IHA DUES	A	-802	0	ADMINISTRATIVE & GENERAL	5.00	33.05
33.06 MARKETING & ADVERTISING	A	-5,267	0	ADMINISTRATIVE & GENERAL	5.00	33.06
33.07 PHYSICIAN RECRUITING	A	-9,934	0	ADMINISTRATIVE & GENERAL	5.00	33.07
33.08 CRNA COSTS	A	-288,504	0	ANESTHESIOLOGY	53.00	33.08
33.09 CRNA BENEFITS	A	-100,501	0	EMPLOYEE BENEFITS	4.00	33.09
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-1,083,000				50.00

Cost Center	Description	Wkst.	A-7	Ref.	
		5.00			
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0		1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0		2.00
3.00	Investment income - other (chapter 2)		0		3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		5.00
6.00	Rental of provider space by suppliers (chapter 8)		9		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)		9		11.00
12.00	Related organization transactions (chapter 10)		0		12.00
13.00	Laundry and linen service		0		13.00
14.00	Cafeteria-employees and guests		0		14.00
15.00	Rental of quarters to employee and others		0		15.00
16.00	Sale of medical and surgical supplies to other than patients		0		16.00
17.00	Sale of drugs to other than patients		0		17.00
18.00	Sale of medical records and abstracts		0		18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		19.00
20.00	Vending machines		0		20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)				23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)				24.00
25.00	Utilization review - physicians' compensation (chapter 21)				25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0		26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0		27.00
28.00	Non-physician Anesthetist				28.00
29.00	Physicians' assistant		0		29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)				30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)				31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		32.00
33.00	FLU SHOTS		0		33.00
33.01	CPR TRAINING		0		33.01
33.02	MISC INCOME		0		33.02
33.03	MISC NON-ALLOWABLE EXPENSE		0		33.03
33.04	AHA DUES		0		33.04
33.05	IHA DUES		0		33.05
33.06	MARKETING & ADVERTISING		0		33.06
33.07	PHYSICIAN RECRUITING		0		33.07
33.08	CRNA COSTS		0		33.08
33.09	CRNA BENEFITS		0		33.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)				50.00

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

Provider CCN: 151317

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

Worksheet A-8-1

Date/Time Prepared:
5/29/2012 5:55 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	194.00	FOUNDATION/ MOBS	FOUNDATION/MOB- NET LOSS	1.00
2.00	0.00			2.00
3.00	0.00			3.00
4.00	0.00			4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.			5.00

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

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

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

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

6.00	C	GCGH FOUNDATION	0.00	6.00
7.00	C	GCH-WORTHINGTON	0.00	7.00
8.00	C	GCH-BLOOMFIELD	0.00	8.00
9.00	C	GCGH, LLC	0.00	9.00
10.00	C	GC HOME HEALTH	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: 151317

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

Worksheet A-8-1

Date/Time Prepared:
5/29/2012 5:55 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	504,012	0	504,012	0	1.00
2.00	0	0	0	0	2.00
3.00	0	0	0	0	3.00
4.00	0	0	0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	504,012	0	504,012	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		0.00	6.00
7.00		0.00	7.00
8.00		0.00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:		100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151317

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

Worksheet A-8-2

Date/Time Prepared:
5/29/2012 5:55 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	91.00	EMERGENCY	1,207,761	758,185	1.00
2.00	60.00	LABORATORY	40,000	40,000	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
200.00			1,247,761	798,185	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151317

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

Worksheet A-8-2

Date/Time Prepared:
5/29/2012 5:55 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	449,576	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	449,576	0	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151317

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

Worksheet A-8-2

Date/Time Prepared:
5/29/2012 5:55 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: 151317

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

Worksheet A-8-2

Date/Time Prepared:
5/29/2012 5:55 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	758,185	1.00
2.00	0	40,000	2.00
3.00	0	0	3.00
4.00	0	0	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	798,185	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151317	Period: From 01/01/2011 To 12/31/2011	Worksheet A-8-3 Par Date/Time Prepared: 5/29/2012 5:55 pm
		Occupational Therapy	Cost

							1.00	
PART I -- GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)						52	1.00
2.00	Line 1 multiplied by 15 hours per week						780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						238	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						5.50	7.00
8.00	Optional travel expense rate per mile						0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	1,607.93	0.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	68.25	0.00	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.13	34.13	0.00				11.00
12.00	Number of travel hours (provider site)	0	0	0				12.00
12.01	Number of travel hours (offsite)	0	0	0				12.01
13.00	Number of miles driven (provider site)	0	0	0				13.00
13.01	Number of miles driven (offsite)	0	0	0				13.01
							1.00	
Part II - SALARY EQUIVALENCY COMPUTATION								
14.00	Supervisors (column 1, line 9 times column 1, line 10)						0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						109,741	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)						0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						109,741	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)						0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						109,741	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.								
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						0	22.00
23.00	Total salary equivalency (see instructions)						109,741	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE								
Standard Travel Allowance								
24.00	Therapists (line 3 times column 2, line 11)						8,123	24.00
25.00	Assistants (line 4 times column 3, line 11)						0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						8,123	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						1,309	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						9,432	28.00
Optional Travel Allowance and Optional Travel Expense								
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)						9,432	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						1,309	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE								
Standard Travel Expense								
36.00	Therapists (line 5 times column 2, line 11)						0	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
Optional Travel Allowance and Optional Travel Expense								
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.								
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151317	Period: From 01/01/2011 To 12/31/2011	Worksheet A-8-3 Par Date/Time Prepared: 5/29/2012 5:55 pm
		Occupational Therapy	Cost

							1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						0	46.00
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	68.25	0.00	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	0	56.00
							1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						109,741	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						9,432	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						119,173	63.00
64.00	Total cost of outside supplier services (from your records)						92,920	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						8,123	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						1,309	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						9,432	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						1,309	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						1,309	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151317	Period: From 01/01/2011 To 12/31/2011	Worksheet A-8-3 Par Date/Time Prepared: 5/29/2012 5:55 pm
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		Speech Pathology					Cost
							1.00
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					112	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.50	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	197.20	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	65.60	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	32.80	32.80	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
							1.00
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					12,936	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					12,936	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					12,936	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					65.60	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					51,168	22.00
23.00	Total salary equivalency (see instructions)					51,168	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					3,674	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					3,674	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					616	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					4,290	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					4,290	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					616	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY
OUTSIDE SUPPLIERS

Provider CCN: 151317

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

Worksheet A-8-3 Par
Date/Time Prepared:
5/29/2012 5:55 pm

		Speech Pathology					Cost	
							1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						0	46.00
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	65.60	0.00	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						51,168	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35)						4,290	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						55,458	63.00
64.00	Total cost of outside supplier services (from your records)						10,434	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						3,674	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						616	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						4,290	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						616	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						616	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151317

Period:
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	324,372	324,372			1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	148,841		148,841		2.00
4.00	EMPLOYEE BENEFITS	3,521,266	0	0	3,521,266	4.00
5.00	ADMINISTRATIVE & GENERAL	2,963,920	49,306	22,624	337,502	3,373,352
7.00	OPERATION OF PLANT	1,185,606	31,226	14,329	115,283	1,346,444
8.00	LAUNDRY & LINEN SERVICE	125,157	4,206	1,930	0	131,293
9.00	HOUSEKEEPING	377,205	3,097	1,421	93,575	475,298
10.00	DIETARY	105,581	19,093	8,761	15,764	149,199
11.00	CAFETERIA	479,956	11,649	5,345	108,850	605,800
13.00	NURSING ADMINISTRATION	585,840	2,919	1,339	164,771	754,869
14.00	CENTRAL SERVICES & SUPPLY	7,136	4,416	2,026	0	13,578
15.00	PHARMACY	683,339	5,047	2,316	193,975	884,677
16.00	MEDICAL RECORDS & LIBRARY	243,414	6,424	2,948	65,042	317,828
17.00	SOCIAL SERVICE	105,819	1,574	722	32,818	140,933
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,527,445	57,781	26,515	757,770	3,369,511
31.00	INTENSIVE CARE UNIT	774,385	16,690	7,658	230,911	1,029,644
43.00	NURSERY	28,150	3,250	1,491	8,505	41,396
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	477,896	27,632	12,679	110,752	628,959
52.00	DELIVERY ROOM & LABOR ROOM	31,309	13,281	6,094	9,031	59,715
53.00	ANESTHESIOLOGY	31,367	0	0	0	31,367
54.00	RADIOLOGY-DIAGNOSTIC	1,711,527	19,603	8,995	264,997	2,005,122
60.00	LABORATORY	2,271,051	12,312	5,650	243,884	2,532,897
65.00	RESPIRATORY THERAPY	488,552	2,912	1,336	141,379	634,179
66.00	PHYSICAL THERAPY	271,259	5,232	2,401	78,939	357,831
67.00	OCCUPATIONAL THERAPY	92,920	5,232	2,401	0	100,553
68.00	SPEECH PATHOLOGY	10,434	1,281	588	0	12,303
69.00	ELECTROCARDIOLOGY	105,188	2,511	1,152	8,773	117,624
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	272,645	0	0	0	272,645
72.00	IMPL. DEV. CHARGED TO PATIENT	8,323	0	0	0	8,323
73.00	DRUGS CHARGED TO PATIENTS	1,333,888	0	0	0	1,333,888
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	846,730	10,611	4,869	111,414	973,624
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	22,140,521	317,285	145,590	3,093,935	21,702,852
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,230	564	0	1,794
192.00	PHYSICIANS' PRIVATE OFFICES	0	5,857	2,687	0	8,544
194.00	FOUNDATION/ MOBS	504,012	0	0	427,331	931,343
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	22,644,533	324,372	148,841	3,521,266	22,644,533

COST ALLOCATION - GENERAL SERVICE COSTS

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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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	3,373,352					5.00
7.00	OPERATION OF PLANT	235,690	1,582,134				7.00
8.00	LAUNDRY & LINEN SERVICE	22,982	27,290	181,565			8.00
9.00	HOUSEKEEPING	83,199	20,096	12,940	591,533		9.00
10.00	DIETARY	26,117	123,881	6,638	0	305,835	10.00
11.00	CAFETERIA	106,043	75,586	0	0	267,146	11.00
13.00	NURSING ADMINISTRATION	132,137	18,938	0	43,910	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	2,377	28,655	0	4,705	0	14.00
15.00	PHARMACY	154,859	32,748	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	55,635	41,680	0	6,273	0	16.00
17.00	SOCIAL SERVICE	24,670	10,213	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	589,826	374,913	70,853	241,192	33,319	30.00
31.00	INTENSIVE CARE UNIT	180,235	108,293	12,541	46,419	5,370	31.00
43.00	NURSERY	7,246	21,088	0	5,018	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	110,097	179,289	17,994	63,356	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	10,453	86,171	0	6,273	0	52.00
53.00	ANESTHESIOLOGY	5,491	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	350,989	127,189	14,198	22,582	0	54.00
60.00	LABORATORY	443,373	79,886	0	24,151	0	60.00
65.00	RESPIRATORY THERAPY	111,010	18,896	0	14,428	0	65.00
66.00	PHYSICAL THERAPY	62,637	33,947	11,461	6,900	0	66.00
67.00	OCCUPATIONAL THERAPY	17,601	33,947	0	0	0	67.00
68.00	SPEECH PATHOLOGY	2,154	8,311	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	20,590	16,291	0	3,764	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	47,725	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	1,457	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	233,492	0	0	1,255	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	170,429	68,846	28,019	79,352	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,208,514	1,536,154	174,644	569,578	305,835	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	314	7,980	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	1,496	38,000	6,921	21,955	0	192.00
194.00	FOUNDATION/ MOBS	163,028	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	3,373,352	1,582,134	181,565	591,533	305,835	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	1,054,575					11.00
13.00	NURSING ADMINISTRATION	48,628	998,482				13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	49,315			14.00
15.00	PHARMACY	39,193	0	0	1,111,477		15.00
16.00	MEDICAL RECORDS & LIBRARY	37,741	0	0	0	459,157	16.00
17.00	SOCIAL SERVICE	14,516	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	362,169	666,991	0	0	127,172	30.00
31.00	INTENSIVE CARE UNIT	81,289	149,705	0	0	14,725	31.00
43.00	NURSERY	7,258	13,367	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	46,451	85,546	0	0	1,339	50.00
52.00	DELIVERY ROOM & LABOR ROOM	3,629	0	0	0	6,693	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	117,578	0	0	0	151,267	54.00
60.00	LABORATORY	128,465	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	61,692	0	0	0	2,677	65.00
66.00	PHYSICAL THERAPY	36,290	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	7,258	0	0	0	153,945	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	47,868	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	1,447	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	19,596	0	0	1,111,477	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	42,822	82,873	0	0	1,339	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,054,575	998,482	49,315	1,111,477	459,157	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	FOUNDATION/ MOBS	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,054,575	998,482	49,315	1,111,477	459,157	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
7.00	OPERATION OF PLANT					7.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION					13.00
14.00	CENTRAL SERVICES & SUPPLY					14.00
15.00	PHARMACY					15.00
16.00	MEDICAL RECORDS & LIBRARY					16.00
17.00	SOCIAL SERVICE	190,332				17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	183,149	6,019,095	0	6,019,095	30.00
31.00	INTENSIVE CARE UNIT	0	1,628,221	0	1,628,221	31.00
43.00	NURSERY	0	95,373	0	95,373	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	5,387	1,138,418	0	1,138,418	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	172,934	0	172,934	52.00
53.00	ANESTHESIOLOGY	0	36,858	0	36,858	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	2,788,925	0	2,788,925	54.00
60.00	LABORATORY	0	3,208,772	0	3,208,772	60.00
65.00	RESPIRATORY THERAPY	0	842,882	0	842,882	65.00
66.00	PHYSICAL THERAPY	0	509,066	0	509,066	66.00
67.00	OCCUPATIONAL THERAPY	0	152,101	0	152,101	67.00
68.00	SPEECH PATHOLOGY	0	22,768	0	22,768	68.00
69.00	ELECTROCARDIOLOGY	0	319,472	0	319,472	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	368,238	0	368,238	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	11,227	0	11,227	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	2,699,708	0	2,699,708	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	1,796	1,449,100	0	1,449,100	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	190,332	21,463,158	0	21,463,158	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,088	0	10,088	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	76,916	0	76,916	192.00
194.00	FOUNDATION/ MOBS	0	1,094,371	0	1,094,371	194.00
200.00	Cross Foot Adjustments		0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	190,332	22,644,533	0	22,644,533	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151317

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	0	0	0	0	4.00
5.00	ADMINISTRATIVE & GENERAL	0	49,306	22,624	71,930	5.00
7.00	OPERATION OF PLANT	0	31,226	14,329	45,555	7.00
8.00	LAUNDRY & LINEN SERVICE	0	4,206	1,930	6,136	8.00
9.00	HOUSEKEEPING	0	3,097	1,421	4,518	9.00
10.00	DIETARY	0	19,093	8,761	27,854	10.00
11.00	CAFETERIA	0	11,649	5,345	16,994	11.00
13.00	NURSING ADMINISTRATION	0	2,919	1,339	4,258	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	4,416	2,026	6,442	14.00
15.00	PHARMACY	0	5,047	2,316	7,363	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	6,424	2,948	9,372	16.00
17.00	SOCIAL SERVICE	0	1,574	722	2,296	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	57,781	26,515	84,296	30.00
31.00	INTENSIVE CARE UNIT	0	16,690	7,658	24,348	31.00
43.00	NURSERY	0	3,250	1,491	4,741	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	27,632	12,679	40,311	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	13,281	6,094	19,375	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	19,603	8,995	28,598	54.00
60.00	LABORATORY	0	12,312	5,650	17,962	60.00
65.00	RESPIRATORY THERAPY	0	2,912	1,336	4,248	65.00
66.00	PHYSICAL THERAPY	0	5,232	2,401	7,633	66.00
67.00	OCCUPATIONAL THERAPY	0	5,232	2,401	7,633	67.00
68.00	SPEECH PATHOLOGY	0	1,281	588	1,869	68.00
69.00	ELECTROCARDIOLOGY	0	2,511	1,152	3,663	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	0	10,611	4,869	15,480	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	317,285	145,590	462,875	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,230	564	1,794	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	5,857	2,687	8,544	192.00
194.00	FOUNDATION/ MOBS	0	0	0	0	194.00
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)	0	324,372	148,841	473,213	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151317

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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 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL	71,930					5.00
7.00 OPERATION OF PLANT	5,026	50,581				7.00
8.00 LAUNDRY & LINEN SERVICE	490	872	7,498			8.00
9.00 HOUSEKEEPING	1,774	642	534	7,468		9.00
10.00 DIETARY	557	3,961	274	0	32,646	10.00
11.00 CAFETERIA	2,261	2,416	0	0	28,516	11.00
13.00 NURSING ADMINISTRATION	2,818	605	0	554	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	51	916	0	59	0	14.00
15.00 PHARMACY	3,302	1,047	0	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	1,186	1,333	0	79	0	16.00
17.00 SOCIAL SERVICE	526	327	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	12,570	11,987	2,927	3,046	3,557	30.00
31.00 INTENSIVE CARE UNIT	3,844	3,462	518	586	573	31.00
43.00 NURSERY	155	674	0	63	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	2,348	5,732	743	800	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	223	2,755	0	79	0	52.00
53.00 ANESTHESIOLOGY	117	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	7,485	4,066	586	285	0	54.00
60.00 LABORATORY	9,455	2,554	0	305	0	60.00
65.00 RESPIRATORY THERAPY	2,367	604	0	182	0	65.00
66.00 PHYSICAL THERAPY	1,336	1,085	473	87	0	66.00
67.00 OCCUPATIONAL THERAPY	375	1,085	0	0	0	67.00
68.00 SPEECH PATHOLOGY	46	266	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	439	521	0	48	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,018	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	31	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	4,979	0	0	16	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	3,635	2,201	1,157	1,002	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	68,414	49,111	7,212	7,191	32,646	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	7	255	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	32	1,215	286	277	0	192.00
194.00 FOUNDATION/ MOBS	3,477	0	0	0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	71,930	50,581	7,498	7,468	32,646	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151317

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA	50,187					11.00
13.00 NURSING ADMINISTRATION	2,314	10,549				13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	7,468			14.00
15.00 PHARMACY	1,865	0	0	13,577		15.00
16.00 MEDICAL RECORDS & LIBRARY	1,796	0	0	0	13,766	16.00
17.00 SOCIAL SERVICE	691	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	17,234	7,046	0	0	3,813	30.00
31.00 INTENSIVE CARE UNIT	3,869	1,582	0	0	441	31.00
43.00 NURSERY	345	141	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	2,211	904	0	0	40	50.00
52.00 DELIVERY ROOM & LABOR ROOM	173	0	0	0	201	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	5,596	0	0	0	4,535	54.00
60.00 LABORATORY	6,114	0	0	0	0	60.00
65.00 RESPIRATORY THERAPY	2,936	0	0	0	80	65.00
66.00 PHYSICAL THERAPY	1,727	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	345	0	0	0	4,616	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	7,249	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	219	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	933	0	0	13,577	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	2,038	876	0	0	40	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	50,187	10,549	7,468	13,577	13,766	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 FOUNDATION/ MOBS	0	0	0	0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	50,187	10,549	7,468	13,577	13,766	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151317

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 EMPLOYEE BENEFITS					4.00
5.00 ADMINISTRATIVE & GENERAL					5.00
7.00 OPERATION OF PLANT					7.00
8.00 LAUNDRY & LINEN SERVICE					8.00
9.00 HOUSEKEEPING					9.00
10.00 DIETARY					10.00
11.00 CAFETERIA					11.00
13.00 NURSING ADMINISTRATION					13.00
14.00 CENTRAL SERVICES & SUPPLY					14.00
15.00 PHARMACY					15.00
16.00 MEDICAL RECORDS & LIBRARY					16.00
17.00 SOCIAL SERVICE	3,840				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS	3,695	150,171	0	150,171	30.00
31.00 INTENSIVE CARE UNIT	0	39,223	0	39,223	31.00
43.00 NURSERY	0	6,119	0	6,119	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	109	53,198	0	53,198	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	22,806	0	22,806	52.00
53.00 ANESTHESIOLOGY	0	117	0	117	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	51,151	0	51,151	54.00
60.00 LABORATORY	0	36,390	0	36,390	60.00
65.00 RESPIRATORY THERAPY	0	10,417	0	10,417	65.00
66.00 PHYSICAL THERAPY	0	12,341	0	12,341	66.00
67.00 OCCUPATIONAL THERAPY	0	9,093	0	9,093	67.00
68.00 SPEECH PATHOLOGY	0	2,181	0	2,181	68.00
69.00 ELECTROCARDIOLOGY	0	9,632	0	9,632	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,267	0	8,267	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	250	0	250	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	19,505	0	19,505	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00 EMERGENCY	36	26,465	0	26,465	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
SPECIAL PURPOSE COST CENTERS					
118.00 SUBTOTALS (SUM OF LINES 1-117)	3,840	457,326	0	457,326	118.00
NONREIMBURSABLE COST CENTERS					
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,056	0	2,056	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	10,354	0	10,354	192.00
194.00 FOUNDATION/ MOBS	0	3,477	0	3,477	194.00
200.00 Cross Foot Adjustments		0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	3,840	473,213	0	473,213	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151317

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	50,900					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		50,900				2.00
4.00	EMPLOYEE BENEFITS	0	0	11,353,898			4.00
5.00	ADMINISTRATIVE & GENERAL	7,737	7,737	1,088,236	-3,373,352	19,271,181	5.00
7.00	OPERATION OF PLANT	4,900	4,900	371,717	0	1,346,444	7.00
8.00	LAUNDRY & LINEN SERVICE	660	660	0	0	131,293	8.00
9.00	HOUSEKEEPING	486	486	301,720	0	475,298	9.00
10.00	DIETARY	2,996	2,996	50,829	0	149,199	10.00
11.00	CAFETERIA	1,828	1,828	350,975	0	605,800	11.00
13.00	NURSING ADMINISTRATION	458	458	531,285	0	754,869	13.00
14.00	CENTRAL SERVICES & SUPPLY	693	693	0	0	13,578	14.00
15.00	PHARMACY	792	792	625,449	0	884,677	15.00
16.00	MEDICAL RECORDS & LIBRARY	1,008	1,008	209,720	0	317,828	16.00
17.00	SOCIAL SERVICE	247	247	105,819	0	140,933	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	9,067	9,067	2,443,328	0	3,369,511	30.00
31.00	INTENSIVE CARE UNIT	2,619	2,619	744,546	0	1,029,644	31.00
43.00	NURSERY	510	510	27,423	0	41,396	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	4,336	4,336	357,108	0	628,959	50.00
52.00	DELIVERY ROOM & LABOR ROOM	2,084	2,084	29,118	0	59,715	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	31,367	53.00
54.00	RADIOLOGY-DIAGNOSTIC	3,076	3,076	854,453	0	2,005,122	54.00
60.00	LABORATORY	1,932	1,932	786,375	0	2,532,897	60.00
65.00	RESPIRATORY THERAPY	457	457	455,860	0	634,179	65.00
66.00	PHYSICAL THERAPY	821	821	254,531	0	357,831	66.00
67.00	OCCUPATIONAL THERAPY	821	821	0	0	100,553	67.00
68.00	SPEECH PATHOLOGY	201	201	0	0	12,303	68.00
69.00	ELECTROCARDIOLOGY	394	394	28,288	0	117,624	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	272,645	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	8,323	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,333,888	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	1,665	1,665	359,240	0	973,624	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	49,788	49,788	9,976,020	-3,373,352	18,329,500	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	193	193	0	0	1,794	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	919	919	0	0	8,544	192.00
194.00	FOUNDATION/ MOBS	0	0	1,377,878	0	931,343	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per wkst. B, Part I)	324,372	148,841	3,521,266		3,373,352	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	6.372731	2.924185	0.310137		0.175046	203.00
204.00	Cost to be allocated (per wkst. B, Part II)			0		71,930	204.00
205.00	Unit cost multiplier (wkst. B, Part II)			0.000000		0.003733	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151317

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
	7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT	38,263					7.00
8.00 LAUNDRY & LINEN SERVICE	660	17,315				8.00
9.00 HOUSEKEEPING	486	1,234	1,886			9.00
10.00 DIETARY	2,996	633	0	92,891		10.00
11.00 CAFETERIA	1,828	0	0	81,140	1,453	11.00
13.00 NURSING ADMINISTRATION	458	0	140	0	67	13.00
14.00 CENTRAL SERVICES & SUPPLY	693	0	15	0	0	14.00
15.00 PHARMACY	792	0	0	0	54	15.00
16.00 MEDICAL RECORDS & LIBRARY	1,008	0	20	0	52	16.00
17.00 SOCIAL SERVICE	247	0	0	0	20	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	9,067	6,757	769	10,120	499	30.00
31.00 INTENSIVE CARE UNIT	2,619	1,196	148	1,631	112	31.00
43.00 NURSERY	510	0	16	0	10	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	4,336	1,716	202	0	64	50.00
52.00 DELIVERY ROOM & LABOR ROOM	2,084	0	20	0	5	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	3,076	1,354	72	0	162	54.00
60.00 LABORATORY	1,932	0	77	0	177	60.00
65.00 RESPIRATORY THERAPY	457	0	46	0	85	65.00
66.00 PHYSICAL THERAPY	821	1,093	22	0	50	66.00
67.00 OCCUPATIONAL THERAPY	821	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	201	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	394	0	12	0	10	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	4	0	27	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	1,665	2,672	253	0	59	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	37,151	16,655	1,816	92,891	1,453	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	193	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	919	660	70	0	0	192.00
194.00 FOUNDATION/ MOBS	0	0	0	0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per wkst. B, Part I)	1,582,134	181,565	591,533	305,835	1,054,575	202.00
203.00 Unit cost multiplier (wkst. B, Part I)	41.348927	10.485995	313.644221	3.292407	725.791466	203.00
204.00 Cost to be allocated (per wkst. B, Part II)	50,581	7,498	7,468	32,646	50,187	204.00
205.00 Unit cost multiplier (wkst. B, Part II)	1.321930	0.433035	3.959703	0.351444	34.540262	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151317

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
	13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA						11.00
13.00 NURSING ADMINISTRATION	747					13.00
14.00 CENTRAL SERVICES & SUPPLY	0	283,739				14.00
15.00 PHARMACY	0	0	100			15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	0	343		16.00
17.00 SOCIAL SERVICE	0	0	0	0	106	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	499	0	0	95	102	30.00
31.00 INTENSIVE CARE UNIT	112	0	0	11	0	31.00
43.00 NURSERY	10	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	64	0	0	1	3	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	5	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	113	0	54.00
60.00 LABORATORY	0	0	0	0	0	60.00
65.00 RESPIRATORY THERAPY	0	0	0	2	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	115	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	275,416	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	8,323	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	100	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	62	0	0	1	1	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	747	283,739	100	343	106	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 FOUNDATION/ MOBS	0	0	0	0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per wkst. B, Part I)	998,482	49,315	1,111,477	459,157	190,332	202.00
203.00 Unit cost multiplier (wkst. B, Part I)	1,336.655957	0.173804	11,114.770000	1,338.650146	1,795.584906	203.00
204.00 Cost to be allocated (per wkst. B, Part II)	10,549	7,468	13,577	13,766	3,840	204.00
205.00 Unit cost multiplier (wkst. B, Part II)	14.121821	0.026320	135.770000	40.134111	36.226415	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151317

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2012 5:55 pm

		Title XVIII		Hospital		Cost	
Cost Center Description	Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Total 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	6,019,095		6,019,095	0	0	30.00
31.00	INTENSIVE CARE UNIT	1,628,221		1,628,221	0	0	31.00
43.00	NURSERY	95,373		95,373	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	1,138,418		1,138,418	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	172,934		172,934	0	0	52.00
53.00	ANESTHESIOLOGY	36,858		36,858	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,788,925		2,788,925	0	0	54.00
60.00	LABORATORY	3,208,772		3,208,772	0	0	60.00
65.00	RESPIRATORY THERAPY	842,882	0	842,882	0	0	65.00
66.00	PHYSICAL THERAPY	509,066	0	509,066	0	0	66.00
67.00	OCCUPATIONAL THERAPY	152,101	0	152,101	0	0	67.00
68.00	SPEECH PATHOLOGY	22,768	0	22,768	0	0	68.00
69.00	ELECTROCARDIOLOGY	319,472		319,472	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	368,238		368,238	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	11,227		11,227	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,699,708		2,699,708	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	1,449,100		1,449,100	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1,246,987		1,246,987	0	0	92.00
200.00	Subtotal (see instructions)	22,710,145	0	22,710,145	0	0	200.00
201.00	Less observation Beds	1,246,987		1,246,987	0	0	201.00
202.00	Total (see instructions)	21,463,158	0	21,463,158	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151317

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2012 5:55 pm

		Title XVIII			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				
	9.00	10.00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,405,655		2,405,655			30.00
31.00	INTENSIVE CARE UNIT	594,145		594,145			31.00
43.00	NURSERY	169,035		169,035			43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	468,839	1,869,611	2,338,450	0.486826	0.000000	50.00
52.00	DELIVERY ROOM & LABOR ROOM	72,881	177,830	250,711	0.689774	0.000000	52.00
53.00	ANESTHESIOLOGY	1,701	0	1,701	21.668430	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	910,675	10,529,201	11,439,876	0.243790	0.000000	54.00
60.00	LABORATORY	1,199,240	9,024,785	10,224,025	0.313846	0.000000	60.00
65.00	RESPIRATORY THERAPY	478,895	145,963	624,858	1.348918	0.000000	65.00
66.00	PHYSICAL THERAPY	76,525	868,801	945,326	0.538508	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	23,364	269,205	292,569	0.519881	0.000000	67.00
68.00	SPEECH PATHOLOGY	20,328	23,862	44,190	0.515230	0.000000	68.00
69.00	ELECTROCARDIOLOGY	336,929	1,253,941	1,590,870	0.200816	0.000000	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,084,134	740,744	1,824,878	0.201788	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	1,312	49,856	51,168	0.219414	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,887,536	4,447,731	6,335,267	0.426140	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	41,438	3,815,966	3,857,404	0.375667	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	882,021	882,021	1.413784	0.000000	92.00
200.00	Subtotal (see instructions)	9,772,632	34,099,517	43,872,149			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	9,772,632	34,099,517	43,872,149			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151317

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2012 5:55 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
31.00	INTENSIVE CARE UNIT				31.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000			50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	ANESTHESIOLOGY	0.000000			53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	LABORATORY	0.000000			60.00
65.00	RESPIRATORY THERAPY	0.000000			65.00
66.00	PHYSICAL THERAPY	0.000000			66.00
67.00	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	SPEECH PATHOLOGY	0.000000			68.00
69.00	ELECTROCARDIOLOGY	0.000000			69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
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: 151317

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2012 5:55 pm

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS		6,019,095	0	0	30.00	
31.00	INTENSIVE CARE UNIT		1,628,221	0	0	31.00	
43.00	NURSERY		95,373	0	0	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM		1,138,418	0	0	50.00	
52.00	DELIVERY ROOM & LABOR ROOM		172,934	0	0	52.00	
53.00	ANESTHESIOLOGY		36,858	0	0	53.00	
54.00	RADIOLOGY-DIAGNOSTIC		2,788,925	0	0	54.00	
60.00	LABORATORY		3,208,772	0	0	60.00	
65.00	RESPIRATORY THERAPY	0	842,882	0	0	65.00	
66.00	PHYSICAL THERAPY	0	509,066	0	0	66.00	
67.00	OCCUPATIONAL THERAPY	0	152,101	0	0	67.00	
68.00	SPEECH PATHOLOGY	0	22,768	0	0	68.00	
69.00	ELECTROCARDIOLOGY		319,472	0	0	69.00	
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		368,238	0	0	71.00	
72.00	IMPL. DEV. CHARGED TO PATIENT		11,227	0	0	72.00	
73.00	DRUGS CHARGED TO PATIENTS		2,699,708	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY		1,449,100	0	0	91.00	
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		1,246,987	0	0	92.00	
200.00	Subtotal (see instructions)	0	22,710,145	0	0	200.00	
201.00	Less Observation Beds		1,246,987	0	0	201.00	
202.00	Total (see instructions)	0	21,463,158	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151317

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2012 5:55 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				
			9.00	10.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,405,655		2,405,655			30.00
31.00	INTENSIVE CARE UNIT	594,145		594,145			31.00
43.00	NURSERY	169,035		169,035			43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	468,839	1,869,611	2,338,450	0.486826	0.000000	50.00
52.00	DELIVERY ROOM & LABOR ROOM	72,881	177,830	250,711	0.689774	0.000000	52.00
53.00	ANESTHESIOLOGY	1,701	0	1,701	21.668430	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	910,675	10,529,201	11,439,876	0.243790	0.000000	54.00
60.00	LABORATORY	1,199,240	9,024,785	10,224,025	0.313846	0.000000	60.00
65.00	RESPIRATORY THERAPY	478,895	145,963	624,858	1.348918	0.000000	65.00
66.00	PHYSICAL THERAPY	76,525	868,801	945,326	0.538508	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	23,364	269,205	292,569	0.519881	0.000000	67.00
68.00	SPEECH PATHOLOGY	20,328	23,862	44,190	0.515230	0.000000	68.00
69.00	ELECTROCARDIOLOGY	336,929	1,253,941	1,590,870	0.200816	0.000000	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,084,134	740,744	1,824,878	0.201788	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	1,312	49,856	51,168	0.219414	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,887,536	4,447,731	6,335,267	0.426140	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	41,438	3,815,966	3,857,404	0.375667	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	882,021	882,021	1.413784	0.000000	92.00
200.00	Subtotal (see instructions)	9,772,632	34,099,517	43,872,149			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	9,772,632	34,099,517	43,872,149			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151317

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2012 5:55 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
31.00	INTENSIVE CARE UNIT				31.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000			50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	ANESTHESIOLOGY	0.000000			53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	LABORATORY	0.000000			60.00
65.00	RESPIRATORY THERAPY	0.000000			65.00
66.00	PHYSICAL THERAPY	0.000000			66.00
67.00	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	SPEECH PATHOLOGY	0.000000			68.00
69.00	ELECTROCARDIOLOGY	0.000000			69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
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: 151317

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

Worksheet D
Part II
Date/Time Prepared:
5/29/2012 5:55 pm

Cost Center Description		Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	53,198	2,338,450	0.022749	186,474	4,242	50.00
52.00	DELIVERY ROOM & LABOR ROOM	22,806	250,711	0.090965	0	0	52.00
53.00	ANESTHESIOLOGY	117	1,701	0.068783	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	51,151	11,439,876	0.004471	652,820	2,919	54.00
60.00	LABORATORY	36,390	10,224,025	0.003559	897,310	3,194	60.00
65.00	RESPIRATORY THERAPY	10,417	624,858	0.016671	278,392	4,641	65.00
66.00	PHYSICAL THERAPY	12,341	945,326	0.013055	47,277	617	66.00
67.00	OCCUPATIONAL THERAPY	9,093	292,569	0.031080	11,708	364	67.00
68.00	SPEECH PATHOLOGY	2,181	44,190	0.049355	16,989	838	68.00
69.00	ELECTROCARDIOLOGY	9,632	1,590,870	0.006055	315,614	1,911	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,267	1,824,878	0.004530	63,927	290	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	250	51,168	0.004886	1,312	6	72.00
73.00	DRUGS CHARGED TO PATIENTS	19,505	6,335,267	0.003079	1,695,711	5,221	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	26,465	3,857,404	0.006861	1,607	11	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	882,021	0.000000	0	0	92.00
200.00	Total (lines 50-199)	261,813	40,703,314		4,169,141	24,254	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151317

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2012 5:55 pm

		Title XVIII			Hospital		Cost	
Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	OPERATING ROOM	0	0	0	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	EMERGENCY	0	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151317

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2012 5:55 pm

Cost Center Description		Title XVIII			Hospital		
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I; col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	2,338,450	0.000000	0.000000	186,474	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	250,711	0.000000	0.000000	0	52.00
53.00	ANESTHESIOLOGY	0	1,701	0.000000	0.000000	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	11,439,876	0.000000	0.000000	652,820	54.00
60.00	LABORATORY	0	10,224,025	0.000000	0.000000	897,310	60.00
65.00	RESPIRATORY THERAPY	0	624,858	0.000000	0.000000	278,392	65.00
66.00	PHYSICAL THERAPY	0	945,326	0.000000	0.000000	47,277	66.00
67.00	OCCUPATIONAL THERAPY	0	292,569	0.000000	0.000000	11,708	67.00
68.00	SPEECH PATHOLOGY	0	44,190	0.000000	0.000000	16,989	68.00
69.00	ELECTROCARDIOLOGY	0	1,590,870	0.000000	0.000000	315,614	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,824,878	0.000000	0.000000	63,927	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	51,168	0.000000	0.000000	1,312	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	6,335,267	0.000000	0.000000	1,695,711	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	0	3,857,404	0.000000	0.000000	1,607	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	882,021	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	40,703,314			4,169,141	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151317

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2012 5:55 pm

		Title XVIII			Hospital		Cost
Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School		
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151317

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2012 5:55 pm

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Cost
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	LABORATORY	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
91.00	EMERGENCY	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151317

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

Worksheet D
Part V
Date/Time Prepared:
5/29/2012 5:55 pm

		Title XVIII		Hospital		Cost	
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges					
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)			
	1.00	2.00	3.00	4.00			
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0.486826	0	760,815	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.689774	0	0	0		52.00
53.00	ANESTHESIOLOGY	21.668430	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.243790	0	4,180,546	0		54.00
60.00	LABORATORY	0.313846	0	4,423,522	0		60.00
65.00	RESPIRATORY THERAPY	1.348918	0	36,294	0		65.00
66.00	PHYSICAL THERAPY	0.538508	0	329,848	0		66.00
67.00	OCCUPATIONAL THERAPY	0.519881	0	108,528	0		67.00
68.00	SPEECH PATHOLOGY	0.515230	0	9,446	0		68.00
69.00	ELECTROCARDIOLOGY	0.200816	0	683,131	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.201788	0	277,168	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.219414	0	40,552	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.426140	0	2,246,809	741		73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	0.375667	0	1,190,373	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.413784	0	304,195	0		92.00
200.00	Subtotal (see instructions)		0	14,591,227	741		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		0	14,591,227	741		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151317	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/29/2012 5:55 pm
Title XVIII		Hospital	Cost

Cost Center Description	Costs			Cost
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)	
	5.00	6.00	7.00	
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	370,385	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	1,019,175	0	54.00
60.00 LABORATORY	0	1,388,305	0	60.00
65.00 RESPIRATORY THERAPY	0	48,958	0	65.00
66.00 PHYSICAL THERAPY	0	177,626	0	66.00
67.00 OCCUPATIONAL THERAPY	0	56,422	0	67.00
68.00 SPEECH PATHOLOGY	0	4,867	0	68.00
69.00 ELECTROCARDIOLOGY	0	137,184	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	55,929	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	8,898	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	957,455	316	73.00
OUTPATIENT SERVICE COST CENTERS				
91.00 EMERGENCY	0	447,184	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	430,066	0	92.00
200.00 Subtotal (see instructions)	0	5,102,454	316	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	5,102,454	316	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151317

Period: From 01/01/2011

Worksheet D

Component CCN: 152317

To 12/31/2011

Part V

Date/Time Prepared: 5/29/2012 5:55 pm

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
	1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0.486826	0	0	0		50.00
52.00 DELIVERY ROOM & LABOR ROOM	0.689774	0	0	0		52.00
53.00 ANESTHESIOLOGY	21.668430	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.243790	0	0	0		54.00
60.00 LABORATORY	0.313846	0	0	0		60.00
65.00 RESPIRATORY THERAPY	1.348918	0	0	0		65.00
66.00 PHYSICAL THERAPY	0.538508	0	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0.519881	0	0	0		67.00
68.00 SPEECH PATHOLOGY	0.515230	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	0.200816	0	0	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.201788	0	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.219414	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.426140	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	0.375667	0	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.413784	0	0	0		92.00
200.00 Subtotal (see instructions)		0	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00 Net Charges (line 200 +/- line 201)		0	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151317

Period: From 01/01/2011

Worksheet D

Component CCN: 15Z317

To 12/31/2011

Part V

Date/Time Prepared: 5/29/2012 5:55 pm

		Title XVIII			Swing Beds - SNF	Cost
Cost Center Description	Costs					
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)			
	5.00	6.00	7.00			
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	ANESTHESIOLOGY	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	LABORATORY	0	0	0		60.00
65.00	RESPIRATORY THERAPY	0	0	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	SPEECH PATHOLOGY	0	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Subtotal (see instructions)	0	0	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151317	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/29/2012 5:55 pm
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Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,521 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,292 2.00
3.00	Private room days (excluding swing-bed and observation bed days)			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			3,292 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			216 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			13 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			1,891 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)			216 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			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			152.53 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)			6,019,095 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)			1,983 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)			372,477 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			5,646,618 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			2,415,217 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			2,415,217 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			2.337934 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)			733.66 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)			5,646,618 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,715.25 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			3,243,538 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			3,243,538 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151317

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

Worksheet D-1

Date/Time Prepared:
5/29/2012 5:55 pm

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)	Cost
42.00 NURSERY (title V & XIX only)		0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT		1,628,221	294	5,538.17	263	1,456,539	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						1,747,157	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						6,447,234	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)						370,494	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)						370,494	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)						727	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,715.25	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						1,246,987	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151317

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

Worksheet D-1
Date/Time Prepared:
5/29/2012 5:55 pm

Cost Center Description	Cost	Title XVIII		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	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	0	0	0.000000	0	0	90.00
91.00 Nursing School cost	0	0	0.000000	0	0	91.00
92.00 Allied health cost	0	0	0.000000	0	0	92.00
93.00 All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151317

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

Worksheet D-1

Date/Time Prepared:
5/29/2012 5:55 pm

Title XIX		Hospital	Cost
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,521	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,292	2.00
3.00	Private room days (excluding swing-bed and observation bed days)	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,292	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	216	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	13	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)	69	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)	177	15.00
16.00	Nursery days (title V or XIX only)	80	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		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)	6,019,095	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)	370,617	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,648,478	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed charges)	2,415,217	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	2,415,217	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	2.338704	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)	733.66	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)	5,648,478	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,715.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	118,392	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)	118,392	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151317

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

Worksheet D-1

Date/Time Prepared:
5/29/2012 5:55 pm

Cost Center Description	Title XIX			Hospital	Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	95,373	177	538.83	80	43,106	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	1,628,221	294	5,538.17	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					306,988	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					468,486	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)					727	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,715.82	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,247,401	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151317

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

Worksheet D-1

Date/Time Prepared:
5/29/2012 5:55 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	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	0	0	0.000000	0	0	90.00
91.00 Nursing School cost	0	0	0.000000	0	0	91.00
92.00 Allied health cost	0	0	0.000000	0	0	92.00
93.00 All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151317

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

Worksheet D-3

Date/Time Prepared:
5/29/2012 5:55 pm

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		1,816,943		30.00
31.00	INTENSIVE CARE UNIT		435,400		31.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.486826	186,474	90,780	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.689774	0	0	52.00
53.00	ANESTHESIOLOGY	21.668430	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.243790	652,820	159,151	54.00
60.00	LABORATORY	0.313846	897,310	281,617	60.00
65.00	RESPIRATORY THERAPY	1.348918	278,392	375,528	65.00
66.00	PHYSICAL THERAPY	0.538508	47,277	25,459	66.00
67.00	OCCUPATIONAL THERAPY	0.519881	11,708	6,087	67.00
68.00	SPEECH PATHOLOGY	0.515230	16,989	8,753	68.00
69.00	ELECTROCARDIOLOGY	0.200816	315,614	63,380	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.201788	63,927	12,900	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.219414	1,312	288	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.426140	1,695,711	722,610	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	EMERGENCY	0.375667	1,607	604	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.413784	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		4,169,141	1,747,157	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		4,169,141		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151317

Period: From 01/01/2011

Worksheet D-3

Component CCN: 152317

To 12/31/2011

Date/Time Prepared: 5/29/2012 5:55 pm

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		1,141		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.486826	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.689774	0	0	52.00
53.00	ANESTHESIOLOGY	21.668430	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.243790	19,353	4,718	54.00
60.00	LABORATORY	0.313846	40,491	12,708	60.00
65.00	RESPIRATORY THERAPY	1.348918	17,273	23,300	65.00
66.00	PHYSICAL THERAPY	0.538508	16,832	9,064	66.00
67.00	OCCUPATIONAL THERAPY	0.519881	8,901	4,627	67.00
68.00	SPEECH PATHOLOGY	0.515230	1,295	667	68.00
69.00	ELECTROCARDIOLOGY	0.200816	11,003	2,210	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.201788	64,198	12,954	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.219414	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.426140	64,306	27,403	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	EMERGENCY	0.375667	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.413784	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		243,652	97,651	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		243,652		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151317

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

Worksheet D-3

Date/Time Prepared:
5/29/2012 5:55 pm

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		207,178		30.00
31.00	INTENSIVE CARE UNIT		28,135		31.00
43.00	NURSERY		89,770		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.486826	167,830	81,704	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.689774	53,256	36,735	52.00
53.00	ANESTHESIOLOGY	21.668430	1,701	36,858	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.243790	53,533	13,051	54.00
60.00	LABORATORY	0.313846	145,326	45,610	60.00
65.00	RESPIRATORY THERAPY	1.348918	13,873	18,714	65.00
66.00	PHYSICAL THERAPY	0.538508	1,472	793	66.00
67.00	OCCUPATIONAL THERAPY	0.519881	299	155	67.00
68.00	SPEECH PATHOLOGY	0.515230	1,181	608	68.00
69.00	ELECTROCARDIOLOGY	0.200816	10,312	2,071	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.201788	44,838	9,048	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.219414	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.426140	127,519	54,341	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	EMERGENCY	0.375667	19,431	7,300	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.413784	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		640,571	306,988	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)		640,571		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 151317

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

Worksheet E
Part B
Date/Time Prepared:
5/29/2012 5:55 pm

		Title XVIII	Hospital	Cost	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			5,102,770	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0	2.00
3.00	PPS payments			0	3.00
4.00	Outlier payment (see instructions)			0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000	5.00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from worksheet D, Part IV, column 13, line 200			0	9.00
10.00	Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5,102,770	11.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)			0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
Customary charges					
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)			0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
18.00	Total customary charges (see instructions)			0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			5,153,798	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
25.00	Deductibles and coinsurance (for CAH, see instructions)			29,002	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,068,149	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			3,056,647	27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 50)			0	28.00
29.00	ESRD direct medical education costs (from worksheet E-4, line 36)			0	29.00
30.00	Subtotal (sum of lines 27 through 29)			3,056,647	30.00
31.00	Primary payer payments			211	31.00
32.00	Subtotal (line 30 minus line 31)			3,056,436	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)					
33.00	Composite rate ESRD (from worksheet I-5, line 11)			0	33.00
34.00	Allowable bad debts (see instructions)			333,568	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			333,568	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			333,568	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			3,390,004	37.00
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			3,390,004	40.00
41.00	Interim payments			3,486,597	41.00
42.00	Tentative settlement (for contractors use only)			0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)			-96,593	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			121,651	44.00
TO BE COMPLETED BY CONTRACTOR					
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money			0.00	92.00
93.00	Time value of Money (see instructions)			0	93.00
94.00	Total (sum of lines 91 and 93)			0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 151317

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

Worksheet E
Part B
Date/Time Prepared:
5/29/2012 5:55 pm

		Title XVIII	Hospital	Cost	Overrides
					1.00
WORKSHEET OVERRIDE VALUES					
112.00	Override of Ancillary service charges (line 12)			0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151317

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2012 5:55 pm

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,589,426		3,426,768	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	08/31/2011	239,585	08/31/2011	70,423	3.01
3.02		11/01/2011	170,338		0	3.02
3.03		08/31/2011	23,975		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0	08/31/2011	7,907	3.50
3.51			0	11/01/2011	2,687	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		433,898		59,829	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		6,023,324		3,486,597	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		131,620		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		96,593	6.02
7.00	Total Medicare program liability (see instructions)		6,154,944		3,390,004	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151317

Period:

Worksheet E-1

Component CCN: 152317

From 01/01/2011
To 12/31/2011

Part I
Date/Time Prepared:
5/29/2012 5:55 pm

		Title XVIII		Swing Beds - SNF		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		425,428		0	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	08/31/2011	8,045		0	3.01	
3.02		11/01/2011	9,913		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		17,958		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		443,386		0	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		17,130		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		460,516		0	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 151317

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

Worksheet E-1
Part II
Date/Time Prepared:
5/29/2012 5:55 pm

		Title XVIII	Hospital	Cost	
				1.00	
DATA COLLECTION NEEDED FOR THE HIT CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from wkst S-3, Part I column 15 line 14			868	1.00
2.00	Medicare days from wkst S-3, Part I, column 6 sum of lines 1, 8-12			2,154	2.00
3.00	Medicare HMO days from wkst S-3, Part I, column 6. line 2			0	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			2,859	4.00
5.00	Total hospital charges from wkst C, Part I, column 8 line 200			43,872,149	5.00
6.00	Total hospital charity care charges from wkst S-10, column 3 line 20			1,068,220	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology worksheet S-2, Part I line 168			136,932	7.00
8.00	Calculation of the HIT incentive payment (see instructions)			133,142	8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH					
30.00	Initial/interim HIT payment(s)			0	30.00
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 minus line 30, plus or minus line 31)			133,142	32.00
				Overrides	
				1.00	
CONTRACTOR OVERRIDES					
108.00	Override of HIT payment				108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151317

Period: From 01/01/2011

Worksheet E-2

Component CCN: 152317

To 12/31/2011

Date/Time Prepared: 5/29/2012 5:55 pm

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		374,199	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from wkst. D-3, column 3, line 200 for Part A, and sum of wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)		98,628	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		216	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		472,827	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		472,827	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		472,827	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		12,311	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		460,516	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
17.00	Reimbursable bad debts (see instructions)		0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)		460,516	0	19.00
20.00	Interim payments		443,386	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)		17,130	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		15,365	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151317	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part V Date/Time Prepared: 5/29/2012 5:55 pm
		Title XVIII	Hospital	Cost
				1.00
PART V -- CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHS)				
1.00	Inpatient services		6,447,234	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 thru 3)		6,447,234	4.00
5.00	Primary payer payments		6,483	5.00
6.00	Total cost (line 4 less line 5) . For CAH (see instructions)		6,505,223	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		6,505,223	19.00
20.00	Deductibles (exclude professional component)		431,745	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		6,073,478	22.00
23.00	Coinsurance		2,547	23.00
24.00	Subtotal (line 22 minus line 23)		6,070,931	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		84,013	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		84,013	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		84,013	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26)		6,154,944	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		6,154,944	30.00
31.00	Interim payments		6,023,324	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)		131,620	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		209,163	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151317	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2012 5:55 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		468,486	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)		468,486	4.00
5.00	Inpatient primary payer payments		0	5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		468,486	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		325,083	8.00
9.00	Ancillary service charges		640,571	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)		965,654	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)		965,654	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		497,168	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		468,486	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 V or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX enter the sum of lines 27 and 21.		468,486	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		468,486	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)		468,486	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		468,486	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)		468,486	40.00
41.00	Interim payments		468,486	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: 151317

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

Worksheet G

Date/Time Prepared:
5/29/2012 5:55 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	3,475,223	0	0	0	1.00
2.00	Temporary investments	2,156,512	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	14,641,014	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	285,576	0	0	0	7.00
8.00	Prepaid expenses	83,456	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	6,832,850	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	27,474,631	0	0	0	11.00
FIXED ASSETS						
12.00	Land	759,198	0	0	0	12.00
13.00	Land improvements	425,781	0	0	0	13.00
14.00	Accumulated depreciation	-384,900	0	0	0	14.00
15.00	Buildings	7,255,971	0	0	0	15.00
16.00	Accumulated depreciation	-5,722,535	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	1,059,033	0	0	0	19.00
20.00	Accumulated depreciation	-804,496	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	3,296,254	0	0	0	23.00
24.00	Accumulated depreciation	-2,806,394	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)	3,077,912	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	48,137	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	48,137	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	30,600,680	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	343,692	0	0	0	37.00
38.00	Salaries, wages, and fees payable	885,182	0	0	0	38.00
39.00	Payroll taxes payable	182,175	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	3,205,851	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,616,900	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	4,616,900	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	25,983,780				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	25,983,780	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	30,600,680	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151317

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

Worksheet G-1

Date/Time Prepared:
5/29/2012 5:55 pm

	General Fund		Special Purpose Fund			
	1.00	2.00	3.00	4.00		
1.00 Fund balances at beginning of period		23,831,862			0	1.00
2.00 Net income (loss) (from wkst. G-3, line 29)		2,151,914				2.00
3.00 Total (sum of line 1 and line 2)		25,983,776			0	3.00
4.00 Additions (credit adjustments) (specify)	4			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)		4			0	10.00
11.00 Subtotal (line 3 plus line 10)		25,983,780			0	11.00
12.00 Deductions (debit adjustments) (specify)	0			0		12.00
13.00	0			0		13.00
14.00	0			0		14.00
15.00	0			0		15.00
16.00	0			0		16.00
17.00	0			0		17.00
18.00 Total deductions (sum of lines 12-17)		0			0	18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		25,983,780			0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151317

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

Worksheet G-1

Date/Time Prepared:
5/29/2012 5:55 pm

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151317

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

Worksheet G-2 Parts

Date/Time Prepared:
5/29/2012 5:55 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,415,217		2,415,217	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				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,415,217		2,415,217	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	594,145		594,145	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)	594,145		594,145	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,009,362		3,009,362	17.00
18.00	Ancillary services	6,481,170	38,103,675	44,584,845	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	9,490,532	38,103,675	47,594,207	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		23,727,533		29.00
30.00	BAD DEBT	2,744,812			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)		2,744,812		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)		26,472,345		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151317

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

Worksheet G-3

Date/Time Prepared:
5/29/2012 5:55 pm

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	47,594,207	1.00
2.00	Less contractual allowances and discounts on patients' accounts	20,438,016	2.00
3.00	Net patient revenues (line 1 minus line 2)	27,156,191	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	26,472,345	4.00
5.00	Net income from service to patients (line 3 minus line 4)	683,846	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	735	6.00
7.00	Income from investments	27,133	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	249,067	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	10,241	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	19,885	22.00
23.00	Governmental appropriations	0	23.00
24.00	GRANTS	49,293	24.00
24.01	MISC INCOME	27,834	24.01
24.02	DSH PAYMENT	1,081,758	24.02
24.03	CPR TRAINING	1,943	24.03
24.04	LEASE PAYMENTS RECEIVED	179	24.04
25.00	Total other income (sum of lines 6-24)	1,468,068	25.00
26.00	Total (line 5 plus line 25)	2,151,914	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,151,914	29.00