

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: 150172 Period: From 01/01/2011 To 12/31/2011 Worksheet S Parts I-III Date/Time Prepared: 5/21/2012 8:41 am

PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report Date: 5/21/2012 Time: 8:41 am
 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

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 PHYSICIANS MEDICAL CENTER for the cost reporting period beginning 01/01/2011 and ending 12/31/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title XVIII			HIT	Title XIX	
	Title V	Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	11,174	57,576	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	11,174	57,576	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: 150172	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/21/2012 8:23 am
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1.00	2.00	3.00	4.00	1.00
Hospital and Hospital Health Care Complex Address:				
1.00	Street: 4023 RASE LANE	PO Box:		1.00
2.00	City: NEW ALBANE	State: IN	Zip Code: 47150	2.00
			County: FLOYD	

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
						V	XVIII	XIX	
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		

Hospital and Hospital-Based Component Identification:										
3.00	Hospital	PHYSICIANS MEDICAL CENTER	150172	31140	1	10/30/2008	N	P	N	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			8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) 1									17.00
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)	4		21.00

Inpatient PPS Information										
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					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.					2	N			23.00

	In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	

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

						Urban/Rural S	Date of Geogr		
						1.00	2.00		

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150172	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/21/2012 8:23 am		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00	61.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00	
		Program Name 1.00	Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 150172

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

Worksheet S-2
Part I
Date/Time Prepared:
5/21/2012 8:23 am

		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: 150172	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/21/2012 8:23 am	
			1.00	2.00	3.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.		N		75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.			N	80.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(i)? Enter "Y" for yes and "N" for no.			N	86.00
			V	XIX	
			1.00	2.00	
Title V or XIX Inpatient Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	N	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		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.		N	N	109.00
			1.00		2.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.		N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			0	118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.			0	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00

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		1.00	2.00				
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.						134.00
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y				140.00
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:			141.00
142.00	Street:	PO Box:		Zip Code:			142.00
143.00	City:	State:					143.00
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y				144.00
145.00	If costs for renal services are claimed on Worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N				145.00
						1.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N				146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N				147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N				148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N				149.00
						Part A 1.00	Part B 2.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital		N			N	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
							1.00
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150172	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part II Date/Time Prepared: 5/21/2012 8:23 am	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	06/30/2012	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?				6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.				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.				8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.				9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.				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.				11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			N	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A			
		Description	Y/N	Date	
		0	1.00	2.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/02/2012		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N			20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 150172

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

Worksheet S-2
Part II
Date/Time Prepared:
5/21/2012 8:23 am

		Part A			
		Description	Y/N	Date	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	1.00 N	2.00	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				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.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				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
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				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.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				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
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/02/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150172

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

Worksheet S-3
Part I
Date/Time Prepared:
5/21/2012 8:23 am

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	12	4,380	0.00	1.00
2.00	HMO					2.00
3.00	HMO IPF					3.00
4.00	HMO IRF					4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					5.00
6.00	Hospital Adults & Peds. Swing Bed NF					6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		12	4,380	0.00	7.00
8.00	INTENSIVE CARE UNIT					8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY					13.00
14.00	Total (see instructions)		12	4,380	0.00	14.00
15.00	CAH visits					15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					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					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER					26.25
27.00	Total (sum of lines 14-26)		12			27.00
28.00	Observation Bed Days					28.00
29.00	Ambulance Trips					29.00
30.00	Employee discount days (see instruction)					30.00
31.00	Employee discount days - IRF					31.00
32.00	Labor & delivery days (see instructions)					32.00
33.00	LTCH non-covered days					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150172

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

Worksheet S-3
Part I
Date/Time Prepared:
5/21/2012 8:23 am

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	195	40	561		1.00
2.00 HMO		2	0			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	195	40	561		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	195	40	561		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0		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	0		30	174		28.00
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				0		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			0	0		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150172

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

Worksheet S-3
Part I
Date/Time Prepared:
5/21/2012 8:23 am

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	141	1.00
2.00 HMO					1	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	42.00	0.00	0	141	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00	0.00	0.00			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)	0.00	42.00	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150172

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

Worksheet S-3
Part I
Date/Time Prepared:
5/21/2012 8:23 am

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)	27	252		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)	27	252		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
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
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150172

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

Worksheet S-3
Part II
Date/Time Prepared:
5/21/2012 8:23 am

		Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
		1.00	2.00	3.00	4.00	5.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	2,764,045	0	2,764,045	87,990.00	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	3.00
4.00	Physician-Part A		0	0	0	0.00	4.00
4.01	Physicians - Part A - direct teaching		0	0	0	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	7.00
7.01	Contracted interns and residents (in approved programs)		0	0	0	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	9.00
10.00	Excluded area salaries (see instructions)		0	0	0	0.00	10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		0	0	0	0.00	11.00
12.00	Management and administrative services		0	0	0	0.00	12.00
13.00	Contract labor: physician-Part A		0	0	0	0.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	14.00
15.00	Home office: physician Part A		0	0	0	0.00	15.00
16.00	Teaching physician salaries (see instructions)		0	0	0	0.00	16.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24		540,703	0	540,703		17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV Line 25		0	0	0		18.00
19.00	Excluded areas		0	0	0		19.00
20.00	Non-physician anesthetist Part A		0	0	0		20.00
21.00	Non-physician anesthetist Part B		0	0	0		21.00
22.00	Physician Part A		0	0	0		22.00
23.00	Physician Part B		0	0	0		23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0		24.00
25.00	Interns & residents (in an approved program)		0	0	0		25.00
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits	4.00	0	0	0	0.00	26.00
27.00	Administrative & General	5.00	567,060	-81,212	485,848	15,500.00	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	29.00
30.00	Operation of Plant	7.00	46,606	0	46,606	2,000.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	31.00
32.00	Housekeeping	9.00	29,080	0	29,080	1,694.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	33.00
34.00	Dietary	10.00	0	0	0	0.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	37.00
38.00	Nursing Administration	13.00	0	81,212	81,212	1,944.00	38.00
39.00	Central Services and Supply	14.00	93,823	0	93,823	5,774.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150172

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

Worksheet S-3
Part II
Date/Time Prepared:
5/21/2012 8:23 am

		Average Hourly Wage (col. 4 ÷ col. 5)	
		6.00	
PART II - WAGE DATA			
SALARIES			
1.00	Total salaries (see instructions)	31.41	1.00
2.00	Non-physician anesthetist Part A	0.00	2.00
3.00	Non-physician anesthetist Part B	0.00	3.00
4.00	Physician-Part A	0.00	4.00
4.01	Physicians - Part A - direct teaching	0.00	4.01
5.00	Physician-Part B	0.00	5.00
6.00	Non-physician-Part B	0.00	6.00
7.00	Interns & residents (in an approved program)	0.00	7.00
7.01	Contracted interns and residents (in approved programs)	0.00	7.01
8.00	Home office personnel	0.00	8.00
9.00	SNF	0.00	9.00
10.00	Excluded area salaries (see instructions)	0.00	10.00
OTHER WAGES & RELATED COSTS			
11.00	Contract labor (see instructions)	0.00	11.00
12.00	Management and administrative services	0.00	12.00
13.00	Contract labor: physician-Part A	0.00	13.00
14.00	Home office salaries & wage-related costs	0.00	14.00
15.00	Home office: physician Part A	0.00	15.00
16.00	Teaching physician salaries (see instructions)	0.00	16.00
WAGE-RELATED COSTS			
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24		17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV Line 25		18.00
19.00	Excluded areas		19.00
20.00	Non-physician anesthetist Part A		20.00
21.00	Non-physician anesthetist Part B		21.00
22.00	Physician Part A		22.00
23.00	Physician Part B		23.00
24.00	Wage-related costs (RHC/FOHC)		24.00
25.00	Interns & residents (in an approved program)		25.00
OVERHEAD COSTS - DIRECT SALARIES			
26.00	Employee Benefits	0.00	26.00
27.00	Administrative & General	31.35	27.00
28.00	Administrative & General under contract (see inst.)	0.00	28.00
29.00	Maintenance & Repairs	0.00	29.00
30.00	Operation of Plant	23.30	30.00
31.00	Laundry & Linen Service	0.00	31.00
32.00	Housekeeping	17.17	32.00
33.00	Housekeeping under contract (see instructions)	0.00	33.00
34.00	Dietary	0.00	34.00
35.00	Dietary under contract (see instructions)	0.00	35.00
36.00	Cafeteria	0.00	36.00
37.00	Maintenance of Personnel	0.00	37.00
38.00	Nursing Administration	41.78	38.00
39.00	Central Services and Supply	16.25	39.00
40.00	Pharmacy	0.00	40.00
41.00	Medical Records & Medical Records Library	0.00	41.00
42.00	Social Service	0.00	42.00
43.00	Other General Service	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150172

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

Worksheet S-3
Part III
Date/Time Prepared:
5/21/2012 8:23 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
	1.00	2.00	3.00	4.00	5.00	
PART III - HOSPITAL WAGE INDEX SUMMARY						
1.00	Net salaries (see instructions)	2,764,045	0	2,764,045	87,990.00	1.00
2.00	Excluded area salaries (see instructions)	0	0	0	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	2,764,045	0	2,764,045	87,990.00	3.00
4.00	Subtotal other wages & related costs (see inst.)	0	0	0	0.00	4.00
5.00	Subtotal wage-related costs (see inst.)	540,703	0	540,703	0.00	5.00
6.00	Total (sum of lines 3 thru 5)	3,304,748	0	3,304,748	87,990.00	6.00
7.00	Total overhead cost (see instructions)	736,569	0	736,569	26,912.00	7.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150172

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

Worksheet S-3
Part III
Date/Time Prepared:
5/21/2012 8:23 am

		Average Hourly Wage (col. 4 ÷ col. 5)	
		6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY			
1.00	Net salaries (see instructions)	31.41	1.00
2.00	Excluded area salaries (see instructions)	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	31.41	3.00
4.00	Subtotal other wages & related costs (see inst.)	0.00	4.00
5.00	Subtotal wage-related costs (see inst.)	19.56	5.00
6.00	Total (sum of lines 3 thru 5)	37.56	6.00
7.00	Total overhead cost (see instructions)	27.37	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 150172

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

Worksheet S-3
Part IV
Date/Time Prepared:
5/21/2012 8:23 am

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

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150172

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

Worksheet S-3
Part V
Date/Time Prepared:
5/21/2012 8:23 am

Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis			17.00
18.00		0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150172	Period: From 01/01/2011 To 12/31/2011	Worksheet S-10 Date/Time Prepared: 5/21/2012 8:23 am
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			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)		0.222700	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		553,375	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		3,689,166	6.00
7.00	Medicaid cost (line 1 times line 6)		821,577	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)		268,202	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)		268,202	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?		N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		416,053	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		68,651	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		347,402	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		77,366	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		77,366	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		345,568	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150172

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

Worksheet A
Date/Time Prepared:
5/21/2012 8:23 am

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT		1,054,675	1,054,675	232,144	1,286,819	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		50,129	50,129	0	50,129	2.00
3.00 OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00 EMPLOYEE BENEFITS	0	585,684	585,684	0	585,684	4.00
5.00 ADMINISTRATIVE & GENERAL	567,060	2,218,843	2,785,903	-81,212	2,704,691	5.00
7.00 OPERATION OF PLANT	46,606	549,675	596,281	0	596,281	7.00
8.00 LAUNDRY & LINEN SERVICE	0	55,862	55,862	0	55,862	8.00
9.00 HOUSEKEEPING	29,080	92,529	121,609	0	121,609	9.00
10.00 DIETARY	0	24,946	24,946	0	24,946	10.00
13.00 NURSING ADMINISTRATION	0	0	0	81,212	81,212	13.00
14.00 CENTRAL SERVICES & SUPPLY	93,823	170,403	264,226	0	264,226	14.00
15.00 PHARMACY	0	0	0	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	87,919	87,919	0	87,919	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICALS	660,941	58,280	719,221	0	719,221	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	1,281,660	13,566	1,295,226	0	1,295,226	50.00
54.00 RADIOLOGY-DIAGNOSTIC	84,875	0	84,875	0	84,875	54.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	893,529	893,529	0	893,529	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	718,274	718,274	0	718,274	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	267,276	267,276	0	267,276	73.00
OUTPATIENT SERVICE COST CENTERS						
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE		232,144	232,144	-232,144	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	2,764,045	7,073,734	9,837,779	0	9,837,779	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01 SHELLED SPACE	0	0	0	0	0	190.01
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
200.00 TOTAL (SUM OF LINES 118-199)	2,764,045	7,073,734	9,837,779	0	9,837,779	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150172

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

Worksheet A
Date/Time Prepared:
5/21/2012 8:23 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	-2,526	1,284,293	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	50,129	2.00
3.00	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	EMPLOYEE BENEFITS	0	585,684	4.00
5.00	ADMINISTRATIVE & GENERAL	-984,607	1,720,084	5.00
7.00	OPERATION OF PLANT	0	596,281	7.00
8.00	LAUNDRY & LINEN SERVICE	0	55,862	8.00
9.00	HOUSEKEEPING	0	121,609	9.00
10.00	DIETARY	0	24,946	10.00
13.00	NURSING ADMINISTRATION	0	81,212	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	264,226	14.00
15.00	PHARMACY	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	87,919	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-54,600	664,621	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	1,295,226	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	84,875	54.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	-49	893,480	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	718,274	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	267,276	73.00
OUTPATIENT SERVICE COST CENTERS				
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-1,041,782	8,795,997	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	SHELLED SPACE	0	0	190.01
191.00	RESEARCH	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	NONPAID WORKERS	0	0	193.00
200.00	TOTAL (SUM OF LINES 118-199)	-1,041,782	8,795,997	200.00

Provider CCN: 150172

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

Worksheet A-6
Date/Time Prepared:
5/21/2012 8:23 am

		Increases			
Cost Center		Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - INTEREST					
1.00	NEW CAP REL COSTS-BLDG & FI XT	1.00	0	232,144	1.00
	TOTALS		0	232,144	
B - NURSING ADMINISTRATION					
1.00	NURSING ADMINISTRATION	13.00	81,212	0	1.00
	TOTALS		81,212	0	
500.00	Grand Total: Increases		81,212	232,144	500.00

Provider CCN: 150172

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

Worksheet A-6
Date/Time Prepared:
5/21/2012 8:23 am

Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - INTEREST							
1.00	INTEREST EXPENSE	113.00	0	232,144	11		1.00
	TOTALS		0	232,144			
B - NURSING ADMINISTRATION							
1.00	ADMINISTRATIVE & GENERAL	5.00	81,212	0	0		1.00
	TOTALS		81,212	0			
500.00	Grand Total: Decreases		81,212	232,144			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150172

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/21/2012 8:23 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	850,190	139,382	0	139,382	0	1.00
2.00	Land Improvements	768,718	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	7,399,067	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	3,898,187	63,886	0	63,886	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	12,916,162	203,268	0	203,268	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	12,916,162	203,268	0	203,268	0	10.00
SUMMARY OF CAPITAL							
Cost Center Description		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	891,355	0	0	0	163,320	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	24,159	25,970	0	0	0	2.00
3.00	Total (sum of lines 1-2)	915,514	25,970	0	0	163,320	3.00
COMPUTATION OF RATIOS							
Cost Center Description		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	9,157,358	0	9,157,358	0.698000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	3,962,072	0	3,962,072	0.302000	0	2.00
3.00	Total (sum of lines 1-2)	13,119,430	0	13,119,430	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150172

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/21/2012 8:23 am

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	989,572	0			1.00
2.00	Land Improvements	768,718	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	7,399,067	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	3,962,073	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	13,119,430	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	13,119,430	0			10.00
SUMMARY OF CAPITAL						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,054,675			1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	50,129			2.00
3.00	Total (sum of lines 1-2)	0	1,104,804			3.00
ALLOCATION OF OTHER CAPITAL						
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	891,355	0
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	24,159	25,970
3.00	Total (sum of lines 1-2)	0	0	0	915,514	25,970

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150172

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/21/2012 8:23 am

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	229,618	0	163,320	0	1,284,293	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	50,129	2.00
3.00	Total (sum of lines 1-2)	229,618	0	163,320	0	1,334,422	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150172

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

Worksheet A-8
Date/Time Prepared:
5/21/2012 8:23 am

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)	B	-109	NEW CAP REL COSTS-BLDG & FIXT		1.00 1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP		2.00 2.00
3.00 Investment income - other (chapter 2)		0			0.00 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00 7.00
8.00 Television and radio service (chapter 21)		0			0.00 8.00
9.00 Parking lot (chapter 21)		0			0.00 9.00
10.00 Provider-based physician adjustment	A-8-2	-54,600			10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0			12.00
13.00 Laundry and linen service		0			0.00 13.00
14.00 Cafeteria-employees and guests		0			0.00 14.00
15.00 Rental of quarters to employee and others		0			0.00 15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00 16.00
17.00 Sale of drugs to other than patients		0			0.00 17.00
18.00 Sale of medical records and abstracts		0			0.00 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00 19.00
20.00 Vending machines		0			0.00 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***		65.00 23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***		66.00 24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***		114.00 25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT		1.00 26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP		2.00 27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***		19.00 28.00
29.00 Physicians' assistant		0			0.00 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***		67.00 30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***		68.00 31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	0			0.00 32.00
33.00 REMOVAL OF SUITE LEASE	A	-894,000	ADMINISTRATIVE & GENERAL		5.00 33.00
34.00 AJE #4 TO DEPRECIATION EXPENSE	A	-2,417	NEW CAP REL COSTS-BLDG & FIXT		1.00 34.00
35.00 AJE #2 FINANCE CHARGES	A	828	ADMINISTRATIVE & GENERAL		5.00 35.00
36.00 MARKETING COSTS	A	-85,435	ADMINISTRATIVE & GENERAL		5.00 36.00
37.00 AJE #1 TO DISPOSABLE MEDICAL SUPPLIE	A	-49	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00 37.00
38.00 AJE #3 TO OTHER TAXES	A	-6,000	ADMINISTRATIVE & GENERAL		5.00 38.00
39.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00 39.00
40.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00 40.00
41.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00 41.00
42.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00 42.00
43.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00 43.00
44.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00 44.00
45.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00 45.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,041,782			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150172

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

Worksheet A-8

Date/Time Prepared:
5/21/2012 8:23 am

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	11	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	REMOVAL OF SUITE LEASE	0	33.00
34.00	AJE #4 TO DEPRECIATION EXPENSE	11	34.00
35.00	AJE #2 FINANCE CHARGES	0	35.00
36.00	MARKETING COSTS	0	36.00
37.00	AJE #1 TO DISPOSABLE MEDICAL SUPPLIE	0	37.00
38.00	AJE #3 TO OTHER TAXES	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

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

Provider CCN: 150172

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

Worksheet A-8-1

Date/Time Prepared:
5/21/2012 8:23 am

		Line No.	Cost Center	Expense Items	
		1.00	2.00	3.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		5.00	ADMINISTRATIVE & GENERAL		1.00
2.00		0.00			2.00
3.00		0.00			3.00
4.00		0.00			4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				5.00

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

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

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

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

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

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

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

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

Provider CCN: 150172

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

Worksheet A-8-1

Date/Time Prepared: 5/21/2012 8:23 am

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

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

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

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

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

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

6.00		PHYS MED CTR	0.00	HOSPITAL	6.00
7.00		PHYS SURG PROP	0.00	PROPERTY CO	7.00
8.00			0.00		8.00
9.00			0.00		9.00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150172

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

Worksheet A-8-2

Date/Time Prepared:
5/21/2012 8:23 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	30.00	ADULTS & PEDIATRICS	54,600	54,600	1.00
2.00	0.00		0	0	2.00
3.00	0.00		0	0	3.00
4.00	0.00		0	0	4.00
5.00	0.00		0	0	5.00
6.00	0.00		0	0	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00			54,600	54,600	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150172

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

Worksheet A-8-2

Date/Time Prepared:
5/21/2012 8:23 am

	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: 150172

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

Worksheet A-8-2

Date/Time Prepared:
5/21/2012 8:23 am

	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: 150172

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

Worksheet A-8-2
Date/Time Prepared:
5/21/2012 8:23 am

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	54,600	1.00
2.00	0	0	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	54,600	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150172

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

Worksheet B
Part I
Date/Time Prepared:
5/21/2012 8:23 am

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	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT	1,284,293	1,284,293				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	50,129		50,129			2.00
4.00 EMPLOYEE BENEFITS	585,684	0	0	585,684		4.00
5.00 ADMINISTRATIVE & GENERAL	1,720,084	220,138	8,593	102,948	2,051,763	5.00
7.00 OPERATION OF PLANT	596,281	81,732	3,190	9,876	691,079	7.00
8.00 LAUNDRY & LINEN SERVICE	55,862	0	0	0	55,862	8.00
9.00 HOUSEKEEPING	121,609	18,163	709	6,162	146,643	9.00
10.00 DIETARY	24,946	19,760	771	0	45,477	10.00
13.00 NURSING ADMINISTRATION	81,212	0	0	17,208	98,420	13.00
14.00 CENTRAL SERVICES & SUPPLY	264,226	204,582	7,985	19,881	496,674	14.00
15.00 PHARMACY	0	5,003	195	0	5,198	15.00
16.00 MEDICAL RECORDS & LIBRARY	87,919	20,097	784	0	108,800	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	664,621	332,225	12,968	140,049	1,149,863	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	1,295,226	376,623	14,701	271,575	1,958,125	50.00
54.00 RADIOLOGY-DIAGNOSTIC	84,875	5,970	233	17,985	109,063	54.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	893,480	0	0	0	893,480	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	718,274	0	0	0	718,274	72.00
73.00 DRUGS CHARGED TO PATIENTS	267,276	0	0	0	267,276	73.00
OUTPATIENT SERVICE COST CENTERS						
92.00 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	8,795,997	1,284,293	50,129	585,684	8,795,997	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01 SHELLED SPACE	0	0	0	0	0	190.01
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	8,795,997	1,284,293	50,129	585,684	8,795,997	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150172

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

Worksheet B
Part I
Date/Time Prepared:
5/21/2012 8:23 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	2,051,763					5.00
7.00	OPERATION OF PLANT	210,244	901,323				7.00
8.00	LAUNDRY & LINEN SERVICE	16,995	0	72,857			8.00
9.00	HOUSEKEEPING	44,612	16,663	0	207,918		9.00
10.00	DIETARY	13,835	18,129	0	4,261	81,702	10.00
13.00	NURSING ADMINISTRATION	29,942	0	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	151,101	187,694	0	44,113	0	14.00
15.00	PHARMACY	1,581	4,590	0	1,079	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	33,100	18,438	0	4,333	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	349,817	304,800	5,100	71,636	81,702	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	595,708	345,532	65,571	81,209	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC	33,180	5,477	2,186	1,287	0	54.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	271,819	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	218,517	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	81,312	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,051,763	901,323	72,857	207,918	81,702	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	SHELLED SPACE	0	0	0	0	0	190.01
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	2,051,763	901,323	72,857	207,918	81,702	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150172

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

Worksheet B
Part I
Date/Time Prepared:
5/21/2012 8:23 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
13.00	NURSING ADMINISTRATION	128,362					13.00
14.00	CENTRAL SERVICES & SUPPLY	0	879,582				14.00
15.00	PHARMACY	0	0	12,448			15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	164,671		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	26,017	0	0	1,324	1,990,259	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	102,345	0	0	122,114	3,270,604	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	11,839	163,032	54.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	483,770	0	17,143	1,666,212	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	395,812	0	7,158	1,339,761	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	12,448	5,093	366,129	73.00
OUTPATIENT SERVICE COST CENTERS							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	128,362	879,582	12,448	164,671	8,795,997	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	SHELLED SPACE	0	0	0	0	0	190.01
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	128,362	879,582	12,448	164,671	8,795,997	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150172

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

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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	EMPLOYEE BENEFITS			4.00
5.00	ADMINISTRATIVE & GENERAL			5.00
7.00	OPERATION OF PLANT			7.00
8.00	LAUNDRY & LINEN SERVICE			8.00
9.00	HOUSEKEEPING			9.00
10.00	DIETARY			10.00
13.00	NURSING ADMINISTRATION			13.00
14.00	CENTRAL SERVICES & SUPPLY			14.00
15.00	PHARMACY			15.00
16.00	MEDICAL RECORDS & LIBRARY			16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	1,990,259	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	3,270,604	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	163,032	54.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,666,212	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	1,339,761	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	366,129	73.00
OUTPATIENT SERVICE COST CENTERS				
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE			113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	8,795,997	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	SHELLED SPACE	0	0	190.01
191.00	RESEARCH	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	NONPAID WORKERS	0	0	193.00
200.00	Cross Foot Adjustments	0	0	200.00
201.00	Negative Cost Centers	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	8,795,997	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150172

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

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	0	0	0	0	4.00
5.00	ADMINISTRATIVE & GENERAL	0	220,138	8,593	228,731	5.00
7.00	OPERATION OF PLANT	0	81,732	3,190	84,922	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	HOUSEKEEPING	0	18,163	709	18,872	9.00
10.00	DIETARY	0	19,760	771	20,531	10.00
13.00	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	204,582	7,985	212,567	14.00
15.00	PHARMACY	0	5,003	195	5,198	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	20,097	784	20,881	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	332,225	12,968	345,193	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	376,623	14,701	391,324	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	5,970	233	6,203	54.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,284,293	50,129	1,334,422	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01	SHELLED SPACE	0	0	0	0	190.01
191.00	RESEARCH	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	193.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,284,293	50,129	1,334,422	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150172	Period: From 01/01/2011 To 12/31/2011	Worksheet B Part II Date/Time Prepared: 5/21/2012 8:23 am
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	228,731					5.00
7.00	OPERATION OF PLANT	23,438	108,360				7.00
8.00	LAUNDRY & LINEN SERVICE	1,895	0	1,895			8.00
9.00	HOUSEKEEPING	4,973	2,003	0	25,848		9.00
10.00	DIETARY	1,542	2,180	0	530	24,783	10.00
13.00	NURSING ADMINISTRATION	3,338	0	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	16,845	22,565	0	5,484	0	14.00
15.00	PHARMACY	176	552	0	134	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	3,690	2,217	0	539	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	38,998	36,644	133	8,906	24,783	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	66,410	41,541	1,705	10,095	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC	3,699	658	57	160	0	54.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,302	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	24,360	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	9,065	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	228,731	108,360	1,895	25,848	24,783	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	SHELLED SPACE	0	0	0	0	0	190.01
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	228,731	108,360	1,895	25,848	24,783	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150172

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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
13.00	NURSING ADMINISTRATION	3,338					13.00
14.00	CENTRAL SERVICES & SUPPLY	0	257,461				14.00
15.00	PHARMACY	0	0	6,060			15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	27,327		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	677	0	0	220	455,554	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	2,661	0	0	20,266	534,002	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,964	12,741	54.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	141,604	0	2,844	174,750	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	115,857	0	1,188	141,405	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	6,060	845	15,970	73.00
OUTPATIENT SERVICE COST CENTERS							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,338	257,461	6,060	27,327	1,334,422	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	SHELLED SPACE	0	0	0	0	0	190.01
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	3,338	257,461	6,060	27,327	1,334,422	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150172

Period:
From 01/01/2011
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	EMPLOYEE BENEFITS			4.00
5.00	ADMINISTRATIVE & GENERAL			5.00
7.00	OPERATION OF PLANT			7.00
8.00	LAUNDRY & LINEN SERVICE			8.00
9.00	HOUSEKEEPING			9.00
10.00	DIETARY			10.00
13.00	NURSING ADMINISTRATION			13.00
14.00	CENTRAL SERVICES & SUPPLY			14.00
15.00	PHARMACY			15.00
16.00	MEDICAL RECORDS & LIBRARY			16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	455,554	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	534,002	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	12,741	54.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	174,750	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	141,405	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	15,970	73.00
OUTPATIENT SERVICE COST CENTERS				
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE			113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,334,422	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	SHELLED SPACE	0	0	190.01
191.00	RESEARCH	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	NONPAID WORKERS	0	0	193.00
200.00	Cross Foot Adjustments	0	0	200.00
201.00	Negative Cost Centers	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,334,422	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150172

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

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Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	30,547					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		30,547				2.00
4.00	EMPLOYEE BENEFITS	0	0	2,764,045			4.00
5.00	ADMINISTRATIVE & GENERAL	5,236	5,236	485,848	-2,051,763	6,744,234	5.00
7.00	OPERATION OF PLANT	1,944	1,944	46,606	0	691,079	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	0	0	55,862	8.00
9.00	HOUSEKEEPING	432	432	29,080	0	146,643	9.00
10.00	DIETARY	470	470	0	0	45,477	10.00
13.00	NURSING ADMINISTRATION	0	0	81,212	0	98,420	13.00
14.00	CENTRAL SERVICES & SUPPLY	4,866	4,866	93,823	0	496,674	14.00
15.00	PHARMACY	119	119	0	0	5,198	15.00
16.00	MEDICAL RECORDS & LIBRARY	478	478	0	0	108,800	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	7,902	7,902	660,941	0	1,149,863	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	8,958	8,958	1,281,660	0	1,958,125	50.00
54.00	RADIOLOGY-DIAGNOSTIC	142	142	84,875	0	109,063	54.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	893,480	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	718,274	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	267,276	73.00
OUTPATIENT SERVICE COST CENTERS							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	30,547	30,547	2,764,045	-2,051,763	6,744,234	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	SHELLED SPACE	0	0	0	0	0	190.01
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,284,293	50,129	585,684		2,051,763	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	42.043179	1.641045	0.211894		0.304225	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0		228,731	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.033915	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150172

Period:
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	NURSING ADMINISTRATION (NURSING HOURS)	
		7.00	8.00	9.00	10.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT	23,367					7.00
8.00	LAUNDRY & LINEN SERVICE	0	100				8.00
9.00	HOUSEKEEPING	432	0	22,935			9.00
10.00	DIETARY	470	0	470	100		10.00
13.00	NURSING ADMINISTRATION	0	0	0	0	54,814	13.00
14.00	CENTRAL SERVICES & SUPPLY	4,866	0	4,866	0	0	14.00
15.00	PHARMACY	119	0	119	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	478	0	478	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	7,902	7	7,902	100	11,110	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	8,958	90	8,958	0	43,704	50.00
54.00	RADIOLOGY-DIAGNOSTIC	142	3	142	0	0	54.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	23,367	100	22,935	100	54,814	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	SHELLED SPACE	0	0	0	0	0	190.01
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	901,323	72,857	207,918	81,702	128,362	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	38.572474	728.570000	9.065533	817.020000	2.341774	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	108,360	1,895	25,848	24,783	3,338	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	4.637309	18.950000	1.127011	247.830000	0.060897	205.00

COST ALLOCATION - STATISTICAL BASIS

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Period:
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Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUISITION)	MEDICAL RECORDS & LIBRARY (PATIENT REVENUE)	
		14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	EMPLOYEE BENEFITS				4.00
5.00	ADMINISTRATIVE & GENERAL				5.00
7.00	OPERATION OF PLANT				7.00
8.00	LAUNDRY & LINEN SERVICE				8.00
9.00	HOUSEKEEPING				9.00
10.00	DIETARY				10.00
13.00	NURSING ADMINISTRATION				13.00
14.00	CENTRAL SERVICES & SUPPLY	100			14.00
15.00	PHARMACY	0	100		15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	41,459,594	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	0	0	333,427	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0	30,745,523	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	2,980,594	54.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	55	0	4,315,860	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	45	0	1,802,062	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	100	1,282,128	73.00
OUTPATIENT SERVICE COST CENTERS					
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	CORF	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
113.00	INTEREST EXPENSE				113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	100	100	41,459,594	118.00
NONREIMBURSABLE COST CENTERS					
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
190.01	SHELLED SPACE	0	0	0	190.01
191.00	RESEARCH	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	193.00
200.00	Cross Foot Adjustments				200.00
201.00	Negative Cost Centers				201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	879,582	12,448	164,671	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	8,795.820000	124.480000	0.003972	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	257,461	6,060	27,327	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2,574.610000	60.600000	0.000659	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150172

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

Worksheet C
Part I
Date/Time Prepared:
5/21/2012 8:23 am

		Title XVIII		Hospital		PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,990,259	1,990,259	0	1,990,259	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	3,270,604	3,270,604	0	3,270,604	50.00
54.00	RADIOLOGY-DIAGNOSTIC	163,032	163,032	0	163,032	54.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,666,212	1,666,212	0	1,666,212	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	1,339,761	1,339,761	0	1,339,761	72.00
73.00	DRUGS CHARGED TO PATIENTS	366,129	366,129	0	366,129	73.00
OUTPATIENT SERVICE COST CENTERS						
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	471,164	471,164		471,164	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF	0	0		0	99.10
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	9,267,161	9,267,161	0	9,267,161	200.00
201.00	Less Observation Beds	471,164	471,164		471,164	201.00
202.00	Total (see instructions)	8,795,997	8,795,997	0	8,795,997	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150172

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

Worksheet C
Part I
Date/Time Prepared:
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		Title XVIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	333,428		333,428			30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	5,227,022	25,518,501	30,745,523	0.106377	0.000000	50.00
54.00	RADIOLOGY-DIAGNOSTIC	114,427	2,866,167	2,980,594	0.054698	0.000000	54.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	968,111	3,347,749	4,315,860	0.386067	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	1,026,645	775,417	1,802,062	0.743460	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	182,206	1,099,922	1,282,128	0.285564	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	6,054	147,137	153,191	3.075664	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0			99.10
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	7,857,893	33,754,893	41,612,786			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	7,857,893	33,754,893	41,612,786			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150172

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
30.00	ADULTS & PEDIATRICS				30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.106377			50.00
54.00	RADIOLOGY-DIAGNOSTIC	0.054698			54.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.386067			71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.743460			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.285564			73.00
	OUTPATIENT SERVICE COST CENTERS				
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	3.075664			92.00
	OTHER REIMBURSABLE COST CENTERS				
99.10	CORF				99.10
	SPECIAL PURPOSE COST CENTERS				
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: 150172

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

Worksheet C
Part I
Date/Time Prepared:
5/21/2012 8:23 am

		Title XIX		Hospital		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,990,259	1,990,259	0	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	3,270,604	3,270,604	0	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC	163,032	163,032	0	0	54.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,666,212	1,666,212	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	1,339,761	1,339,761	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	366,129	366,129	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	471,164	471,164		0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF	0	0		0	99.10
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	9,267,161	9,267,161	0	0	200.00
201.00	Less Observation Beds	471,164	471,164			201.00
202.00	Total (see instructions)	8,795,997	8,795,997	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150172

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

Worksheet C
Part I
Date/Time Prepared:
5/21/2012 8:23 am

		Title XIX			Hospital	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	333,428		333,428		30.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	5,227,022	25,518,501	30,745,523	0.106377	50.00
54.00	RADIOLOGY-DIAGNOSTIC	114,427	2,866,167	2,980,594	0.054698	54.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	968,111	3,347,749	4,315,860	0.386067	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	1,026,645	775,417	1,802,062	0.743460	72.00
73.00	DRUGS CHARGED TO PATIENTS	182,206	1,099,922	1,282,128	0.285564	73.00
OUTPATIENT SERVICE COST CENTERS						
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	6,054	147,137	153,191	3.075664	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	7,857,893	33,754,893	41,612,786		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	7,857,893	33,754,893	41,612,786		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150172	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/21/2012 8:23 am
Cost Center Description		PPS Inpatient Ratio 11.00	Title XIX	Hospital
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.000000		50.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS				
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	CORF			99.10
SPECIAL PURPOSE COST CENTERS				
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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150172		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part I Date/Time Prepared: 5/21/2012 8:23 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	455,554	0	455,554	735	619.80	30.00
200.00	Total (Lines 30-199)	455,554		455,554	735		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150172		Period: From 01/01/2011 To 12/31/2011	Worksheet D Part I Date/Time Prepared: 5/21/2012 8:23 am
		Title XVIII		Hospital	PPS
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	195	120,861		
200.00	Total (Lines 30-199)	195	120,861		30.00 200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150172		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part II Date/Time Prepared: 5/21/2012 8:23 am	
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)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	534,002	30,745,523	0.017368	1,612,351	28,003	50.00
54.00	RADIOLOGY-DIAGNOSTIC	12,741	2,980,594	0.004275	38,631	165	54.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	174,750	4,315,860	0.040490	292,353	11,837	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	141,405	1,802,062	0.078468	508,668	39,914	72.00
73.00	DRUGS CHARGED TO PATIENTS	15,970	1,282,128	0.012456	66,942	834	73.00
OUTPATIENT SERVICE COST CENTERS							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	107,846	153,191	0.703997	0	0	92.00
200.00	Total (Lines 50-199)	986,714	41,279,358		2,518,945	80,753	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150172		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part III Date/Time Prepared: 5/21/2012 8:23 am	
Cost Center Description		Title XVIII		Hospital		PPS	
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00	Total (Lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150172		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part III Date/Time Prepared: 5/21/2012 8:23 am	
Cost Center Description		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PPS	
		6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	735	0.00	195	0		30.00
200.00	Total (Lines 30-199)	735		195	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150172

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

Worksheet D
Part IV
Date/Time Prepared:
5/21/2012 8:23 am

Cost Center Description		Title XVIII			Hospital		PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
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: 150172	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/21/2012 8:23 am
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Cost Center Description	Title XVIII					Inpatient Program Charges	
	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)	Hospital		
	6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0	30,745,523	0.000000	0.000000	1,612,351	50.00	
54.00 RADIOLOGY-DIAGNOSTIC	0	2,980,594	0.000000	0.000000	38,631	54.00	
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,315,860	0.000000	0.000000	292,353	71.00	
72.00 IMPL. DEV. CHARGED TO PATIENT	0	1,802,062	0.000000	0.000000	508,668	72.00	
73.00 DRUGS CHARGED TO PATIENTS	0	1,282,128	0.000000	0.000000	66,942	73.00	
OUTPATIENT SERVICE COST CENTERS							
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	153,191	0.000000	0.000000	0	92.00	
200.00 Total (Lines 50-199)	0	41,279,358			2,518,945	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150172	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/21/2012 8:23 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	PPS
ANCILLARY SERVICE COST CENTERS		11.00	12.00	13.00		
50.00	OPERATING ROOM	0	7,435,487	0		50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	626,781	0		54.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	843,317	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	227,735	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	330,543	0		73.00
OUTPATIENT SERVICE COST CENTERS						
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	32,500	0		92.00
200.00	Total (Lines 50-199)	0	9,496,363	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150172	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/21/2012 8:23 am		
		Title XVIII	Hospital	PPS		
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
	1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.106377	7,435,487	0	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0.054698	626,781	0	0	54.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.386067	843,317	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.743460	227,735	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.285564	330,543	0	751	73.00
OUTPATIENT SERVICE COST CENTERS						
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	3.075664	32,500	0	0	92.00
200.00	Subtotal (see instructions)		9,496,363	0	751	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		9,496,363	0	751	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150172	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/21/2012 8:23 am
Title XVIII		Hospital	PPS

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	790,965	0	0		50.00
54.00 RADIOLOGY-DIAGNOSTIC	34,284	0	0		54.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	325,577	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	169,312	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	94,391	0	214		73.00
OUTPATIENT SERVICE COST CENTERS					
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	99,959	0	0		92.00
200.00 Subtotal (see instructions)	1,514,488	0	214		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	1,514,488	0	214		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150172	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/21/2012 8:23 am		
		Title XIX	Hospital			
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
	1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.106377	0	0	643,904	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0.054698	0	0	72,322	54.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.386067	0	0	84,473	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.743460	0	0	19,566	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.285564	0	0	27,754	73.00
OUTPATIENT SERVICE COST CENTERS						
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	3.075664	0	0	3,773	92.00
200.00	Subtotal (see instructions)		0	0	851,792	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	851,792	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150172	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/21/2012 8:23 am
Title XIX		Hospital	

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0	68,497	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	3,956	54.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	32,612	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	14,547	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	7,926	73.00
OUTPATIENT SERVICE COST CENTERS					
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	11,604	92.00
200.00	Subtotal (see instructions)	0	0	139,142	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges				201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	139,142	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150172	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/21/2012 8:23 am
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			735 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			735 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)			735 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)			195 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			1,990,259 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,990,259 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			333,427 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			333,427 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			5.969100 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)			453.64 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			1,990,259 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			2,707.84 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			528,029 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)			528,029 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150172		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 5/21/2012 8:23 am	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT							43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					683,788		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,211,817		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)					120,861		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					80,753		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					201,614		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,010,203		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)					174		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,707.84		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					471,164		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150172		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 5/21/2012 8:23 am	
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	455,554	1,990,259	0.228892	471,164	107,846	90.00
91.00	Nursing School cost	0	1,990,259	0.000000	471,164	0	91.00
92.00	Allied health cost	0	1,990,259	0.000000	471,164	0	92.00
93.00	All other Medical Education	0	1,990,259	0.000000	471,164	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150172	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/21/2012 8:23 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		116,415		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.106377	1,612,351	171,517	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0.054698	38,631	2,113	54.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.386067	292,353	112,868	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.743460	508,668	378,174	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.285564	66,942	19,116	73.00
OUTPATIENT SERVICE COST CENTERS					
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	3.075664	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		2,518,945	683,788	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)		2,518,945		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150172	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/21/2012 8:23 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		14,361		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000	226,756	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000	4,964	0	54.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	41,998	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000	44,537	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000	7,904	0	73.00
OUTPATIENT SERVICE COST CENTERS					
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	263	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		326,422	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		326,422		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150172	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part A Date/Time Prepared: 5/21/2012 8:23 am
		Title XVIIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		724,643	1.00
2.00	Outlier payments for discharges. (see instructions)		0	2.00
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		11.52	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		0.00	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		0.00	31.00
32.00	Sum of lines 30 and 31		0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00
34.00	Disproportionate share adjustment (see instructions)		0	34.00
Additional payment for high percentage of ESRD beneficiary discharges				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0	46.00
47.00	Subtotal (see instructions)		724,643	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		724,643	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		58,263	50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0	56.00
57.00	Routine service other pass through costs		0	57.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150172	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part A Date/Time Prepared: 5/21/2012 8:23 am
		Title XVIII	Hospital	PPS
				1.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)			0 58.00
59.00	Total (sum of amounts on lines 49 through 58)			782,906 59.00
60.00	Primary payer payments			0 60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			782,906 61.00
62.00	Deductibles billed to program beneficiaries			142,600 62.00
63.00	Coinsurance billed to program beneficiaries			0 63.00
64.00	Allowable bad debts (see instructions)			15,964 64.00
65.00	Adjusted reimbursable bad debts (see instructions)			11,175 65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			15,964 66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			651,481 67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)			0 68.00
69.00	Outlier payments reconciliation			0 69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 70.00
70.95	Recovery of Accelerated Depreciation			0 70.95
70.96	Low Volume Payment-1			0 70.96
70.97	Low Volume Payment-2			0 70.97
70.98	Low Volume Payment-3			0 70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			651,481 71.00
72.00	Interim payments			640,307 72.00
73.00	Tentative settlement (for contractor use only)			0 73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)			11,174 74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 75.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Operating outlier amount from Worksheet E, Part A line 2			0 90.00
91.00	Capital outlier from Worksheet L, Part I, line 2			0 91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0 92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0 93.00
94.00	The rate used to calculate the Time Value of Money			0.00 94.00
95.00	Time Value of Money for operating expenses(see instructions)			0 95.00
96.00	Time Value of Money for capital related expenses (see instructions)			0 96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150172	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/21/2012 8:23 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		214	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,514,488	2.00
3.00	PPS payments		2,252,977	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)		214	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		751	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)		751	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a 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)		751	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		537	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)		214	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)		2,252,977	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		510,727	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)		1,742,464	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)		1,742,464	30.00
31.00	Primary payer payments		5,830	31.00
32.00	Subtotal (line 30 minus line 31)		1,736,634	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		82,108	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		57,476	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		82,108	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		1,794,110	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-79	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)		1,794,189	40.00
41.00	Interim payments		1,736,613	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)		57,576	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150172

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

Worksheet E-1
Part I
Date/Time Prepared:
5/21/2012 8:23 am

Title XVIII

Hospital

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		640,307		1,736,613	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		640,307		1,736,613	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		11,174		57,576	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		651,481		1,794,189	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

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

Provider CCN: 150172

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

Worksheet G
Date/Time Prepared:
5/21/2012 8:23 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	105,064	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,402,355	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,822,504	0	0	0	6.00
7.00	Inventory	312,850	0	0	0	7.00
8.00	Prepaid expenses	159,693	0	0	0	8.00
9.00	Other current assets	307,879	0	0	0	9.00
10.00	Due from other funds	1,340,168	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,805,505	0	0	0	11.00
FIXED ASSETS						
12.00	Land	989,573	0	0	0	12.00
13.00	Land improvements	768,718	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	7,399,067	0	0	0	17.00
18.00	Accumulated depreciation	-859,662	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	2,763,414	0	0	0	23.00
24.00	Accumulated depreciation	-1,372,544	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	1,207,159	0	0	0	27.00
28.00	Accumulated depreciation	-740,834	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)	10,154,891	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	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)	13,960,396	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	563,396	0	0	0	37.00
38.00	Salaries, wages, and fees payable	159,271	0	0	0	38.00
39.00	Payroll taxes payable	8,725	0	0	0	39.00
40.00	Notes and loans payable (short term)	7,969,698	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	1,340,168	0	0	0	43.00
44.00	Other current liabilities	412,927	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,454,185	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	10,454,185	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	3,506,211				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)	3,506,211	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	13,960,396	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150172

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

Worksheet G-1

Date/Time Prepared:
5/21/2012 8:23 am

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
		1.00	Fund balances at beginning of period		2,759,109		
2.00	Net income (loss) (From Wkst. G-3, line 29)		1,131,185			2.00	
3.00	Total (sum of line 1 and line 2)		3,890,294		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)		3,890,294		0	11.00	
12.00	Deductions (debit adjustments) (specify)	384,083		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)		384,083		0	18.00	
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		3,506,211		0	19.00	

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150172

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

Worksheet G-1

Date/Time Prepared:
5/21/2012 8:23 am

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
1.00 Fund balances at beginning of period		0		0		1.00
2.00 Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00 Total (sum of line 1 and line 2)		0		0		3.00
4.00 Additions (credit adjustments) (specify)	0		0			4.00
5.00	0		0			5.00
6.00	0		0			6.00
7.00	0		0			7.00
8.00	0		0			8.00
9.00	0		0			9.00
10.00 Total additions (sum of line 4-9)		0		0		10.00
11.00 Subtotal (line 3 plus line 10)		0		0		11.00
12.00 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)		0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150172

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

Worksheet G-2 Parts

Date/Time Prepared:
5/21/2012 8:23 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	333,427		333,427	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	333,427		333,427	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	333,427		333,427	17.00
18.00	Ancillary services	7,524,466	33,754,893	41,279,359	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
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)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,857,893	33,754,893	41,612,786	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		9,837,779		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	AJE	7,638			37.00
38.00	ROUNDING	3			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)		7,641		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		9,830,138		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150172

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

Worksheet G-3

Date/Time Prepared:
5/21/2012 8:23 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	41,612,786	1.00
2.00	Less contractual allowances and discounts on patients' accounts	31,583,731	2.00
3.00	Net patient revenues (line 1 minus line 2)	10,029,055	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	9,830,138	4.00
5.00	Net income from service to patients (line 3 minus line 4)	198,917	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	37,611	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	894,000	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	657	24.00
25.00	Total other income (sum of lines 6-24)	932,268	25.00
26.00	Total (line 5 plus line 25)	1,131,185	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)	1,131,185	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150172	Period: From 01/01/2011 To 12/31/2011	Worksheet L Parts I-III Date/Time Prepared: 5/21/2012 8:23 am
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		58,263	1.00
2.00	Capital DRG outlier payments		0	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		1.54	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		58,263	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00