

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151334	Period: From 01/01/2011 To 12/31/2011	Worksheet S Parts I-III Date/Time Prepared: 5/17/2012 2:02 pm
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**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/17/2012 Time: 2:02 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 SCOTT MEMORIAL HOSPITAL for the cost reporting period beginning 01/01/2011 and ending 12/31/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

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

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	652,101	-100,468	0	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	0	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	652,101	-100,468	0	0	200.00

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 151334

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

Worksheet S Parts I-III Date/Time Prepared: 5/17/2012 2:02 pm

**PART I - COST REPORT STATUS**

Provider use only

1.  Electronically filed cost report Date: 5/17/2012 Time: 2:02 pm

2.  Manually submitted cost report

3.  If this is an amended report enter the number of times the provider resubmitted this cost report

4.  Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5.  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.  Initial Report for this Provider CCN

9.  Final Report for this Provider CCN

10. NPR Date: 11. Contractor's Vendor Code: 04

12.  If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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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 SCOTT MEMORIAL 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: 5/17/2012 Time: 2:02 pm  
4yHqcLNARZb8qbAOZumT8I kxNF35EO  
HEJdn0OZYnbW4i WwvyC34eywMM7Efj  
S2u: 0wSRCGOPSutV

PI: Date: 5/17/2012 Time: 2:02 pm  
Hh5ugKM. 7xgt7dRCC8dpQGi eUzDrqO  
AVkr00e3Mi CUdu9k42LfAj ymaEvnbv  
jedXGAnShE0Wvdi

(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			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	652,101	-100,468	0	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	0	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	652,101	-100,468	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151334		Period: From 01/01/2011 To 12/31/2011		Worksheet S-2 Part I Date/Time Prepared: 5/17/2012 1:59 pm				
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IN		4.00 Zip Code: 47170- County: SCOTT				
1.00 Street: 1451 NORTH GARDNER		2.00 City: SCOTTSBURG								
Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
3.00 Hospital and Hospital-Based Component Identification:										
3.00	Hospital	SCOTT MEMORIAL HOSPITAL	151334	99915	1	07/01/1966	N	O	T	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF						N	N	N	7.00
8.00	Swing Beds - NF						N	N	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						N	N	N	15.00
16.00	Hospital-Based Health Clinic - FQHC						N	N	N	16.00
17.00	Hospital-Based (CMHC) 1									17.00
17.10	Hospital-Based (CORF) 1						N	N	N	17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00
					From:		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		
					Beginning:	Ending:				
					1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscriber line 36 for number of periods in excess of one and enter subsequent dates.							36.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151334	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/17/2012 1:59 pm		
		Beginning:	Ending:			
		1.00	2.00			
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V	XVIII	XIX		
		1.00	2.00	3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	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	
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00	61.00	
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01	
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
<b>Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.</b>						
64.00	If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151334

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

Worksheet S-2  
Part I  
Date/Time Prepared:  
5/17/2012 1:59 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151334	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/17/2012 1:59 pm	
			1.00	2.00	3.00
<b>Inpatient Rehabilitation Facility PPS</b>					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.		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		
<b>Long Term Care Hospital PPS</b>					
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.			N	80.00
<b>TEFRA Providers</b>					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(i)? Enter "Y" for yes and "N" for no.			N	86.00
			V	XIX	
			1.00	2.00	
<b>Title V or XIX Inpatient Services</b>					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	97.00
<b>Rural Providers</b>					
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
			1.00	2.00	3.00
					Respiratory
					4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		Y	N	109.00
			1.00		2.00
<b>Miscellaneous Cost Reporting Information</b>					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.		N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			0	118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.			0	0
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
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
<b>Transplant Center Information</b>					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 151334		Period: From 01/01/2011 To 12/31/2011		Worksheet S-2 Part I Date/Time Prepared: 5/17/2012 1:59 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)						N		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:						142.00	
143.00	City:	State:		Zip Code:				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						Y	Y	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	161.00
161.10	CORF							N	161.10
							1.00		
Multi campus									
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N		165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5							0.00	166.00
							1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N		167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								0168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151334	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part II Date/Time Prepared: 5/17/2012 1:59 pm
		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
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	Type	Date
		1.00	2.00	3.00
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	Legal Oper.	
		1.00	2.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		
		Description	Y/N	Date
		0	1.00	2.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/03/2012	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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 151334

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
5/17/2012 1:59 pm

		Part B		
		Y/N	Date	
PS&R Data		3.00	4.00	
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/03/2012	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151334

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/17/2012 1:59 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	21	7,665	78,816.00		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)		21	7,665	78,816.00		7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	10,008.00		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	88,824.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0			17.00
18.00 SUBPROVIDER	42.00	0	0			18.00
19.00 SKILLED NURSING FACILITY						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
25.10 CMHC - CORF	99.10					25.10
26.00 RURAL HEALTH CLINIC	88.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00					26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days						28.00
28.02 SUBPROVIDER - IRF	41.00					28.02
28.03 SUBPROVIDER	42.00					28.03
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151334

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/17/2012 1:59 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	1,842	664	3,284		1.00
2.00 HMO		195	0			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,842	664	3,284		7.00
8.00 INTENSIVE CARE UNIT	0	271	49	417		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		300	410		13.00
14.00 Total (see instructions)	0	2,113	1,013	4,111		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0		17.00
18.00 SUBPROVIDER	0	0	0	0		18.00
19.00 SKILLED NURSING FACILITY						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
25.10 CMHC - CORF	0	0	0	0		25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0		26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	594		28.00
28.02 SUBPROVIDER - IRF				0		28.02
28.03 SUBPROVIDER				0		28.03
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				0		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			0	0		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151334

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/17/2012 1:59 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	543	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	190.79	0.00	0	543	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0.00	0.00	0	0	17.00
18.00 SUBPROVIDER	0.00	0.00	0.00	0	0	18.00
19.00 SKILLED NURSING FACILITY						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
25.10 CMHC - CORF	0.00	0.00	0.00			25.10
26.00 RURAL HEALTH CLINIC	0.00	0.00	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00 Total (sum of lines 14-26)	0.00	190.79	0.00			27.00
28.00 Observation Bed Days						28.00
28.02 SUBPROVIDER - IRF						28.02
28.03 SUBPROVIDER						28.03
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151334

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/17/2012 1:59 pm

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	241	1,223		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)	241	1,223		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF	0	0		17.00
18.00 SUBPROVIDER	0	0		18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
25.10 CMHC - CORF				25.10
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
28.02 SUBPROVIDER - IRF				28.02
28.03 SUBPROVIDER				28.03
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 151334	Period: From 01/01/2011 To 12/31/2011	Worksheet S-10 Date/Time Prepared: 5/17/2012 1:59 pm
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			1.00	
<b>Uncompensated and indigent care cost computation</b>				
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)		0.353509	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		1,823,757	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		1,351,627	5.00
6.00	Medicaid charges		12,689,965	6.00
7.00	Medicaid cost (line 1 times line 6)		4,486,017	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)		1,310,633	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)		1,310,633	19.00
			1.00	
			2.00	
			3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	0	0	0
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	0	0	0
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	0	0	0
			1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		7,021,467	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		625,391	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		6,396,076	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		2,261,070	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		2,261,070	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,571,703	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151334

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

Worksheet A  
Date/Time Prepared:  
5/17/2012 1:59 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 NEW CAP REL COSTS-BLDG & FIXT		0	0	933,897	933,897	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		2,259,500	2,259,500	-933,897	1,325,603	2.00
4.00 EMPLOYEE BENEFITS	67,455	2,585,963	2,653,418	0	2,653,418	4.00
5.00 ADMINISTRATIVE & GENERAL	1,159,731	1,388,593	2,548,324	-70,634	2,477,690	5.00
7.00 OPERATION OF PLANT	229,501	696,425	925,926	0	925,926	7.00
9.00 HOUSEKEEPING	181,291	215,339	396,630	0	396,630	9.00
10.00 DIETARY	191,875	305,286	497,161	-333,009	164,152	10.00
11.00 CAFETERIA	0	0	0	333,009	333,009	11.00
13.00 NURSING ADMINISTRATION	349,678	726	350,404	0	350,404	13.00
15.00 PHARMACY	0	0	0	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	278,973	54,420	333,393	0	333,393	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	1,481,546	156,719	1,638,265	-161,761	1,476,504	30.00
31.00 INTENSIVE CARE UNIT	280,762	2,555	283,317	0	283,317	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	0	0	0	140,550	140,550	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	457,507	678,804	1,136,311	-387,018	749,293	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	21,211	21,211	52.00
54.00 RADIOLOGY-DIAGNOSTIC	669,107	1,409,098	2,078,205	-82,444	1,995,761	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	515,419	825,918	1,341,337	0	1,341,337	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	103,632	103,632	0	103,632	63.00
65.00 RESPIRATORY THERAPY	448,562	74,066	522,628	-168,103	354,525	65.00
66.00 PHYSICAL THERAPY	0	507,195	507,195	-788	506,407	66.00
69.00 ELECTROCARDIOLOGY	0	0	0	168,103	168,103	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	71,307	226,170	297,477	222,722	520,199	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	165,559	165,559	72.00
73.00 DRUGS CHARGED TO PATIENTS	152,352	667,575	819,927	82,444	902,371	73.00
76.00 CARDIAC REHAB	52,648	5,936	58,584	-474	58,110	76.00
76.01 SLEEP LAB	0	17,409	17,409	0	17,409	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 EMERGENCY	923,578	266,391	1,189,969	0	1,189,969	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	7,511,292	12,447,720	19,959,012	-70,633	19,888,379	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 PUBLIC RELATIONS	0	0	0	70,633	70,633	192.01
192.02 AZIZ/KASARENENI PHY CLINIC	0	0	0	0	0	192.02
192.03 AQUINO CAMPUS	0	0	0	0	0	192.03
192.04 MEDICAL SPECIALTY CLINIC	0	0	0	0	0	192.04
192.05 MEDICAL OFFICE	0	0	0	0	0	192.05
192.06 AUSTIN-COOKE OFFICE	0	0	0	0	0	192.06
192.07 QUALITY CARE/URGENT CARE	0	0	0	0	0	192.07
192.08 ALFREFAI CAMPUS	0	0	0	0	0	192.08
200.00 TOTAL (SUM OF LINES 118-199)	7,511,292	12,447,720	19,959,012	0	19,959,012	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151334

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

Worksheet A  
Date/Time Prepared:  
5/17/2012 1:59 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	933,897	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,325,603	2.00
4.00	EMPLOYEE BENEFITS	0	2,653,418	4.00
5.00	ADMINISTRATIVE & GENERAL	-124,464	2,353,226	5.00
7.00	OPERATION OF PLANT	0	925,926	7.00
9.00	HOUSEKEEPING	0	396,630	9.00
10.00	DIETARY	0	164,152	10.00
11.00	CAFETERIA	-85,470	247,539	11.00
13.00	NURSING ADMINISTRATION	0	350,404	13.00
15.00	PHARMACY	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	-9,792	323,601	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	0	1,476,504	30.00
31.00	INTENSIVE CARE UNIT	0	283,317	31.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	140,550	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	-24,000	725,293	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	21,211	52.00
54.00	RADIOLOGY-DIAGNOSTIC	-720,000	1,275,761	54.00
57.00	CT SCAN	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	0	1,341,337	60.00
60.01	BLOOD LABORATORY	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	103,632	63.00
65.00	RESPIRATORY THERAPY	0	354,525	65.00
66.00	PHYSICAL THERAPY	0	506,407	66.00
69.00	ELECTROCARDIOLOGY	0	168,103	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	520,199	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	165,559	72.00
73.00	DRUGS CHARGED TO PATIENTS	-1,816	900,555	73.00
76.00	CARDIAC REHAB	0	58,110	76.00
76.01	SLEEP LAB	0	17,409	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	RURAL HEALTH CLINIC	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	EMERGENCY	0	1,189,969	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	CORF	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
109.00	PANCREAS ACQUISITION	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	110.00
111.00	ISLET ACQUISITION	0	0	111.00
113.00	INTEREST EXPENSE	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-965,542	18,922,837	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	PUBLIC RELATIONS	0	70,633	192.01
192.02	AZIZ/KASARENENI PHY CLINIC	0	0	192.02
192.03	AQUINO CAMPUS	0	0	192.03
192.04	MEDICAL SPECIALTY CLINIC	0	0	192.04
192.05	MEDICAL OFFICE	0	0	192.05
192.06	AUSTIN-COOKE OFFICE	0	0	192.06
192.07	QUALITY CARE/URGENT CARE	0	0	192.07
192.08	ALFREFAI CAMPUS	0	0	192.08
200.00	TOTAL (SUM OF LINES 118-199)	-965,542	18,993,470	200.00

RECLASSIFICATIONS

Provider CCN: 151334

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

Worksheet A-6

Date/Time Prepared:  
5/17/2012 1:59 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - CAFETERIA</b>					
1.00	CAFETERIA	11.00	128,522	204,487	1.00
	TOTALS		128,522	204,487	
<b>B - DEFAULT</b>					
1.00	NURSERY	43.00	129,079	11,471	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	19,480	1,731	2.00
	TOTALS		148,559	13,202	
<b>C - EKG</b>					
1.00	ELECTROCARDIOLOGY	69.00	144,280	23,823	1.00
	TOTALS		144,280	23,823	
<b>D - PUBLIC RELATIONS</b>					
1.00	PUBLIC RELATIONS	192.01	27,612	43,021	1.00
	TOTALS		27,612	43,021	
<b>E - MEDICAL SUPPLIES</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	222,722	1.00
2.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	165,559	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		0	388,281	
<b>F - CHARGEABLE DRUGS</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	82,444	1.00
	TOTALS		0	82,444	
<b>G - DEPRECIATION</b>					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	933,897	1.00
	TOTALS		0	933,897	
500.00	Grand Total : Increases		448,973	1,689,155	500.00

RECLASSIFICATIONS

Provider CCN: 151334

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

Worksheet A-6

Date/Time Prepared:  
5/17/2012 1:59 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - CAFETERIA</b>							
1.00	DIETARY	10.00	128,522	204,487	0		1.00
	TOTALS		128,522	204,487			
<b>B - DEFAULT</b>							
1.00	ADULTS & PEDIATRICS	30.00	148,559	13,202	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		148,559	13,202			
<b>C - EKG</b>							
1.00	RESPIRATORY THERAPY	65.00	144,280	23,823	0		1.00
	TOTALS		144,280	23,823			
<b>D - PUBLIC RELATIONS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	27,612	43,021	0		1.00
	TOTALS		27,612	43,021			
<b>E - MEDICAL SUPPLIES</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1	0		1.00
2.00	OPERATING ROOM	50.00	0	387,018	0		2.00
3.00	PHYSICAL THERAPY	66.00	0	788	0		3.00
4.00	CARDIAC REHAB	76.00	0	474	0		4.00
	TOTALS		0	388,281			
<b>F - CHARGEABLE DRUGS</b>							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	82,444	0		1.00
	TOTALS		0	82,444			
<b>G - DEPRECIATION</b>							
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	933,897	9		1.00
	TOTALS		0	933,897			
500.00	Grand Total: Decreases		448,973	1,689,155			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151334

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
5/17/2012 1:59 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	241,233	0	0	0	1.00
2.00	Land Improvements	506,198	14,310	0	14,310	2.00
3.00	Buildings and Fixtures	18,349,895	628,060	0	628,060	3.00
4.00	Building Improvements	221,636	0	0	0	4.00
5.00	Fixed Equipment	2,363,391	41,863	0	41,863	5.00
6.00	Movable Equipment	12,562,282	2,141,692	0	2,141,692	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	34,244,635	2,825,925	0	2,825,925	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	34,244,635	2,825,925	0	2,825,925	10.00
<b>SUMMARY OF CAPITAL</b>						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,259,500	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,259,500	0	0	0	3.00
<b>COMPUTATION OF RATIOS</b>						
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	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	22,186,163	0	22,186,163	0.601412	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	14,703,974	0	14,703,974	0.398588	2.00
3.00	Total (sum of lines 1-2)	36,890,137	0	36,890,137	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151334

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
5/17/2012 1:59 pm

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	241,233	0		1.00	
2.00	Land Improvements	520,508	0		2.00	
3.00	Buildings and Fixtures	18,977,955	0		3.00	
4.00	Building Improvements	41,213	0		4.00	
5.00	Fixed Equipment	2,405,254	0		5.00	
6.00	Movable Equipment	14,703,974	0		6.00	
7.00	HIT designated Assets	0	0		7.00	
8.00	Subtotal (sum of lines 1-7)	36,890,137	0		8.00	
9.00	Reconciling Items	0	0		9.00	
10.00	Total (line 8 minus line 9)	36,890,137	0		10.00	
<b>SUMMARY OF CAPITAL</b>						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0		1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2,259,500		2.00	
3.00	Total (sum of lines 1-2)	0	2,259,500		3.00	
<b>ALLOCATION OF OTHER CAPITAL</b>						
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	933,897	0
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,325,603	0
3.00	Total (sum of lines 1-2)	0	0	0	2,259,500	0

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151334

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
5/17/2012 1:59 pm

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	933,897	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,325,603	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	2,259,500	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151334

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

Worksheet A-8

Date/Time Prepared:  
5/17/2012 1:59 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center		Line #
			1.00	2.00	3.00
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		0.00 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0	0		0.00 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0	0		0.00 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0	0		0.00 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0	0		0.00 7.00
8.00 Television and radio service (chapter 21)		0	0		0.00 8.00
9.00 Parking lot (chapter 21)		0	0		0.00 9.00
10.00 Provider-based physician adjustment	A-8-2	-744,000	0		10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0	0		0.00 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0	0		12.00
13.00 Laundry and linen service		0	0		0.00 13.00
14.00 Cafeteria-employees and guests	B	-85,470	0	CAFETERIA	11.00 14.00
15.00 Rental of quarters to employee and others		0	0		0.00 15.00
16.00 Sale of medical and surgical supplies to other than patients		0	0		0.00 16.00
17.00 Sale of drugs to other than patients	B	-1,816	0	DRUGS CHARGED TO PATIENTS	73.00 17.00
18.00 Sale of medical records and abstracts	B	-9,792	0	MEDICAL RECORDS & LIBRARY	16.00 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0	0		0.00 19.00
20.00 Vending machines		0	0		0.00 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0	0		0.00 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0	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	0	*** Cost Center Deleted ***	114.00 25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	0	NEW CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	0	NEW CAP REL COSTS-MVBLE EQUIP	2.00 27.00
28.00 Non-physician Anesthetist		0	0	*** Cost Center Deleted ***	19.00 28.00
29.00 Physicians' assistant		0	0		0.00 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	*** Cost Center Deleted ***	67.00 30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	0	*** Cost Center Deleted ***	68.00 31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	0	0		0.00 32.00
33.00 OTHER MISCELLANEOUS INCOME	B	-8,975	0	ADMINISTRATIVE & GENERAL	5.00 33.00
34.00 IHA & AHA DUES	A	-2,591	0	ADMINISTRATIVE & GENERAL	5.00 34.00
35.00 PHYSICIAN RECRUITMENT	A	-112,898	0	ADMINISTRATIVE & GENERAL	5.00 35.00
36.00 OTHER ADJUSTMENTS (SPECIFY)		0	0		0.00 36.00
37.00 OTHER ADJUSTMENTS (SPECIFY)		0	0		0.00 37.00
38.00 OTHER ADJUSTMENTS (SPECIFY)		0	0		0.00 38.00
39.00 OTHER ADJUSTMENTS (SPECIFY)		0	0		0.00 39.00
40.00 OTHER ADJUSTMENTS (SPECIFY)		0	0		0.00 40.00
41.00 OTHER ADJUSTMENTS (SPECIFY)		0	0		0.00 41.00
42.00 OTHER ADJUSTMENTS (SPECIFY)		0	0		0.00 42.00
43.00 OTHER ADJUSTMENTS (SPECIFY)		0	0		0.00 43.00
44.00 OTHER ADJUSTMENTS (SPECIFY)		0	0		0.00 44.00
45.00 OTHER ADJUSTMENTS (SPECIFY)		0	0		0.00 45.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-965,542			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151334

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

Worksheet A-8

Date/Time Prepared:  
5/17/2012 1:59 pm

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	OTHER MISCELLANEOUS INCOME	0	33.00
34.00	IHA & AHA DUES	0	34.00
35.00	PHYSICIAN RECRUITMENT	0	35.00
36.00	OTHER ADJUSTMENTS (SPECIFY)	0	36.00
37.00	OTHER ADJUSTMENTS (SPECIFY)	0	37.00
38.00	OTHER ADJUSTMENTS (SPECIFY)	0	38.00
39.00	OTHER ADJUSTMENTS (SPECIFY)	0	39.00
40.00	OTHER ADJUSTMENTS (SPECIFY)	0	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY)	0	41.00
42.00	OTHER ADJUSTMENTS (SPECIFY)	0	42.00
43.00	OTHER ADJUSTMENTS (SPECIFY)	0	43.00
44.00	OTHER ADJUSTMENTS (SPECIFY)	0	44.00
45.00	OTHER ADJUSTMENTS (SPECIFY)	0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151334

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

Worksheet A-8-2

Date/Time Prepared:  
5/17/2012 1:59 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	50.00	DR. A	24,000	24,000	1.00
2.00	54.00	DR. B	720,000	720,000	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			744,000	744,000	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151334

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

Worksheet A-8-2

Date/Time Prepared:  
5/17/2012 1:59 pm

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151334

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

Worksheet A-8-2

Date/Time Prepared:  
5/17/2012 1:59 pm

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 16.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	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: 151334

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

Worksheet A-8-2

Date/Time Prepared:  
5/17/2012 1:59 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	24,000	1.00
2.00	0	720,000	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	744,000	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151334		Period: From 01/01/2011 To 12/31/2011		Worksheet A-8-3 Part	
						Date/Time Prepared: 5/17/2012 1:59 pm	
						Physical Therapy	
						Cost	
						1.00	
<b>PART I - GENERAL INFORMATION</b>							
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)					0	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					0.00	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	1,807.00	4,844.50	56.25	1,549.25	0.00	9.00
10.00	AHSEA (see instructions)	85.16	74.05	55.54	41.65	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)	37.03	37.03	27.77			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	
<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					153,884	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					358,735	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					3,124	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					515,743	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					64,526	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)					580,269	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)					580,269	23.00
<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>							
<b>Standard Travel Allowance</b>							
24.00	Therapists (line 3 times column 2, line 11)					0	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)					0	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)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
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)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
<b>PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>							
<b>Standard Travel Expense</b>							
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
<b>Optional Travel Allowance and Optional Travel Expense</b>							
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: 151334				Period: From 01/01/2011 To 12/31/2011	Worksheet A-8-3 Part
						Physical Therapy	Date/Time Prepared: 5/17/2012 1:59 pm
						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	
<b>PART V - OVERTIME COMPUTATION</b>							
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	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
<b>CALCULATION OF LIMIT</b>							
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
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52.00	Adjusted hourly salary equivalency amount (see instructions)	74.05	55.54	41.65	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	
<b>Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT</b>							
57.00	Salary equivalency amount (from line 23)					580,269	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	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)					580,269	63.00
64.00	Total cost of outside supplier services (from your records)					457,018	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
<b>LINE 33 CALCULATION</b>							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					0	100.02
<b>LINE 34 CALCULATION</b>							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	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					0	101.02
<b>LINE 35 CALCULATION</b>							
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: 151334		Period: From 01/01/2011 To 12/31/2011		Worksheet A-8-3 Part	
						Date/Time Prepared: 5/17/2012 1:59 pm	
						Speech Pathology	
						Cost	
						1.00	
<b>PART I - GENERAL INFORMATION</b>							
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)					0	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					0.00	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	459.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	67.47	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)	33.74	33.74	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	
<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>							
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)					30,969	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)					30,969	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)					30,969	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)					67.47	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					52,627	22.00
23.00	Total salary equivalency (see instructions)					52,627	23.00
<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>							
<b>Standard Travel Allowance</b>							
24.00	Therapists (line 3 times column 2, line 11)					0	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)					0	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)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
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)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
<b>PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>							
<b>Standard Travel Expense</b>							
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
<b>Optional Travel Allowance and Optional Travel Expense</b>							
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: 151334				Period: From 01/01/2011 To 12/31/2011	Worksheet A-8-3 Part
						Speech Pathology	Date/Time Prepared: 5/17/2012 1:59 pm
						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	
<b>PART V - OVERTIME COMPUTATION</b>							
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	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
<b>CALCULATION OF LIMIT</b>							
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
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52.00	Adjusted hourly salary equivalency amount (see instructions)	67.47	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	56.00
						1.00	
<b>Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT</b>							
57.00	Salary equivalency amount (from line 23)					52,627	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	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)					52,627	63.00
64.00	Total cost of outside supplier services (from your records)					24,883	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
<b>LINE 33 CALCULATION</b>							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					0	100.02
<b>LINE 34 CALCULATION</b>							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	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					0	101.02
<b>LINE 35 CALCULATION</b>							
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: 151334

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/17/2012 1:59 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 NEW CAP REL COSTS-BLDG & FIXT	933,897	933,897				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	1,325,603		1,325,603			2.00
4.00 EMPLOYEE BENEFITS	2,653,418	0	0	2,653,418		4.00
5.00 ADMINISTRATIVE & GENERAL	2,353,226	128,653	182,614	403,553	3,068,046	5.00
7.00 OPERATION OF PLANT	925,926	20,287	28,796	81,807	1,056,816	7.00
9.00 HOUSEKEEPING	396,630	9,556	13,564	64,623	484,373	9.00
10.00 DIETARY	164,152	21,031	29,852	22,583	237,618	10.00
11.00 CAFETERIA	247,539	22,480	31,909	45,813	347,741	11.00
13.00 NURSING ADMINISTRATION	350,404	1,410	2,001	124,646	478,461	13.00
15.00 PHARMACY	0	0	0	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	323,601	13,061	18,539	99,442	454,643	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	1,476,504	206,639	293,306	475,154	2,451,603	30.00
31.00 INTENSIVE CARE UNIT	283,317	7,950	11,285	100,080	402,632	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	140,550	2,203	3,127	46,011	191,891	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	725,293	189,141	268,473	163,082	1,345,989	50.00
52.00 DELIVERY ROOM & LABOR ROOM	21,211	7,226	10,256	6,944	45,637	52.00
54.00 RADIOLOGY-DIAGNOSTIC	1,275,761	72,002	102,203	238,509	1,688,475	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	1,341,337	37,215	52,825	183,725	1,615,102	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	103,632	0	0	0	103,632	63.00
65.00 RESPIRATORY THERAPY	354,525	19,484	27,656	108,464	510,129	65.00
66.00 PHYSICAL THERAPY	506,407	34,268	48,641	0	589,316	66.00
69.00 ELECTROCARDIOLOGY	168,103	22,196	31,506	51,430	273,235	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	520,199	23,537	33,410	25,418	602,564	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	165,559	0	0	0	165,559	72.00
73.00 DRUGS CHARGED TO PATIENTS	900,555	7,049	10,006	54,307	971,917	73.00
76.00 CARDIAC REHAB	58,110	7,519	10,673	18,767	95,069	76.00
76.01 SLEEP LAB	17,409	0	0	0	17,409	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 EMERGENCY	1,189,969	73,314	104,065	329,217	1,696,565	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	18,922,837	926,221	1,314,707	2,643,575	18,894,422	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,501	9,228	0	15,729	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 PUBLIC RELATIONS	70,633	1,175	1,668	9,843	83,319	192.01
192.02 AZIZ/KASARENENI PHY CLINIC	0	0	0	0	0	192.02
192.03 AQUINO CAMPUS	0	0	0	0	0	192.03
192.04 MEDICAL SPECIALTY CLINIC	0	0	0	0	0	192.04
192.05 MEDICAL OFFICE	0	0	0	0	0	192.05
192.06 AUSTIN-COOKE OFFICE	0	0	0	0	0	192.06
192.07 QUALITY CARE/URGENT CARE	0	0	0	0	0	192.07
192.08 ALFREFAI CAMPUS	0	0	0	0	0	192.08
200.00 Cross Foot Adjustments	0	0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	18,993,470	933,897	1,325,603	2,653,418	18,993,470	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151334

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

Worksheet B Part I Date/Time Prepared: 5/17/2012 1:59 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	
		5.00	7.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	3,068,046					5.00
7.00	OPERATION OF PLANT	203,597	1,260,413				7.00
9.00	HOUSEKEEPING	93,315	15,507	593,195			9.00
10.00	DIETARY	45,777	34,129	0	317,524		10.00
11.00	CAFETERIA	66,993	36,480	15,602	0	466,816	11.00
13.00	NURSING ADMINISTRATION	92,176	2,288	0	0	18,816	13.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	87,587	21,195	10,622	0	31,078	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	472,302	335,329	120,829	282,589	127,961	30.00
31.00	INTENSIVE CARE UNIT	77,567	12,902	20,913	34,935	13,400	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	36,968	3,575	16,266	0	8,950	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	259,306	306,936	119,502	0	33,923	50.00
52.00	DELIVERY ROOM & LABOR ROOM	8,792	11,726	46,141	0	1,352	52.00
54.00	RADIOLOGY-DIAGNOSTIC	325,286	116,845	34,191	0	46,910	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	311,151	60,393	25,228	0	45,147	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	19,965	0	0	0	0	63.00
65.00	RESPIRATORY THERAPY	98,277	31,618	11,950	0	21,733	65.00
66.00	PHYSICAL THERAPY	113,532	55,610	15,934	0	14,401	66.00
69.00	ELECTROCARDIOLOGY	52,639	36,020	13,942	0	11,097	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	116,085	28,600	0	0	10,656	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	31,895	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	187,241	7,627	6,971	0	7,227	73.00
76.00	CARDIAC REHAB	18,315	12,202	5,311	0	6,413	76.00
76.01	SLEEP LAB	3,354	0	9,959	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	326,845	118,974	113,859	0	65,264	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,048,965	1,247,956	587,220	317,524	464,328	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,030	10,550	5,975	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	PUBLIC RELATIONS	16,051	1,907	0	0	2,488	192.01
192.02	AZIZ/KASARENENI PHY CLINIC	0	0	0	0	0	192.02
192.03	AQUINO CAMPUS	0	0	0	0	0	192.03
192.04	MEDICAL SPECIALTY CLINIC	0	0	0	0	0	192.04
192.05	MEDICAL OFFICE	0	0	0	0	0	192.05
192.06	AUSTIN-COOKE OFFICE	0	0	0	0	0	192.06
192.07	QUALITY CARE/URGENT CARE	0	0	0	0	0	192.07
192.08	ALFREFAI CAMPUS	0	0	0	0	0	192.08
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)	3,068,046	1,260,413	593,195	317,524	466,816	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151334

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/17/2012 1:59 pm

Cost Center Description		NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	15.00	16.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION	591,741					13.00
15.00	PHARMACY	0	0				15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	605,125			16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	296,013	0	22,844	4,109,470	0	30.00
31.00	INTENSIVE CARE UNIT	25,901	0	4,289	592,539	0	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	0	0	2,738	260,388	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	79,696	0	55,092	2,200,444	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	4,932	118,580	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	163,343	2,375,050	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	123,865	2,180,886	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	1,109	124,706	0	63.00
65.00	RESPIRATORY THERAPY	0	0	25,681	699,388	0	65.00
66.00	PHYSICAL THERAPY	0	0	25,614	814,407	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	12,177	399,110	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	25,367	783,272	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	3,628	201,082	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	55,229	1,236,212	0	73.00
76.00	CARDIAC REHAB	71,157	0	1,792	210,259	0	76.00
76.01	SLEEP LAB	0	0	9,713	40,435	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	118,974	0	67,712	2,508,193	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	591,741	0	605,125	18,854,421	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	35,284	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	PUBLIC RELATIONS	0	0	0	103,765	0	192.01
192.02	AZIZ/KASARENI PHY CLINIC	0	0	0	0	0	192.02
192.03	AQUINO CAMPUS	0	0	0	0	0	192.03
192.04	MEDICAL SPECIALTY CLINIC	0	0	0	0	0	192.04
192.05	MEDICAL OFFICE	0	0	0	0	0	192.05
192.06	AUSTIN-COOKE OFFICE	0	0	0	0	0	192.06
192.07	QUALITY CARE/URGENT CARE	0	0	0	0	0	192.07
192.08	ALFREFAI CAMPUS	0	0	0	0	0	192.08
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)	591,741	0	605,125	18,993,470	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151334

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/17/2012 1:59 pm

Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	EMPLOYEE BENEFITS		4.00
5.00	ADMINISTRATIVE & GENERAL		5.00
7.00	OPERATION OF PLANT		7.00
9.00	HOUSEKEEPING		9.00
10.00	DIETARY		10.00
11.00	CAFETERIA		11.00
13.00	NURSING ADMINISTRATION		13.00
15.00	PHARMACY		15.00
16.00	MEDICAL RECORDS & LIBRARY		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	ADULTS & PEDIATRICS	4,109,470	30.00
31.00	INTENSIVE CARE UNIT	592,539	31.00
41.00	SUBPROVIDER - IRF	0	41.00
42.00	SUBPROVIDER	0	42.00
43.00	NURSERY	260,388	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	OPERATING ROOM	2,200,444	50.00
52.00	DELIVERY ROOM & LABOR ROOM	118,580	52.00
54.00	RADIOLOGY-DIAGNOSTIC	2,375,050	54.00
57.00	CT SCAN	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	CARDIAC CATHETERIZATION	0	59.00
60.00	LABORATORY	2,180,886	60.00
60.01	BLOOD LABORATORY	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	124,706	63.00
65.00	RESPIRATORY THERAPY	699,388	65.00
66.00	PHYSICAL THERAPY	814,407	66.00
69.00	ELECTROCARDIOLOGY	399,110	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	783,272	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	201,082	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,236,212	73.00
76.00	CARDIAC REHAB	210,259	76.00
76.01	SLEEP LAB	40,435	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00	RURAL HEALTH CLINIC	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
91.00	EMERGENCY	2,508,193	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
99.10	CORF	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>			
109.00	PANCREAS ACQUISITION	0	109.00
110.00	INTESTINAL ACQUISITION	0	110.00
111.00	ISLET ACQUISITION	0	111.00
113.00	INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	18,854,421	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	35,284	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	PUBLIC RELATIONS	103,765	192.01
192.02	AZIZ/KASARENENI PHY CLINIC	0	192.02
192.03	AQUINO CAMPUS	0	192.03
192.04	MEDICAL SPECIALTY CLINIC	0	192.04
192.05	MEDICAL OFFICE	0	192.05
192.06	AUSTIN-COOKE OFFICE	0	192.06
192.07	QUALITY CARE/URGENT CARE	0	192.07
192.08	ALFREFAI CAMPUS	0	192.08
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	18,993,470	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151334

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/17/2012 1:59 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	0	0	0	0	4.00
5.00	ADMINISTRATIVE & GENERAL	0	128,653	182,614	311,267	5.00
7.00	OPERATION OF PLANT	0	20,287	28,796	49,083	7.00
9.00	HOUSEKEEPING	0	9,556	13,564	23,120	9.00
10.00	DIETARY	0	21,031	29,852	50,883	10.00
11.00	CAFETERIA	0	22,480	31,909	54,389	11.00
13.00	NURSING ADMINISTRATION	0	1,410	2,001	3,411	13.00
15.00	PHARMACY	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	13,061	18,539	31,600	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS	0	206,639	293,306	499,945	30.00
31.00	INTENSIVE CARE UNIT	0	7,950	11,285	19,235	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	42.00
43.00	NURSERY	0	2,203	3,127	5,330	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	0	189,141	268,473	457,614	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	7,226	10,256	17,482	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	72,002	102,203	174,205	54.00
57.00	CT SCAN	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	LABORATORY	0	37,215	52,825	90,040	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	RESPIRATORY THERAPY	0	19,484	27,656	47,140	65.00
66.00	PHYSICAL THERAPY	0	34,268	48,641	82,909	66.00
69.00	ELECTROCARDIOLOGY	0	22,196	31,506	53,702	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	23,537	33,410	56,947	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	7,049	10,006	17,055	73.00
76.00	CARDIAC REHAB	0	7,519	10,673	18,192	76.00
76.01	SLEEP LAB	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00	EMERGENCY	0	73,314	104,065	177,379	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	CORF	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	926,221	1,314,707	2,240,928	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,501	9,228	15,729	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	PUBLIC RELATIONS	0	1,175	1,668	2,843	192.01
192.02	AZIZ/KASARENENI PHY CLINIC	0	0	0	0	192.02
192.03	AQUINO CAMPUS	0	0	0	0	192.03
192.04	MEDICAL SPECIALTY CLINIC	0	0	0	0	192.04
192.05	MEDICAL OFFICE	0	0	0	0	192.05
192.06	AUSTIN-COOKE OFFICE	0	0	0	0	192.06
192.07	QUALITY CARE/URGENT CARE	0	0	0	0	192.07
192.08	ALFREFAI CAMPUS	0	0	0	0	192.08
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	933,897	1,325,603	2,259,500	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151334

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

Worksheet B  
Part II  
Date/Time Prepared:  
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	
		5.00	7.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	311,267					5.00
7.00	OPERATION OF PLANT	20,655	69,738				7.00
9.00	HOUSEKEEPING	9,467	858	33,445			9.00
10.00	DIETARY	4,644	1,888	0	57,415		10.00
11.00	CAFETERIA	6,797	2,018	880	0	64,084	11.00
13.00	NURSING ADMINISTRATION	9,352	127	0	0	2,583	13.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	8,886	1,173	599	0	4,266	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	47,925	18,554	6,814	51,098	17,566	30.00
31.00	INTENSIVE CARE UNIT	7,869	714	1,179	6,317	1,840	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	3,751	198	917	0	1,229	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	26,307	16,983	6,738	0	4,657	50.00
52.00	DELIVERY ROOM & LABOR ROOM	892	649	2,601	0	186	52.00
54.00	RADIOLOGY-DIAGNOSTIC	33,001	6,465	1,928	0	6,440	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	31,567	3,341	1,422	0	6,198	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	2,025	0	0	0	0	63.00
65.00	RESPIRATORY THERAPY	9,970	1,749	674	0	2,983	65.00
66.00	PHYSICAL THERAPY	11,518	3,077	898	0	1,977	66.00
69.00	ELECTROCARDIOLOGY	5,340	1,993	786	0	1,523	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,777	1,582	0	0	1,463	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	3,236	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	18,996	422	393	0	992	73.00
76.00	CARDIAC REHAB	1,858	675	299	0	880	76.00
76.01	SLEEP LAB	340	0	561	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	33,159	6,583	6,419	0	8,959	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	309,332	69,049	33,108	57,415	63,742	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	307	584	337	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	PUBLIC RELATIONS	1,628	105	0	0	342	192.01
192.02	AZIZ/KASARENENI PHY CLINIC	0	0	0	0	0	192.02
192.03	AQUINO CAMPUS	0	0	0	0	0	192.03
192.04	MEDICAL SPECIALTY CLINIC	0	0	0	0	0	192.04
192.05	MEDICAL OFFICE	0	0	0	0	0	192.05
192.06	AUSTIN-COOKE OFFICE	0	0	0	0	0	192.06
192.07	QUALITY CARE/URGENT CARE	0	0	0	0	0	192.07
192.08	ALFREFAI CAMPUS	0	0	0	0	0	192.08
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)	311,267	69,738	33,445	57,415	64,084	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151334

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

Worksheet B  
Part II  
Date/Time Prepared:  
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Cost Center Description		NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	15.00	16.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION	15,473					13.00
15.00	PHARMACY	0	0				15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	46,524			16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	7,740	0	1,756	651,398	0	30.00
31.00	INTENSIVE CARE UNIT	677	0	330	38,161	0	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	0	0	210	11,635	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	2,084	0	4,235	518,618	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	379	22,189	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	12,563	234,602	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	9,522	142,090	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	85	2,110	0	63.00
65.00	RESPIRATORY THERAPY	0	0	1,974	64,490	0	65.00
66.00	PHYSICAL THERAPY	0	0	1,969	102,348	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	936	64,280	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,950	73,719	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	279	3,515	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	4,246	42,104	0	73.00
76.00	CARDIAC REHAB	1,861	0	138	23,903	0	76.00
76.01	SLEEP LAB	0	0	747	1,648	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	3,111	0	5,205	240,815	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	15,473	0	46,524	2,237,625	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	16,957	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	PUBLIC RELATIONS	0	0	0	4,918	0	192.01
192.02	AZIZ/KASARENI PHY CLINIC	0	0	0	0	0	192.02
192.03	AQUINO CAMPUS	0	0	0	0	0	192.03
192.04	MEDICAL SPECIALTY CLINIC	0	0	0	0	0	192.04
192.05	MEDICAL OFFICE	0	0	0	0	0	192.05
192.06	AUSTIN-COOKE OFFICE	0	0	0	0	0	192.06
192.07	QUALITY CARE/URGENT CARE	0	0	0	0	0	192.07
192.08	ALFREFAI CAMPUS	0	0	0	0	0	192.08
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)	15,473	0	46,524	2,259,500	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151334

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

Worksheet B  
Part II  
Date/Time Prepared:  
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Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	EMPLOYEE BENEFITS		4.00
5.00	ADMINISTRATIVE & GENERAL		5.00
7.00	OPERATION OF PLANT		7.00
9.00	HOUSEKEEPING		9.00
10.00	DIETARY		10.00
11.00	CAFETERIA		11.00
13.00	NURSING ADMINISTRATION		13.00
15.00	PHARMACY		15.00
16.00	MEDICAL RECORDS & LIBRARY		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	ADULTS & PEDIATRICS	651,398	30.00
31.00	INTENSIVE CARE UNIT	38,161	31.00
41.00	SUBPROVIDER - IRF	0	41.00
42.00	SUBPROVIDER	0	42.00
43.00	NURSERY	11,635	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	OPERATING ROOM	518,618	50.00
52.00	DELIVERY ROOM & LABOR ROOM	22,189	52.00
54.00	RADIOLOGY-DIAGNOSTIC	234,602	54.00
57.00	CT SCAN	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	CARDIAC CATHETERIZATION	0	59.00
60.00	LABORATORY	142,090	60.00
60.01	BLOOD LABORATORY	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	2,110	63.00
65.00	RESPIRATORY THERAPY	64,490	65.00
66.00	PHYSICAL THERAPY	102,348	66.00
69.00	ELECTROCARDIOLOGY	64,280	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	73,719	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	3,515	72.00
73.00	DRUGS CHARGED TO PATIENTS	42,104	73.00
76.00	CARDIAC REHAB	23,903	76.00
76.01	SLEEP LAB	1,648	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00	RURAL HEALTH CLINIC	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
91.00	EMERGENCY	240,815	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
99.10	CORF	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>			
109.00	PANCREAS ACQUISITION	0	109.00
110.00	INTESTINAL ACQUISITION	0	110.00
111.00	ISLET ACQUISITION	0	111.00
113.00	INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,237,625	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,957	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	PUBLIC RELATIONS	4,918	192.01
192.02	AZIZ/KASARENENI PHY CLINIC	0	192.02
192.03	AQUINO CAMPUS	0	192.03
192.04	MEDICAL SPECIALTY CLINIC	0	192.04
192.05	MEDICAL OFFICE	0	192.05
192.06	AUSTIN-COOKE OFFICE	0	192.06
192.07	QUALITY CARE/URGENT CARE	0	192.07
192.08	ALFREFAI CAMPUS	0	192.08
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	2,259,500	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151334

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

Worksheet B-1

Date/Time Prepared:  
5/17/2012 1:59 pm

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				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	95,384					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		95,384				2.00
4.00	EMPLOYEE BENEFITS	0	0	7,443,837			4.00
5.00	ADMINISTRATIVE & GENERAL	13,140	13,140	1,132,119	-3,068,046	15,925,424	5.00
7.00	OPERATION OF PLANT	2,072	2,072	229,501	0	1,056,816	7.00
9.00	HOUSEKEEPING	976	976	181,291	0	484,373	9.00
10.00	DIETARY	2,148	2,148	63,353	0	237,618	10.00
11.00	CAFETERIA	2,296	2,296	128,522	0	347,741	11.00
13.00	NURSING ADMINISTRATION	144	144	349,678	0	478,461	13.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	1,334	1,334	278,973	0	454,643	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	21,105	21,105	1,332,987	0	2,451,603	30.00
31.00	INTENSIVE CARE UNIT	812	812	280,762	0	402,632	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	225	225	129,079	0	191,891	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	19,318	19,318	457,507	0	1,345,989	50.00
52.00	DELIVERY ROOM & LABOR ROOM	738	738	19,480	0	45,637	52.00
54.00	RADIOLOGY-DIAGNOSTIC	7,354	7,354	669,107	0	1,688,475	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	3,801	3,801	515,419	0	1,615,102	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	103,632	63.00
65.00	RESPIRATORY THERAPY	1,990	1,990	304,282	0	510,129	65.00
66.00	PHYSICAL THERAPY	3,500	3,500	0	0	589,316	66.00
69.00	ELECTROCARDIOLOGY	2,267	2,267	144,280	0	273,235	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,404	2,404	71,307	0	602,564	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	165,559	72.00
73.00	DRUGS CHARGED TO PATIENTS	720	720	152,352	0	971,917	73.00
76.00	CARDIAC REHAB	768	768	52,648	0	95,069	76.00
76.01	SLEEP LAB	0	0	0	0	17,409	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	7,488	7,488	923,578	0	1,696,565	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	94,600	94,600	7,416,225	-3,068,046	15,826,376	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	664	664	0	0	15,729	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	PUBLIC RELATIONS	120	120	27,612	0	83,319	192.01
192.02	AZIZ/KASARENENI PHY CLINIC	0	0	0	0	0	192.02
192.03	AQUINO CAMPUS	0	0	0	0	0	192.03
192.04	MEDICAL SPECIALTY CLINIC	0	0	0	0	0	192.04
192.05	MEDICAL OFFICE	0	0	0	0	0	192.05
192.06	AUSTIN-COOKE OFFICE	0	0	0	0	0	192.06
192.07	QUALITY CARE/URGENT CARE	0	0	0	0	0	192.07
192.08	ALFREFAI CAMPUS	0	0	0	0	0	192.08
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)	933,897	1,325,603	2,653,418		3,068,046	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	9.790919	13.897540	0.356458		0.192651	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0		311,267	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.019545	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151334

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

Worksheet B-1

Date/Time Prepared:  
5/17/2012 1:59 pm

Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (HOURS SUPERVISED)	
	7.00	9.00	10.00	11.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT	79,328					7.00
9.00 HOUSEKEEPING	976	1,787				9.00
10.00 DIETARY	2,148	0	14,097			10.00
11.00 CAFETERIA	2,296	47	0	282,527		11.00
13.00 NURSING ADMINISTRATION	144	0	0	11,388	2,079	13.00
15.00 PHARMACY	0	0	0	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	1,334	32	0	18,809	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	21,105	364	12,546	77,445	1,040	30.00
31.00 INTENSIVE CARE UNIT	812	63	1,551	8,110	91	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	225	49	0	5,417	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	19,318	360	0	20,531	280	50.00
52.00 DELIVERY ROOM & LABOR ROOM	738	139	0	818	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	7,354	103	0	28,391	0	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	3,801	76	0	27,324	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00 RESPIRATORY THERAPY	1,990	36	0	13,153	0	65.00
66.00 PHYSICAL THERAPY	3,500	48	0	8,716	0	66.00
69.00 ELECTROCARDIOLOGY	2,267	42	0	6,716	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,800	0	0	6,449	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	480	21	0	4,374	0	73.00
76.00 CARDIAC REHAB	768	16	0	3,881	250	76.00
76.01 SLEEP LAB	0	30	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 EMERGENCY	7,488	343	0	39,499	418	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	78,544	1,769	14,097	281,021	2,079	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	664	18	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 PUBLIC RELATIONS	120	0	0	1,506	0	192.01
192.02 AZIZ/KASARENI PHY CLINIC	0	0	0	0	0	192.02
192.03 AQUINO CAMPUS	0	0	0	0	0	192.03
192.04 MEDICAL SPECIALTY CLINIC	0	0	0	0	0	192.04
192.05 MEDICAL OFFICE	0	0	0	0	0	192.05
192.06 AUSTIN-COOKE OFFICE	0	0	0	0	0	192.06
192.07 QUALITY CARE/URGENT CARE	0	0	0	0	0	192.07
192.08 ALFREFAI CAMPUS	0	0	0	0	0	192.08
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)	1,260,413	593,195	317,524	466,816	591,741	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	15.888627	331.950196	22.524225	1.652288	284.627706	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	69,738	33,445	57,415	64,084	15,473	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.879110	18.715725	4.072852	0.226824	7.442520	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151334

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

Worksheet B-1  
Date/Time Prepared:  
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Cost Center Description		PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	EMPLOYEE BENEFITS			4.00
5.00	ADMINISTRATIVE & GENERAL			5.00
7.00	OPERATION OF PLANT			7.00
9.00	HOUSEKEEPING			9.00
10.00	DIETARY			10.00
11.00	CAFETERIA			11.00
13.00	NURSING ADMINISTRATION			13.00
15.00	PHARMACY	100		15.00
16.00	MEDICAL RECORDS & LIBRARY	0	55,115,647	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	0	2,080,693	30.00
31.00	INTENSIVE CARE UNIT	0	390,688	31.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	249,382	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	0	5,017,970	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	449,254	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	14,876,692	54.00
57.00	CT SCAN	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	0	11,281,963	60.00
60.01	BLOOD LABORATORY	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	101,010	63.00
65.00	RESPIRATORY THERAPY	0	2,339,125	65.00
66.00	PHYSICAL THERAPY	0	2,332,995	66.00
69.00	ELECTROCARDIOLOGY	0	1,109,128	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,310,483	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	330,470	72.00
73.00	DRUGS CHARGED TO PATIENTS	100	5,030,430	73.00
76.00	CARDIAC REHAB	0	163,238	76.00
76.01	SLEEP LAB	0	884,724	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	RURAL HEALTH CLINIC	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	EMERGENCY	0	6,167,402	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	CORF	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
109.00	PANCREAS ACQUISITION	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	110.00
111.00	ISLET ACQUISITION	0	0	111.00
113.00	INTEREST EXPENSE			113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	100	55,115,647	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	PUBLIC RELATIONS	0	0	192.01
192.02	AZIZ/KASARENENI PHY CLINIC	0	0	192.02
192.03	AQUINO CAMPUS	0	0	192.03
192.04	MEDICAL SPECIALTY CLINIC	0	0	192.04
192.05	MEDICAL OFFICE	0	0	192.05
192.06	AUSTIN-COOKE OFFICE	0	0	192.06
192.07	QUALITY CARE/URGENT CARE	0	0	192.07
192.08	ALFREFAI CAMPUS	0	0	192.08
200.00	Cross Foot Adjustments			200.00
201.00	Negative Cost Centers			201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	605,125	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	0.010979	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	46,524	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000844	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151334

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/17/2012 1:59 pm

		Title XVIII		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS	4,109,470		4,109,470	0	0 30.00
31.00	INTENSIVE CARE UNIT	592,539		592,539	0	0 31.00
41.00	SUBPROVIDER - IRF	0		0	0	0 41.00
42.00	SUBPROVIDER	0		0	0	0 42.00
43.00	NURSERY	260,388		260,388	0	0 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	2,200,444		2,200,444	0	0 50.00
52.00	DELIVERY ROOM & LABOR ROOM	118,580		118,580	0	0 52.00
54.00	RADIOLOGY-DIAGNOSTIC	2,375,050		2,375,050	0	0 54.00
57.00	CT SCAN	0		0	0	0 57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0 58.00
59.00	CARDIAC CATHETERIZATION	0		0	0	0 59.00
60.00	LABORATORY	2,180,886		2,180,886	0	0 60.00
60.01	BLOOD LABORATORY	0		0	0	0 60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	124,706		124,706	0	0 63.00
65.00	RESPIRATORY THERAPY	699,388	0	699,388	0	0 65.00
66.00	PHYSICAL THERAPY	814,407	0	814,407	0	0 66.00
69.00	ELECTROCARDIOLOGY	399,110		399,110	0	0 69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	783,272		783,272	0	0 71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	201,082		201,082	0	0 72.00
73.00	DRUGS CHARGED TO PATIENTS	1,236,212		1,236,212	0	0 73.00
76.00	CARDIAC REHAB	210,259		210,259	0	0 76.00
76.01	SLEEP LAB	40,435		40,435	0	0 76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	RURAL HEALTH CLINIC	0		0	0	0 88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0 89.00
91.00	EMERGENCY	2,508,193		2,508,193	0	0 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	629,456		629,456	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	CORF	0		0	0	0 99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00	PANCREAS ACQUISITION	0		0	0	0 109.00
110.00	INTESTINAL ACQUISITION	0		0	0	0 110.00
111.00	ISLET ACQUISITION	0		0	0	0 111.00
113.00	INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	19,483,877	0	19,483,877	0	0 200.00
201.00	Less Observation Beds	629,456		629,456	0	0 201.00
202.00	Total (see instructions)	18,854,421	0	18,854,421	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151334

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

Worksheet C  
Part I  
Date/Time Prepared:  
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		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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	1,512,546		1,512,546			30.00
31.00	INTENSIVE CARE UNIT	390,688		390,688			31.00
41.00	SUBPROVIDER - IRF	0		0			41.00
42.00	SUBPROVIDER	0		0			42.00
43.00	NURSERY	249,382		249,382			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	1,505,714	3,512,256	5,017,970	0.438513	0.000000	50.00
52.00	DELIVERY ROOM & LABOR ROOM	137,939	311,315	449,254	0.263949	0.000000	52.00
54.00	RADIOLOGY-DIAGNOSTIC	856,421	14,020,271	14,876,692	0.159649	0.000000	54.00
57.00	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	LABORATORY	2,079,348	9,202,615	11,281,963	0.193307	0.000000	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	52,023	48,987	101,010	1.234591	0.000000	63.00
65.00	RESPIRATORY THERAPY	1,005,736	1,333,389	2,339,125	0.298996	0.000000	65.00
66.00	PHYSICAL THERAPY	96,027	2,236,968	2,332,995	0.349082	0.000000	66.00
69.00	ELECTROCARDIOLOGY	406,144	702,984	1,109,128	0.359841	0.000000	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	942,963	1,367,520	2,310,483	0.339008	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	102,260	228,210	330,470	0.608473	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,433,495	2,596,935	5,030,430	0.245747	0.000000	73.00
76.00	CARDIAC REHAB	0	163,238	163,238	1.288052	0.000000	76.00
76.01	SLEEP LAB	2,696	882,028	884,724	0.045704	0.000000	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
91.00	EMERGENCY	297,101	5,870,301	6,167,402	0.406686	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	59,267	508,880	568,147	1.107910	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF	0	0	0			99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	PANCREAS ACQUISITION	0	0	0			109.00
110.00	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	ISLET ACQUISITION	0	0	0			111.00
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	12,129,750	42,985,897	55,115,647			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	12,129,750	42,985,897	55,115,647			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151334	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/17/2012 1:59 pm
		Title XVIII	Hospital	Cost

Cost Center Description	PPS Inpatient Ratio		
	11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00 ADULTS & PEDIATRICS			30.00
31.00 INTENSIVE CARE UNIT			31.00
41.00 SUBPROVIDER - IRF			41.00
42.00 SUBPROVIDER			42.00
43.00 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 OPERATING ROOM	0.000000		50.00
52.00 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00 CT SCAN	0.000000		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00 CARDIAC CATHETERIZATION	0.000000		59.00
60.00 LABORATORY	0.000000		60.00
60.01 BLOOD LABORATORY	0.000000		60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00 RESPIRATORY THERAPY	0.000000		65.00
66.00 PHYSICAL THERAPY	0.000000		66.00
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
76.00 CARDIAC REHAB	0.000000		76.00
76.01 SLEEP LAB	0.000000		76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00 RURAL HEALTH CLINIC			88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER			89.00
91.00 EMERGENCY	0.000000		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
99.10 CORF			99.10
<b>SPECIAL PURPOSE COST CENTERS</b>			
109.00 PANCREAS ACQUISITION			109.00
110.00 INTESTINAL ACQUISITION			110.00
111.00 ISLET ACQUISITION			111.00
113.00 INTEREST EXPENSE			113.00
200.00 Subtotal (see instructions)			200.00
201.00 Less Observation Beds			201.00
202.00 Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151334

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/17/2012 1:59 pm

		Title XIX		Hospital		Tefra	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS		4,109,470	0	0	30.00	
31.00	INTENSIVE CARE UNIT		592,539	0	0	31.00	
41.00	SUBPROVIDER - IRF		0	0	0	41.00	
42.00	SUBPROVIDER		0	0	0	42.00	
43.00	NURSERY		260,388	0	0	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM		2,200,444	0	0	50.00	
52.00	DELIVERY ROOM & LABOR ROOM		118,580	0	0	52.00	
54.00	RADIOLOGY-DIAGNOSTIC		2,375,050	0	0	54.00	
57.00	CT SCAN		0	0	0	57.00	
58.00	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00	
59.00	CARDIAC CATHETERIZATION		0	0	0	59.00	
60.00	LABORATORY		2,180,886	0	0	60.00	
60.01	BLOOD LABORATORY		0	0	0	60.01	
63.00	BLOOD STORING, PROCESSING & TRANS.		124,706	0	0	63.00	
65.00	RESPIRATORY THERAPY	0	699,388	0	0	65.00	
66.00	PHYSICAL THERAPY	0	814,407	0	0	66.00	
69.00	ELECTROCARDIOLOGY		399,110	0	0	69.00	
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		783,272	0	0	71.00	
72.00	IMPL. DEV. CHARGED TO PATIENT		201,082	0	0	72.00	
73.00	DRUGS CHARGED TO PATIENTS		1,236,212	0	0	73.00	
76.00	CARDIAC REHAB		210,259	0	0	76.00	
76.01	SLEEP LAB		40,435	0	0	76.01	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC		0	0	0	88.00	
89.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00	
91.00	EMERGENCY		2,508,193	0	0	91.00	
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		629,456	0	0	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF		0	0	0	99.10	
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	PANCREAS ACQUISITION		0	0	0	109.00	
110.00	INTESTINAL ACQUISITION		0	0	0	110.00	
111.00	ISLET ACQUISITION		0	0	0	111.00	
113.00	INTEREST EXPENSE					113.00	
200.00	Subtotal (see instructions)		19,483,877	0	0	200.00	
201.00	Less Observation Beds		629,456			201.00	
202.00	Total (see instructions)		18,854,421	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151334

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/17/2012 1:59 pm

		Title XIX			Hospital	Tefra	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	1,512,546		1,512,546			30.00
31.00	INTENSIVE CARE UNIT	390,688		390,688			31.00
41.00	SUBPROVIDER - IRF	0		0			41.00
42.00	SUBPROVIDER	0		0			42.00
43.00	NURSERY	249,382		249,382			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	1,505,714	3,512,256	5,017,970	0.438513	0.438513	50.00
52.00	DELIVERY ROOM & LABOR ROOM	137,939	311,315	449,254	0.263949	0.263949	52.00
54.00	RADIOLOGY-DIAGNOSTIC	856,421	14,020,271	14,876,692	0.159649	0.159649	54.00
57.00	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	LABORATORY	2,079,348	9,202,615	11,281,963	0.193307	0.193307	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	52,023	48,987	101,010	1.234591	1.234591	63.00
65.00	RESPIRATORY THERAPY	1,005,736	1,333,389	2,339,125	0.298996	0.298996	65.00
66.00	PHYSICAL THERAPY	96,027	2,236,968	2,332,995	0.349082	0.349082	66.00
69.00	ELECTROCARDIOLOGY	406,144	702,984	1,109,128	0.359841	0.359841	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	942,963	1,367,520	2,310,483	0.339008	0.339008	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	102,260	228,210	330,470	0.608473	0.608473	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,433,495	2,596,935	5,030,430	0.245747	0.245747	73.00
76.00	CARDIAC REHAB	0	163,238	163,238	1.288052	1.288052	76.00
76.01	SLEEP LAB	2,696	882,028	884,724	0.045704	0.045704	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
91.00	EMERGENCY	297,101	5,870,301	6,167,402	0.406686	0.406686	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	59,267	508,880	568,147	1.107910	1.107910	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF	0	0	0			99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	PANCREAS ACQUISITION	0	0	0			109.00
110.00	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	ISLET ACQUISITION	0	0	0			111.00
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	12,129,750	42,985,897	55,115,647			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	12,129,750	42,985,897	55,115,647			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151334

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/17/2012 1:59 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Tefra
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS				30.00
31.00	INTENSIVE CARE UNIT				31.00
41.00	SUBPROVIDER - IRF				41.00
42.00	SUBPROVIDER				42.00
43.00	NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.000000			50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	CT SCAN	0.000000			57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	LABORATORY	0.000000			60.00
60.01	BLOOD LABORATORY	0.000000			60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
65.00	RESPIRATORY THERAPY	0.000000			65.00
66.00	PHYSICAL THERAPY	0.000000			66.00
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
76.00	CARDIAC REHAB	0.000000			76.00
76.01	SLEEP LAB	0.000000			76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	RURAL HEALTH CLINIC	0.000000			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.10	CORF				99.10
<b>SPECIAL PURPOSE COST CENTERS</b>					
109.00	PANCREAS ACQUISITION				109.00
110.00	INTESTINAL ACQUISITION				110.00
111.00	ISLET ACQUISITION				111.00
113.00	INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

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

Provider CCN: 151334

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

Worksheet C Part II Date/Time Prepared: 5/17/2012 1:59 pm

Cost Center Description		Title XIX			Hospital	Tefra	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	2,200,444	518,618	1,681,826	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	118,580	22,189	96,391	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	2,375,050	234,602	2,140,448	0	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	2,180,886	142,090	2,038,796	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	124,706	2,110	122,596	0	0	63.00
65.00	RESPIRATORY THERAPY	699,388	64,490	634,898	0	0	65.00
66.00	PHYSICAL THERAPY	814,407	102,348	712,059	0	0	66.00
69.00	ELECTROCARDIOLOGY	399,110	64,280	334,830	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	783,272	73,719	709,553	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	201,082	3,515	197,567	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,236,212	42,104	1,194,108	0	0	73.00
76.00	CARDIAC REHAB	210,259	23,903	186,356	0	0	76.00
76.01	SLEEP LAB	40,435	1,648	38,787	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	2,508,193	240,815	2,267,378	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	629,456	0	629,456	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (sum of lines 50 thru 199)	14,521,480	1,536,431	12,985,049	0	0	200.00
201.00	Less Observation Beds	629,456	0	629,456	0	0	201.00
202.00	Total (line 200 minus line 201)	13,892,024	1,536,431	12,355,593	0	0	202.00

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

Provider CCN: 151334

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

Worksheet C Part II Date/Time Prepared: 5/17/2012 1:59 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
Title XIX Hospital Tefra					
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	2,200,444	5,017,970	0.438513	50.00
52.00	DELIVERY ROOM & LABOR ROOM	118,580	449,254	0.263949	52.00
54.00	RADIOLOGY-DIAGNOSTIC	2,375,050	14,876,692	0.159649	54.00
57.00	CT SCAN	0	0	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	59.00
60.00	LABORATORY	2,180,886	11,281,963	0.193307	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	124,706	101,010	1.234591	63.00
65.00	RESPIRATORY THERAPY	699,388	2,339,125	0.298996	65.00
66.00	PHYSICAL THERAPY	814,407	2,332,995	0.349082	66.00
69.00	ELECTROCARDIOLOGY	399,110	1,109,128	0.359841	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	783,272	2,310,483	0.339008	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	201,082	330,470	0.608473	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,236,212	5,030,430	0.245747	73.00
76.00	CARDIAC REHAB	210,259	163,238	1.288052	76.00
76.01	SLEEP LAB	40,435	884,724	0.045704	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0.000000	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	89.00
91.00	EMERGENCY	2,508,193	6,167,402	0.406686	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	629,456	568,147	1.107910	92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	CORF	0	0	0.000000	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	PANCREAS ACQUISITION	0	0	0.000000	109.00
110.00	INTESTINAL ACQUISITION	0	0	0.000000	110.00
111.00	ISLET ACQUISITION	0	0	0.000000	111.00
113.00	INTEREST EXPENSE				113.00
200.00	Subtotal (sum of lines 50 thru 199)	14,521,480	0		200.00
201.00	Less Observation Beds	629,456	0		201.00
202.00	Total (line 200 minus line 201)	13,892,024	52,963,031		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 151334	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part II Date/Time Prepared: 5/17/2012 1:59 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	518,618	5,017,970	0.103352	428,489	44,285	50.00
52.00	DELIVERY ROOM & LABOR ROOM	22,189	449,254	0.049391	1,139	56	52.00
54.00	RADIOLOGY-DIAGNOSTIC	234,602	14,876,692	0.015770	617,737	9,742	54.00
57.00	CT SCAN	0	0	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	LABORATORY	142,090	11,281,963	0.012594	1,321,447	16,642	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	2,110	101,010	0.020889	21,361	446	63.00
65.00	RESPIRATORY THERAPY	64,490	2,339,125	0.027570	661,161	18,228	65.00
66.00	PHYSICAL THERAPY	102,348	2,332,995	0.043870	55,749	2,446	66.00
69.00	ELECTROCARDIOLOGY	64,280	1,109,128	0.057955	309,805	17,955	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	73,719	2,310,483	0.031906	472,855	15,087	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	3,515	330,470	0.010636	63,934	680	72.00
73.00	DRUGS CHARGED TO PATIENTS	42,104	5,030,430	0.008370	1,405,030	11,760	73.00
76.00	CARDIAC REHAB	23,903	163,238	0.146430	0	0	76.00
76.01	SLEEP LAB	1,648	884,724	0.001863	1,348	3	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	EMERGENCY	240,815	6,167,402	0.039046	138,563	5,410	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	568,147	0.000000	44,200	0	92.00
200.00	Total (lines 50-199)	1,536,431	52,963,031		5,542,818	142,740	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151334

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/17/2012 1:59 pm

Cost Center Description		Title XVIII				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
76.00	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	SLEEP LAB	0	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
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: 151334

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/17/2012 1:59 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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0	5,017,970	0.000000	0.000000	428,489	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	449,254	0.000000	0.000000	1,139	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	14,876,692	0.000000	0.000000	617,737	54.00
57.00	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	LABORATORY	0	11,281,963	0.000000	0.000000	1,321,447	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	101,010	0.000000	0.000000	21,361	63.00
65.00	RESPIRATORY THERAPY	0	2,339,125	0.000000	0.000000	661,161	65.00
66.00	PHYSICAL THERAPY	0	2,332,995	0.000000	0.000000	55,749	66.00
69.00	ELECTROCARDIOLOGY	0	1,109,128	0.000000	0.000000	309,805	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,310,483	0.000000	0.000000	472,855	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	330,470	0.000000	0.000000	63,934	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	5,030,430	0.000000	0.000000	1,405,030	73.00
76.00	CARDIAC REHAB	0	163,238	0.000000	0.000000	0	76.00
76.01	SLEEP LAB	0	884,724	0.000000	0.000000	1,348	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	EMERGENCY	0	6,167,402	0.000000	0.000000	138,563	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	568,147	0.000000	0.000000	44,200	92.00
200.00	Total (lines 50-199)	0	52,963,031			5,542,818	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151334

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/17/2012 1:59 pm

Cost Center Description		Title XVIII			Hospital		Cost
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
76.00	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	SLEEP LAB	0	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
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: 151334	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/17/2012 1:59 pm
	Title XVIII	Hospital	Cost

Cost Center Description	PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	
	23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 OPERATING ROOM	0	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00 CT SCAN	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	59.00
60.00 LABORATORY	0	0	60.00
60.01 BLOOD LABORATORY	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00 RESPIRATORY THERAPY	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	66.00
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
76.00 CARDIAC REHAB	0	0	76.00
76.01 SLEEP LAB	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00 RURAL HEALTH CLINIC	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
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: 151334	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/17/2012 1:59 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost
		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	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 OPERATING ROOM	0.438513	0	627,842	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0.263949	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0.159649	0	3,607,580	0	54.00
57.00 CT SCAN	0.000000	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00 LABORATORY	0.193307	0	2,733,079	0	60.00
60.01 BLOOD LABORATORY	0.000000	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	1.234591	0	18,348	0	63.00
65.00 RESPIRATORY THERAPY	0.298996	0	383,571	0	65.00
66.00 PHYSICAL THERAPY	0.349082	0	641,162	0	66.00
69.00 ELECTROCARDIOLOGY	0.359841	0	286,825	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.339008	0	375,167	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.608473	0	142,307	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.245747	0	829,597	0	73.00
76.00 CARDIAC REHAB	1.288052	0	84,102	0	76.00
76.01 SLEEP LAB	0.045704	0	253,907	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 RURAL HEALTH CLINIC	0.000000				88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
91.00 EMERGENCY	0.406686	0	1,265,077	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.107910	0	88,193	0	92.00
200.00 Subtotal (see instructions)		0	11,336,757	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	11,336,757	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151334	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/17/2012 1:59 pm
	Title XVIII	Hospital	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	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 OPERATING ROOM	0	275,317	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	575,947	0	54.00
57.00 CT SCAN	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 LABORATORY	0	528,323	0	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	22,652	0	63.00
65.00 RESPIRATORY THERAPY	0	114,686	0	65.00
66.00 PHYSICAL THERAPY	0	223,818	0	66.00
69.00 ELECTROCARDIOLOGY	0	103,211	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	127,185	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	86,590	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	203,871	0	73.00
76.00 CARDIAC REHAB	0	108,328	0	76.00
76.01 SLEEP LAB	0	11,605	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00 EMERGENCY	0	514,489	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	97,710	0	92.00
200.00 Subtotal (see instructions)	0	2,993,732	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	2,993,732	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151334	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part I Date/Time Prepared: 5/17/2012 1:59 pm
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Cost Center Description	Title XIX			Hospital	Tefra		
	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	651,398	0	651,398	3,878	167.97	30.00
31.00	INTENSIVE CARE UNIT	38,161		38,161	417	91.51	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	11,635		11,635	410	28.38	43.00
200.00	Total (lines 30-199)	701,194		701,194	4,705		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 151334

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

Worksheet D  
Part I  
Date/Time Prepared:  
5/17/2012 1:59 pm

Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	664	111,532	30.00
31.00	INTENSIVE CARE UNIT	49	4,484	31.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	300	8,514	43.00
200.00	Total (Lines 30-199)	1,013	124,530	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151334

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

Worksheet D  
Part II  
Date/Time Prepared:  
5/17/2012 1:59 pm

Cost Center Description		Title XIX			Hospital	Tefra	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	518,618	5,017,970	0.103352	119,231	12,323	50.00
52.00	DELIVERY ROOM & LABOR ROOM	22,189	449,254	0.049391	7,403	366	52.00
54.00	RADIOLOGY-DIAGNOSTIC	234,602	14,876,692	0.015770	130,561	2,059	54.00
57.00	CT SCAN	0	0	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	LABORATORY	142,090	11,281,963	0.012594	304,957	3,841	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	2,110	101,010	0.020889	6,871	144	63.00
65.00	RESPIRATORY THERAPY	64,490	2,339,125	0.027570	97,434	2,686	65.00
66.00	PHYSICAL THERAPY	102,348	2,332,995	0.043870	5,483	241	66.00
69.00	ELECTROCARDIOLOGY	64,280	1,109,128	0.057955	58,755	3,405	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	73,719	2,310,483	0.031906	194,679	6,211	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	3,515	330,470	0.010636	9,512	101	72.00
73.00	DRUGS CHARGED TO PATIENTS	42,104	5,030,430	0.008370	209,661	1,755	73.00
76.00	CARDIAC REHAB	23,903	163,238	0.146430	0	0	76.00
76.01	SLEEP LAB	1,648	884,724	0.001863	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	EMERGENCY	240,815	6,167,402	0.039046	50,719	1,980	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	99,776	568,147	0.175617	9,607	1,687	92.00
200.00	Total (lines 50-199)	1,636,207	52,963,031		1,204,873	36,799	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151334

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

Worksheet D  
Part III  
Date/Time Prepared:  
5/17/2012 1:59 pm

Cost Center Description	Title XIX			Hospital	Tefra	Total Costs (sum of cols. 1 through 3, minus col. 4)
	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)		
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	0	0	0	0	0	43.00
200.00 Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151334	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part III Date/Time Prepared: 5/17/2012 1:59 pm
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Cost Center Description	Title XIX		Hospital		Tefra	
	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
	6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	3,878	0.00	664	0	0	30.00
31.00 INTENSIVE CARE UNIT	417	0.00	49	0	0	31.00
41.00 SUBPROVIDER - IRF	0	0.00	0	0	0	41.00
42.00 SUBPROVIDER	0	0.00	0	0	0	42.00
43.00 NURSERY	410	0.00	300	0	0	43.00
200.00 Total (lines 30-199)	4,705		1,013	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151334

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

Worksheet D  
Part III  
Date/Time Prepared:  
5/17/2012 1:59 pm

Cost Center Description		PSA Adj .	PSA Adj . All	Hospital	Tefra
		Allied Health Cost	Other Medical Education Cost		
		12.00	13.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	0	0		30.00
31.00	INTENSIVE CARE UNIT	0	0		31.00
41.00	SUBPROVIDER - IRF	0	0		41.00
42.00	SUBPROVIDER	0	0		42.00
43.00	NURSERY	0	0		43.00
200.00	Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151334

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/17/2012 1:59 pm

Cost Center Description		Title XIX				Hospital	Tefra	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	OPERATING ROOM	0	0	0	0	0	50.00	
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00	
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
57.00	CT SCAN	0	0	0	0	0	57.00	
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00	LABORATORY	0	0	0	0	0	60.00	
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01	
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00	
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00	
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00	
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	
76.00	CARDIAC REHAB	0	0	0	0	0	76.00	
76.01	SLEEP LAB	0	0	0	0	0	76.01	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00	
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00	
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: 151334

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/17/2012 1:59 pm

Cost Center Description		Title XIX			Hospital		Tefra	
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	OPERATING ROOM	0	5,017,970	0.000000	0.000000	119,231	50.00	
52.00	DELIVERY ROOM & LABOR ROOM	0	449,254	0.000000	0.000000	7,403	52.00	
54.00	RADIOLOGY-DIAGNOSTIC	0	14,876,692	0.000000	0.000000	130,561	54.00	
57.00	CT SCAN	0	0	0.000000	0.000000	0	57.00	
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00	
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00	
60.00	LABORATORY	0	11,281,963	0.000000	0.000000	304,957	60.00	
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01	
63.00	BLOOD STORING, PROCESSING & TRANS.	0	101,010	0.000000	0.000000	6,871	63.00	
65.00	RESPIRATORY THERAPY	0	2,339,125	0.000000	0.000000	97,434	65.00	
66.00	PHYSICAL THERAPY	0	2,332,995	0.000000	0.000000	5,483	66.00	
69.00	ELECTROCARDIOLOGY	0	1,109,128	0.000000	0.000000	58,755	69.00	
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,310,483	0.000000	0.000000	194,679	71.00	
72.00	IMPL. DEV. CHARGED TO PATIENT	0	330,470	0.000000	0.000000	9,512	72.00	
73.00	DRUGS CHARGED TO PATIENTS	0	5,030,430	0.000000	0.000000	209,661	73.00	
76.00	CARDIAC REHAB	0	163,238	0.000000	0.000000	0	76.00	
76.01	SLEEP LAB	0	884,724	0.000000	0.000000	0	76.01	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00	
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00	
91.00	EMERGENCY	0	6,167,402	0.000000	0.000000	50,719	91.00	
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	568,147	0.000000	0.000000	9,607	92.00	
200.00	Total (lines 50-199)	0	52,963,031			1,204,873	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151334

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/17/2012 1:59 pm

Cost Center Description		Title XIX			Hospital	Tefra		
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School		
		11.00	12.00	13.00	21.00	22.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
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
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
57.00	CT SCAN	0	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
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
76.00	CARDIAC REHAB	0	0	0	0	0	0	76.00
76.01	SLEEP LAB	0	0	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
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: 151334

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/17/2012 1:59 pm

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	CT SCAN	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	0	0	60.00
60.01	BLOOD LABORATORY	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	RESPIRATORY THERAPY	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	66.00
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
76.00	CARDIAC REHAB	0	0	76.00
76.01	SLEEP LAB	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	RURAL HEALTH CLINIC	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
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: 151334	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/17/2012 1:59 pm
	Title XIX	Hospital	Tefra

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see instructions)	Cost		Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	
			Reimbursed Services Subject To Ded. & Coins. (see instructions)	Reimbursed Services Subject To Ded. & Coins. (see instructions)		
	1.00	2.00	3.00	4.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	0.438513	0	342,227	0		50.00
52.00 DELIVERY ROOM & LABOR ROOM	0.263949	0	15,016	0		52.00
54.00 RADIOLOGY-DIAGNOSTIC	0.159649	0	1,692,449	0		54.00
57.00 CT SCAN	0.000000	0	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0.000000	0	0	0		59.00
60.00 LABORATORY	0.193307	0	1,057,081	0		60.00
60.01 BLOOD LABORATORY	0.000000	0	0	0		60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	1.234591	0	16,789	0		63.00
65.00 RESPIRATORY THERAPY	0.298996	0	171,531	0		65.00
66.00 PHYSICAL THERAPY	0.349082	0	227,230	0		66.00
69.00 ELECTROCARDIOLOGY	0.359841	0	110,650	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.339008	0	383,105	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.608473	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.245747	0	143,926	0		73.00
76.00 CARDIAC REHAB	1.288052	0	0	0		76.00
76.01 SLEEP LAB	0.045704	0	188,895	0		76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 RURAL HEALTH CLINIC	0.000000					88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
91.00 EMERGENCY	0.406686	0	748,090	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.107910	0	67,101	0		92.00
200.00 Subtotal (see instructions)		0	5,164,090	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	5,164,090	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151334	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/17/2012 1:59 pm
Title XIX		Hospital	Tefra

Cost Center Description	Costs			
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)	
	5.00	6.00	7.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 OPERATING ROOM	0	150,071	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	3,963	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	270,198	0	54.00
57.00 CT SCAN	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 LABORATORY	0	204,341	0	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	20,728	0	63.00
65.00 RESPIRATORY THERAPY	0	51,287	0	65.00
66.00 PHYSICAL THERAPY	0	79,322	0	66.00
69.00 ELECTROCARDIOLOGY	0	39,816	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	129,876	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	35,369	0	73.00
76.00 CARDIAC REHAB	0	0	0	76.00
76.01 SLEEP LAB	0	8,633	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00 EMERGENCY	0	304,238	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	74,342	0	92.00
200.00 Subtotal (see instructions)	0	1,372,184	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	1,372,184	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151334	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/17/2012 1:59 pm
Cost Center Description			Cost	
			1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,878	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,878	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)		3,878	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,842	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			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)		4,109,470	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,109,470	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,982,108	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		1,982,108	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		2.073283	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)		511.12	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,109,470	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,059.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,951,949	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,951,949	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151334		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1	
Title XVIII		Hospital		Cost		Date/Time Prepared: 5/17/2012 1:59 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)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	592,539	417	1,420.96	271	385,080		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)					1,547,133		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,884,162		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)						594	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,059.69	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						629,456	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151334		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 5/17/2012 1:59 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151334	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/17/2012 1:59 pm
Cost Center Description		Tefra		
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,878	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,878	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)		3,878	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		664	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)		410	15.00
16.00	Nursery days (title V or XIX only)		300	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			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)		4,109,470	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,109,470	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,109,470	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,059.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		703,634	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)		703,634	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151334		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1	
Title XIX		Hospital		Tefra		Date/Time Prepared: 5/17/2012 1:59 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)		
42.00 NURSERY (title V & XIX only)	260,388	410	635.09	300	190,527		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	592,539	417	1,420.96	49	69,627		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)					349,284		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,313,072		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)					124,530		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					36,799		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					161,329		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,151,743		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					241		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)					-1,151,743		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)					161,329		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)					594		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,059.69		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					629,456		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151334		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 5/17/2012 1:59 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	651,398	4,109,470	0.158511	629,456	99,776	90.00
91.00	Nursing School cost	0	4,109,470	0.000000	629,456	0	91.00
92.00	Allied health cost	0	4,109,470	0.000000	629,456	0	92.00
93.00	All other Medical Education	0	4,109,470	0.000000	629,456	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151334	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/17/2012 1:59 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS		798,811		30.00
31.00	INTENSIVE CARE UNIT		253,900		31.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.438513	428,489	187,898	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.263949	1,139	301	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.159649	617,737	98,621	54.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.193307	1,321,447	255,445	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	1.234591	21,361	26,372	63.00
65.00	RESPIRATORY THERAPY	0.298996	661,161	197,684	65.00
66.00	PHYSICAL THERAPY	0.349082	55,749	19,461	66.00
69.00	ELECTROCARDIOLOGY	0.359841	309,805	111,481	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.339008	472,855	160,302	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.608473	63,934	38,902	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.245747	1,405,030	345,282	73.00
76.00	CARDIAC REHAB	1.288052	0	0	76.00
76.01	SLEEP LAB	0.045704	1,348	62	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	EMERGENCY	0.406686	138,563	56,352	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		44,200	48,970	92.00
200.00	Total (sum of lines 50-94 and 96-98)	1.107910	5,542,818	1,547,133	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		5,542,818		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151334	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/17/2012 1:59 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS		150,835		30.00
31.00	INTENSIVE CARE UNIT		39,350		31.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY		18,769		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.438513	119,231	52,284	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.263949	7,403	1,954	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.159649	130,561	20,844	54.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.193307	304,957	58,950	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	1.234591	6,871	8,483	63.00
65.00	RESPIRATORY THERAPY	0.298996	97,434	29,132	65.00
66.00	PHYSICAL THERAPY	0.349082	5,483	1,914	66.00
69.00	ELECTROCARDIOLOGY	0.359841	58,755	21,142	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.339008	194,679	65,998	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.608473	9,512	5,788	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.245747	209,661	51,524	73.00
76.00	CARDIAC REHAB	1.288052	0	0	76.00
76.01	SLEEP LAB	0.045704	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
91.00	EMERGENCY	0.406686	50,719	20,627	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		9,607	10,644	92.00
200.00	Total (sum of lines 50-94 and 96-98)	1.107910	1,204,873	349,284	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		1,204,873		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151334	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/17/2012 1:59 pm
		Title XVIII	Hospital	Cost
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			2,993,732 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)			2,993,732 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			3,023,669 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)			34,290 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,707,012 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			1,282,367 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			1,282,367 30.00
31.00	Primary payer payments			125 31.00
32.00	Subtotal (line 30 minus line 31)			1,282,242 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			514,046 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			514,046 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			443,207 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			1,796,288 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			1,796,288 40.00
41.00	Interim payments			1,896,756 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)			-100,468 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151334	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/17/2012 1:59 pm
		Title XVIII	Hospital	Cost
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151334

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/17/2012 1:59 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		2,842,245		2,109,314	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	09/22/2011	91,670		0		3.01
3.02		11/10/2011	14,126		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	09/22/2011	175,135		3.50
3.51			0	11/10/2011	37,423		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)		105,796		-212,558		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,948,041		1,896,756		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		652,101		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		100,468		6.02
7.00	Total Medicare program liability (see instructions)		3,600,142		1,796,288		7.00
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151334	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part V Date/Time Prepared: 5/17/2012 1:59 pm
		Title XVIII	Hospital	Cost
		1.00		
<b>PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)</b>				
1.00	Inpatient services		3,884,162	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)		3,884,162	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5) . For CAH (see instructions)		3,923,004	6.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
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
<b>Customary charges</b>				
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
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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)		3,923,004	19.00
20.00	Deductibles (exclude professional component)		428,830	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		3,494,174	22.00
23.00	Coinsurance		5,377	23.00
24.00	Subtotal (line 22 minus line 23)		3,488,797	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		111,345	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		111,345	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		87,019	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26)		3,600,142	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)		3,600,142	30.00
31.00	Interim payments		2,948,041	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)		652,101	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 151334

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

Worksheet G  
Date/Time Prepared:  
5/17/2012 1:59 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	2,644,236	0	0	0	1.00
2.00	Temporary investments	3,473,829	0	0	0	2.00
3.00	Notes receivable	12,888	0	0	0	3.00
4.00	Accounts receivable	33,931,071	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-29,818,290	0	0	0	6.00
7.00	Inventory	468,146	0	0	0	7.00
8.00	Prepaid expenses	268,484	0	0	0	8.00
9.00	Other current assets	-5,523	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	10,974,841	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	241,233	0	0	0	12.00
13.00	Land improvements	520,508	0	0	0	13.00
14.00	Accumulated depreciation	-456,955	0	0	0	14.00
15.00	Buildings	18,977,955	0	0	0	15.00
16.00	Accumulated depreciation	-6,125,156	0	0	0	16.00
17.00	Leasehold improvements	41,213	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	2,405,254	0	0	0	19.00
20.00	Accumulated depreciation	-1,942,116	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	14,703,974	0	0	0	23.00
24.00	Accumulated depreciation	-9,470,427	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)	18,895,483	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	29,870,324	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	1,235,420	0	0	0	37.00
38.00	Salaries, wages, and fees payable	739,753	0	0	0	38.00
39.00	Payroll taxes payable	0	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	464,076	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,439,249	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	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)	2,439,249	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	27,431,075				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)	27,431,075	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	29,870,324	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151334

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

Worksheet G-1

Date/Time Prepared:  
5/17/2012 1:59 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		29,401,766	
2.00	Net income (loss) (From Wkst. G-3, line 29)		-1,970,691			2.00
3.00	Total (sum of line 1 and line 2)		27,431,075		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		27,431,075		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)		27,431,075		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151334

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

Worksheet G-1

Date/Time Prepared:  
5/17/2012 1:59 pm

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151334

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

Worksheet G-2 Parts

Date/Time Prepared:  
5/17/2012 1:59 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	1,982,108		1,982,108	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				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)	1,982,108		1,982,108	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	803,095		803,095	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)	803,095		803,095	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,785,203		2,785,203	17.00
18.00	Ancillary services	9,356,813	38,578,444	47,935,257	18.00
19.00	Outpatient services	336,206	6,341,898	6,678,104	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	285,522	-3,027	282,495	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	12,763,744	44,917,315	57,681,059	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		19,959,012		29.00
30.00	BAD DEBT EXPENSE	7,021,467			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)		7,021,467		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)		26,980,479		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151334

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

Worksheet G-3

Date/Time Prepared:  
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	57,681,059	1.00
2.00	Less contractual allowances and discounts on patients' accounts	34,592,000	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,089,059	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	26,980,479	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,891,420	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	450,656	6.00
7.00	Income from investments	2,196	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	8,072	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	85,470	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	1,816	17.00
18.00	Revenue from sale of medical records and abstracts	9,792	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	IDENTIFIED ON TB	1,362,727	24.00
25.00	Total other income (sum of lines 6-24)	1,920,729	25.00
26.00	Total (line 5 plus line 25)	-1,970,691	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,970,691	29.00