

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: 151333	Period: From 01/01/2011 To 12/31/2011	worksheet 5 Parts I-III Date/Time Prepared: 5/29/2012 9:04 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/29/2012 Time: 8:40 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 10. NPR Date: 11. Contractor's Vendor Code: 04 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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

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

Title _____

Date _____

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	80,821	-498,932	0	127,419	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	-68,657	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	12,164	-498,932	0	127,419	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.

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: 151333	Period: From 01/01/2011 To 12/31/2011	Worksheet 5 Parts I-III Date/Time Prepared: 5/29/2012 8:40 am
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PART I - COST REPORT STATUS

Provider use only

1. Electronically filed cost report
 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.

Date: 5/29/2012 Time: 8:40 am

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CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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

Encryption Information

ECR: Date: 5/29/2012 Time: 8:40 am
 QAj1rD6VkcarmJIeoyKL3FSIoZ40L0
 0PByB06AYsnLQqYemDIBMEDVw24JrS
 FmJy0Y:A.x04TpYS
 PI: Date: 5/29/2012 Time: 8:40 am
 zpOzx06bgftrjGcNt6j7U..EceTCC0
 VDByz0BE:mKi2YqWNLMU5qyMG3rR4
 gghvJMNioV0ox9TK

(Signed)

 Officer or Administrator of Provider(s)

 Title

 Date

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	80,821	-499,000	0	127,419	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	-68,657	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0	0	0		0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0		0	11.00
12.00 CMHC I	0	0	0		0	12.00
200.00 Total	0	12,164	-499,000	0	127,419	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: 151333	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/29/2012 9:04 am
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1.00	Hospital and Hospital Health Care Complex Address:		2.00	3.00	4.00
1.00	Street: 1542 SOUTH BLOOMINGTON ST	PO Box:	2.00	3.00	4.00
2.00	City: GREENCASTLE	State: IN	Zip Code: 46135-	County: PUTNAM	2.00

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

Hospital and Hospital-Based Component Identification:										
3.00	Hospital	PUTNAM COUNTY HOSPITAL	151333	99915	1	12/31/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	PUTNAM COUNTY HOSPITAL	152333	99915		12/31/2005	N	O	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC						N	N	N	15.00
16.00	Hospital-Based Health Clinic - FQHC						N	N	N	16.00
17.00	Hospital-Based (CMHC) 1									17.00
17.10	Hospital-Based (CORF) 1						N	N	N	17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

						From:	To:	
						1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2011	12/31/2011	20.00
21.00	Type of Control (see instructions)					9		21.00

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

	In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00	0	0	0	0	0	0	24.00
25.00	0	0	0	0	0	0	25.00

	Urban/Rural S	Date of Geogr	
	1.00	2.00	
26.00	2		26.00
27.00	2		27.00
35.00	0		35.00
		Beginning:	Ending:
		1.00	2.00
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.		36.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151333	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/29/2012 9:04 am		
		Beginning: 1.00	Ending: 2.00			
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V 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		
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.						
64.00	If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00	
		Program Name 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

		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		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010								
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00	
						1.00	2.00	3.00
Inpatient Psychiatric Facility PPS								
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "y" for yes or "N" for no.					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

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				1.00	2.00	3.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N				75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	76.00
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.	N				80.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N				85.00
86.00	Did this facility establish a new other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	N				86.00
				V	XIX	
				1.00	2.00	
Title V or XIX Inpatient Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		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)?	Y				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&RS in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	Y	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.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			2		118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.		1,250,000		5,000,000	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.	N			N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00

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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)		N				140.00	
		1.00	2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.								
141.00	Name:	Contractor's Name:		Contractor's Number:			141.00	
142.00	Street:	PO Box:					142.00	
143.00	City:	State:		Zip Code:			143.00	
						1.00		
144.00	Are provider based physicians' costs included in worksheet A?		Y				144.00	
145.00	If costs for renal services are claimed on worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N				145.00	
						1.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N				146.00	
147.00	was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N				147.00	
148.00	was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N				148.00	
149.00	was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N				149.00	
		Part A		Part B				
		1.00		2.00				
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital		N		N		155.00	
156.00	Subprovider - IPF		N		N		156.00	
157.00	Subprovider - IRF		N		N		157.00	
158.00	SUBPROVIDER		N		N		158.00	
159.00	SNF		N		N		159.00	
160.00	HOME HEALTH AGENCY		N		N		160.00	
161.00	CMHC				N		161.00	
161.10	CORF				N		161.10	
						1.00		
Multicampus								
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
						1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							0168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00169.00

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

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

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

Cost Center Description	Worksheet A	No. of Beds	Bed Days	CAH Hours	
	Line Number		Available		
	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	19	6,935	59,352.00	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)		19	6,935	59,352.00	7.00
8.00 INTENSIVE CARE UNIT	31.00	6	2,190	18,552.00	8.00
9.00 CORONARY CARE UNIT					9.00
10.00 BURN INTENSIVE CARE UNIT					10.00
11.00 SURGICAL INTENSIVE CARE UNIT					11.00
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00
13.00 NURSERY	43.00				13.00
14.00 Total (see instructions)		25	9,125	77,904.00	14.00
15.00 CAH visits					15.00
16.00 SUBPROVIDER - IPF					16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		17.00
18.00 SUBPROVIDER	42.00	0	0		18.00
19.00 SKILLED NURSING FACILITY					19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE					21.00
22.00 HOME HEALTH AGENCY					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00 HOSPICE					24.00
25.00 CMHC - CMHC					25.00
25.10 CMHC - CORF	99.10				25.10
26.00 RURAL HEALTH CLINIC	88.00				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				26.25
27.00 Total (sum of lines 14-26)		25			27.00
28.00 Observation Bed Days					28.00
28.02 SUBPROVIDER - IRF	41.00				28.02
28.03 SUBPROVIDER	42.00				28.03
29.00 Ambulance Trips					29.00
30.00 Employee discount days (see instruction)					30.00
31.00 Employee discount days - IRF					31.00
32.00 Labor & delivery days (see instructions)					32.00
33.00 LTCH non-covered days					33.00

Cost Center Description	I/P Days / O/P Visits / Trips				Total All Patients	
	Title V	Title XVIII	Title XIX			
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	1,796	187	2,743	1.00	
2.00 HMO		0	474		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	640	0	640	5.00	
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	111	6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,436	187	3,494	7.00	
8.00 INTENSIVE CARE UNIT	0	514	0	773	8.00	
9.00 CORONARY CARE UNIT					9.00	
10.00 BURN INTENSIVE CARE UNIT					10.00	
11.00 SURGICAL INTENSIVE CARE UNIT					11.00	
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00	
13.00 NURSERY	0		0	225	13.00	
14.00 Total (see instructions)	0	2,950	187	4,492	14.00	
15.00 CAH visits	0	0	0	0	15.00	
16.00 SUBPROVIDER - IPF					16.00	
17.00 SUBPROVIDER - IRF	0	0	0	0	17.00	
18.00 SUBPROVIDER	0	0	0	0	18.00	
19.00 SKILLED NURSING FACILITY					19.00	
20.00 NURSING FACILITY					20.00	
21.00 OTHER LONG TERM CARE					21.00	
22.00 HOME HEALTH AGENCY					22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00	
24.00 HOSPICE					24.00	
25.00 CMHC - CMHC					25.00	
25.10 CMHC - CORF	0	0	0	0	25.10	
26.00 RURAL HEALTH CLINIC	0	0	0	0	26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	26.25	
27.00 Total (sum of lines 14-26)					27.00	
28.00 Observation Bed Days	0		168	718	28.00	
28.02 SUBPROVIDER - IRF				0	28.02	
28.03 SUBPROVIDER				0	28.03	
29.00 Ambulance Trips		0			29.00	
30.00 Employee discount days (see instruction)				0	30.00	
31.00 Employee discount days - IRF				0	31.00	
32.00 Labor & delivery days (see instructions)			0	0	32.00	
33.00 LTCH non-covered days		0			33.00	

Cost Center Description	Full Time Equivalents			Discharges	Title XVIII	
	Total Interns & Residents	Employees On Payroll	Nonpaid workers	Title v		
	9.00	10.00	11.00	12.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	609	1.00
2.00 HMO					0	2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	250.10	0.00	0	609	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0.00	0.00	0	0	17.00
18.00 SUBPROVIDER	0.00	0.00	0.00	0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00	0.00	0.00			25.10
26.00 RURAL HEALTH CLINIC	0.00	0.00	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00 Total (sum of lines 14-26)	0.00	250.10	0.00			27.00
28.00 Observation Bed Days						28.00
28.02 SUBPROVIDER - IRF						28.02
28.03 SUBPROVIDER						28.03
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

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)	70	1,016	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)	70	1,016	14.00
15.00 CAH visits			15.00
16.00 SUBPROVIDER - IPF			16.00
17.00 SUBPROVIDER - IRF	0	0	17.00
18.00 SUBPROVIDER	0	0	18.00
19.00 SKILLED NURSING FACILITY			19.00
20.00 NURSING FACILITY			20.00
21.00 OTHER LONG TERM CARE			21.00
22.00 HOME HEALTH AGENCY			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)			23.00
24.00 HOSPICE			24.00
25.00 CMHC - CMHC			25.00
25.10 CMHC - CORF			25.10
26.00 RURAL HEALTH CLINIC			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER			26.25
27.00 Total (sum of lines 14-26)			27.00
28.00 Observation Bed Days			28.00
28.02 SUBPROVIDER - IRF			28.02
28.03 SUBPROVIDER			28.03
29.00 Ambulance Trips			29.00
30.00 Employee discount days (see instruction)			30.00
31.00 Employee discount days - IRF			31.00
32.00 Labor & delivery days (see instructions)			32.00
33.00 LTCH non-covered days			33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151333	Period: From 01/01/2011 To 12/31/2011	worksheet S-10
			Date/Time Prepared: 5/29/2012 9:04 am

				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)		0.445811		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		1,498,986		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		1,482,975		5.00
6.00	Medicaid charges		7,999,518		6.00
7.00	Medicaid cost (line 1 times line 6)		3,566,273		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)		584,312		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)		584,312		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,004,736	0	1,004,736	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	447,922	0	447,922	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	447,922	0	447,922	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		5,186,723		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		443,632		27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		4,743,091		28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		2,114,522		29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		2,562,444		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,146,756		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151333

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

Worksheet A

Date/Time Prepared:
5/29/2012 9:04 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT		2,289,945	2,289,945	330,084	2,620,029	1.00
4.00	EMPLOYEE BENEFITS	0	4,211,644	4,211,644	10,305	4,221,949	4.00
5.00	ADMINISTRATIVE & GENERAL	1,655,667	1,665,393	3,321,060	312,254	3,633,314	5.00
7.00	OPERATION OF PLANT	182,933	886,200	1,069,133	36,826	1,105,959	7.00
8.00	LAUNDRY & LINEN SERVICE	20,783	93,870	114,653	0	114,653	8.00
9.00	HOUSEKEEPING	310,350	72,778	383,128	0	383,128	9.00
10.00	DIETARY	317,703	260,890	578,593	-451,300	127,293	10.00
11.00	CAFETERIA	0	0	0	451,300	451,300	11.00
13.00	NURSING ADMINISTRATION	501,376	15,010	516,386	0	516,386	13.00
16.00	MEDICAL RECORDS & LIBRARY	331,557	108,637	440,194	0	440,194	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	UTILIZATION REVIEW	121,277	3,003	124,280	0	124,280	17.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,176,121	108,805	1,284,926	-23,109	1,261,817	30.00
31.00	INTENSIVE CARE UNIT	778,088	40,765	818,853	-10,894	807,959	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	73,613	806	74,419	-135	74,284	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	497,949	831,215	1,329,164	-632,646	696,518	50.00
51.00	RECOVERY ROOM	81,900	12,192	94,092	-6,379	87,713	51.00
52.00	DELIVERY ROOM & LABOR ROOM	49,138	2,866	52,004	-137	51,867	52.00
53.00	ANESTHESIOLOGY	575,338	186,188	761,526	-16,614	744,912	53.00
54.00	RADIOLOGY-DIAGNOSTIC	570,853	246,341	817,194	-11,012	806,182	54.00
54.01	NUCLEAR MEDICINE-DIAGNOSTIC	0	146,929	146,929	-17	146,912	54.01
57.00	CT SCAN	131,342	370,592	501,934	-32,972	468,962	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	557,347	1,356,573	1,913,920	-177,004	1,736,916	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	308,969	96,858	405,827	-8,390	397,437	65.00
66.00	PHYSICAL THERAPY	0	431,894	431,894	-36,386	395,508	66.00
67.00	OCCUPATIONAL THERAPY	0	99,826	99,826	0	99,826	67.00
68.00	SPEECH PATHOLOGY	0	9,003	9,003	0	9,003	68.00
69.00	ELECTROCARDIOLOGY	44,910	90,554	135,464	-30	135,434	69.00
69.01	CARDIAC REHAB	59,677	4,674	64,351	-478	63,873	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,423	55,461	64,884	803,245	868,129	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	206,054	206,054	72.00
73.00	DRUGS CHARGED TO PATIENTS	116,012	1,416,898	1,532,910	1,922,863	3,455,773	73.00
73.01	ONCOLOGY	260,449	2,145,391	2,405,840	-1,928,746	477,094	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	-2,261	2,096	-165	0	-165	90.00
91.00	EMERGENCY	919,973	1,693,590	2,613,563	-47,213	2,566,350	91.00
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							
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	9,650,487	18,956,887	28,607,374	689,469	29,296,843	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	3,124,785	1,022,887	4,147,672	-689,469	3,458,203	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	DME	0	0	0	0	0	193.01
193.02	LACTATION CONSULTING	0	0	0	0	0	193.02
193.03	DIABETIC COUNSELING	0	0	0	0	0	193.03
194.00	VACANT SPACE	0	0	0	0	0	194.00
194.01	BOARD OF HEALTH	0	0	0	0	0	194.01
200.00	TOTAL (SUM OF LINES 118-199)	12,775,272	19,979,774	32,755,046	0	32,755,046	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151333

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

worksheet A

Date/Time Prepared:
5/29/2012 9:04 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	-111,211	2,508,818	1.00
4.00	EMPLOYEE BENEFITS	-153	4,221,796	4.00
5.00	ADMINISTRATIVE & GENERAL	-138,474	3,494,840	5.00
7.00	OPERATION OF PLANT	-2,433	1,103,526	7.00
8.00	LAUNDRY & LINEN SERVICE	0	114,653	8.00
9.00	HOUSEKEEPING	0	383,128	9.00
10.00	DIETARY	-7,376	119,917	10.00
11.00	CAFETERIA	-67,206	384,094	11.00
13.00	NURSING ADMINISTRATION	0	516,386	13.00
16.00	MEDICAL RECORDS & LIBRARY	-6,984	433,210	16.00
17.00	SOCIAL SERVICE	0	0	17.00
17.01	UTILIZATION REVIEW	0	124,280	17.01
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	1,261,817	30.00
31.00	INTENSIVE CARE UNIT	0	807,959	31.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	74,284	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	696,518	50.00
51.00	RECOVERY ROOM	0	87,713	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	51,867	52.00
53.00	ANESTHESIOLOGY	-551,507	193,405	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	806,182	54.00
54.01	NUCLEAR MEDICINE-DIAGNOSTIC	-7,490	139,422	54.01
57.00	CT SCAN	0	468,962	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	0	1,736,916	60.00
60.01	BLOOD LABORATORY	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	64.00
65.00	RESPIRATORY THERAPY	0	397,437	65.00
66.00	PHYSICAL THERAPY	0	395,508	66.00
67.00	OCCUPATIONAL THERAPY	0	99,826	67.00
68.00	SPEECH PATHOLOGY	0	9,003	68.00
69.00	ELECTROCARDIOLOGY	0	135,434	69.00
69.01	CARDIAC REHAB	-4,830	59,043	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	868,129	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	206,054	72.00
73.00	DRUGS CHARGED TO PATIENTS	-37,813	3,417,960	73.00
73.01	ONCOLOGY	-208,491	268,603	73.01
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	CLINIC	-1,560	-1,725	90.00
91.00	EMERGENCY	-1,291,784	1,274,566	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS				
109.00	PANCREAS ACQUISITION	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	110.00
111.00	ISLET ACQUISITION	0	0	111.00
113.00	INTEREST EXPENSE	0	0	113.00
114.00	UTILIZATION REVIEW-SNF	0	0	114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-2,437,312	26,859,531	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	3,458,203	192.00
193.00	NONPAID WORKERS	0	0	193.00
193.01	DME	0	0	193.01
193.02	LACTATION CONSULTING	0	0	193.02
193.03	DIABETIC COUNSELING	0	0	193.03
194.00	VACANT SPACE	0	0	194.00
194.01	BOARD OF HEALTH	0	0	194.01
200.00	TOTAL (SUM OF LINES 118-199)	-2,437,312	30,317,734	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAFÉ RECLASS					
1.00	CAFETERIA	11.00	247,807	203,493	1.00
	TOTALS		247,807	203,493	
B - EMPLOYEE PROMOTIONS					
1.00	EMPLOYEE BENEFITS	4.00		10,305	1.00
	TOTALS		0	10,305	
C - INSURANCE RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	83,019	1.00
	TOTALS		0	83,019	
D - DRUGS CHARGED A/C 660522					
1.00	DRUGS CHARGED TO PATIENTS	73.00		1,923,246	1.00
	TOTALS		0	1,923,246	
E - PPO DEPRECIATION					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	15,013	1.00
	TOTALS		0	15,013	
F - MED SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		1,009,299	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
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
	TOTALS		0	1,009,299	
G - PHYSICIAN PRACTICE A&G					
1.00	ADMINISTRATIVE & GENERAL	5.00	404,708	0	1.00
	TOTALS		404,708	0	
J - CLINIC RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	232,052	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	870	2.00
3.00	OPERATION OF PLANT	7.00	0	36,826	3.00
	TOTALS		0	269,748	
K - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	206,054	1.00
	TOTALS		0	206,054	
500.00	Grand Total: Increases		652,515	3,720,177	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFÉ RECLASS							
1.00	DIETARY	10.00	247,807	203,493	0		1.00
	TOTALS		247,807	203,493			
B - EMPLOYEE PROMOTIONS							
1.00		5.00		10,305	0		1.00
	TOTALS		0	10,305			
C - INSURANCE RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	83,019	9		1.00
	TOTALS		0	83,019			
D - DRUGS CHARGED A/C 660522							
1.00	ONCOLOGY	73.01		1,923,246	0		1.00
	TOTALS		0	1,923,246			
E - PPO DEPRECIATION							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	15,013	9		1.00
	TOTALS		0	15,013			
F - MED SUPPLIES							
1.00		30.00		23,109	0		1.00
2.00		31.00		10,894	0		2.00
3.00		43.00		135	0		3.00
4.00		50.00		632,646	0		4.00
5.00		51.00		6,379	0		5.00
6.00		52.00		137	0		6.00
7.00		53.00		16,614	0		7.00
8.00		54.00		11,012	0		8.00
9.00		54.01		17	0		9.00
10.00		57.00		32,972	0		10.00
11.00		60.00		177,004	0		11.00
12.00		65.00		8,390	0		12.00
13.00		66.00		36,386	0		13.00
14.00		67.00		0	0		14.00
15.00		69.00		30	0		15.00
16.00		69.01		478	0		16.00
17.00		73.00		383	0		17.00
18.00		73.01		5,500	0		18.00
19.00		91.00		47,213	0		19.00
	TOTALS		0	1,009,299			
G - PHYSICIAN PRACTICE A&G							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	404,708	0	0		1.00
	TOTALS		404,708	0			
J - CLINIC RECLASS							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	269,748	10		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	269,748			
K - IMPLANTABLE DEVICES							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	206,054	0		1.00
	TOTALS		0	206,054			
500.00	Grand Total: Decreases		652,515	3,720,177			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151333

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/29/2012 9:04 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	159,364	0	0	0	1.00
2.00	Land Improvements	297,478	0	0	0	2.00
3.00	Buildings and Fixtures	28,166,713	249,818	0	249,818	3.00
4.00	Building Improvements	373,334	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	184,156	5.00
6.00	Movable Equipment	13,725,679	2,004,449	0	2,004,449	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	42,722,568	2,254,267	0	2,254,267	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	42,722,568	2,254,267	0	2,254,267	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	1,700,681	0	589,264	0	1.00
3.00	Total (sum of lines 1-2)	1,700,681	0	589,264	0	3.00
COMPUTATION OF RATIOS						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151333

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/29/2012 9:04 am

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	159,364	0		1.00		
2.00	Land Improvements	297,478	0		2.00		
3.00	Buildings and Fixtures	28,416,531	0		3.00		
4.00	Building Improvements	189,178	0		4.00		
5.00	Fixed Equipment	0	0		5.00		
6.00	Movable Equipment	15,730,128	0		6.00		
7.00	HIT designated Assets	0	0		7.00		
8.00	Subtotal (sum of lines 1-7)	44,792,679	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	44,792,679	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	2,289,945		1.00		
3.00	Total (sum of lines 1-2)	0	2,289,945		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	1,798,713	232,052	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1,798,713	232,052	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151333

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

worksheet A-7
Parts I-III
Date/Time Prepared:
5/29/2012 9:04 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	478,053	0	0	0	2,508,818	1.00
3.00	Total (sum of lines 1-2)	478,053	0	0	0	2,508,818	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted	
			Cost Center	Line #
	1.00	2.00	3.00	4.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0NEW CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0*** Cost Center Deleted ***	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	-1,894,871		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	0RESPIRATORY THERAPY	65.00 23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	0PHYSICAL THERAPY	66.00 24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	0UTILIZATION REVIEW-SNF	114.00 25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	0NEW CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	0*** Cost Center Deleted ***	2.00 27.00
28.00 Non-physician Anesthetist		0	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	0OCCUPATIONAL THERAPY	67.00 30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	0SPEECH PATHOLOGY	68.00 31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	0		0.00 32.00
33.00 DISCOUNTS	B	-3,847	ADMINISTRATIVE & GENERAL	5.00 33.00
34.00 VENDOR REBATE/REFUND	B	-16,836	ADMINISTRATIVE & GENERAL	5.00 34.00
35.00 PHARMACY REBATES	B	-35,053	DRUGS CHARGED TO PATIENTS	73.00 35.00
36.00 SILVER RECOVERY	B	-7,490	NUCLEAR MEDICINE-DIAGNOSTIC	54.01 36.00
37.00 CARDIAC REHAB OTHER MISC INCOME	B	-1,670	CARDIAC REHAB	69.01 37.00
38.00 DIABETIC COUNSELING OTHER INCOME	B	-1,560	CLINIC	90.00 38.00
40.00 MEDICAL RECORDS FEES	B	-6,984	MEDICAL RECORDS & LIBRARY	16.00 40.00
41.00 VENDING MACHINES	B	-7,376	DIETARY	10.00 41.00
42.00 CAFETERIA SALES	B	-67,206	CAFETERIA	11.00 42.00
43.00 OTHER MISC INCOME	B	-5,465	ADMINISTRATIVE & GENERAL	5.00 43.00
44.00 OTHER MISC INCOME	B	-2,760	DRUGS CHARGED TO PATIENTS	73.00 44.00
45.00 NON-ALLOWABLE INTEREST EXPENSE	A	-88,854	NEW CAP REL COSTS-BLDG & FIXT	1.00 45.00
45.01 INVESTMENT INCOME	B	-22,357	NEW CAP REL COSTS-BLDG & FIXT	1.00 45.01
45.02 LOBBYING OFFSET	A	-970	ADMINISTRATIVE & GENERAL	5.00 45.02
45.03 ADVERTISING OFFSET	A	-1,968	ADMINISTRATIVE & GENERAL	5.00 45.03
45.04 COMMUNITY RELATIONS OFFSET	A	-103,056	ADMINISTRATIVE & GENERAL	5.00 45.04
45.05 CRNA FEES OFFSET	A	-120,528	ANESTHESIOLOGY	53.00 45.05
45.06 TELEPHONE WAGES	A	-635	ADMINISTRATIVE & GENERAL	5.00 45.06
45.07 TELEPHONE BENEFITS	A	-153	EMPLOYEE BENEFITS	4.00 45.07

Provider CCN: 151333	Period: From 01/01/2011 To 12/31/2011	Worksheet A-8 Date/Time Prepared: 5/29/2012 9:04 am
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted		
			Cost Center	Line #	
			1.00	2.00	
45.08 TELEPHONE OTHER	A	-697	ADMINISTRATIVE & GENERAL	5.00	45.08
45.09 TELEVISION OFFSET	A	-2,433	OPERATION OF PLANT	7.00	45.09
45.10 PHYSICIAN RECRUITMENT	A	-5,000	ADMINISTRATIVE & GENERAL	5.00	45.10
45.11 CRNA SALARY OFFSET	A	-39,543	ANESTHESIOLOGY	53.00	45.11
45.12		0		0.00	45.12
45.13		0		0.00	45.13
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-2,437,312			50.00

Provider CCN: 151333

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

Worksheet A-8

Date/Time Prepared:
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Cost Center Description	Wkst. A-7 Ref.		
	5.00		
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0		1.00
2.00 Investment income - 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 - 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 DISCOUNTS	0		33.00
34.00 VENDOR REBATE/REFUND	0		34.00
35.00 PHARMACY REBATES	0		35.00
36.00 SILVER RECOVERY	0		36.00
37.00 CARDIAC REHAB OTHER MISC INCOME	0		37.00
38.00 DIABETIC COUNSELING OTHER INCOME	0		38.00
40.00 MEDICAL RECORDS FEES	0		40.00
41.00 VENDING MACHINES	0		41.00
42.00 CAFETERIA SALES	0		42.00
43.00 OTHER MISC INCOME	0		43.00
44.00 OTHER MISC INCOME	0		44.00
45.00 NON-ALLOWABLE INTEREST EXPENSE	11		45.00
45.01 INVESTMENT INCOME	11		45.01
45.02 LOBBYING OFFSET	0		45.02
45.03 ADVERTISING OFFSET	0		45.03
45.04 COMMUNITY RELATIONS OFFSET	0		45.04
45.05 CRNA FEES OFFSET	0		45.05
45.06 TELEPHONE WAGES	0		45.06
45.07 TELEPHONE BENEFITS	0		45.07
45.08 TELEPHONE OTHER	0		45.08
45.09 TELEVISION OFFSET	0		45.09
45.10 PHYSICIAN RECRUITMENT	0		45.10
45.11 CRNA SALARY OFFSET	0		45.11
45.12	0		45.12
45.13	0		45.13
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)			50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151333

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

Worksheet A-8-2

Date/Time Prepared:
5/29/2012 9:04 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	91.00	EMERGENCY	1,444,727	1,291,784	1.00
2.00	60.00	LABORATORY	90,000	0	2.00
3.00	73.01	ONCOLOGY	208,491	208,491	3.00
4.00	69.01	CARDIAC REHAB	3,160	3,160	4.00
5.00	53.00	DR. S	352,495	214,624	5.00
6.00	53.00	DR. P	179,262	176,812	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			2,278,135	1,894,871	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151333

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

Worksheet A-8-2

Date/Time Prepared:
5/29/2012 9:04 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	152,943	0	0	0	0	1.00
2.00	90,000	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	137,871	0	0	0	0	5.00
6.00	2,450	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	383,264					200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151333

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

Worksheet A-8-2

Date/Time Prepared:
5/29/2012 9:04 am

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151333

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

Worksheet A-8-2

Date/Time Prepared:
5/29/2012 9:04 am

	RCE Disallowance	Adjustment	
	17.00	18.00	
1.00	0	1,291,784	1.00
2.00	0	0	2.00
3.00	0	208,491	3.00
4.00	0	3,160	4.00
5.00	0	214,624	5.00
6.00	0	176,812	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	1,894,871	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151333	Period: From 01/01/2011 To 12/31/2011	Worksheet A-8-3 Par Date/Time Prepared: 5/29/2012 9:04 am
Physical Therapy			Cost

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)						52 1.00
2.00	Line 1 multiplied by 15 hours per week						780 2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						520 3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0 4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0 5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0 6.00
7.00	Standard travel expense rate						3.45 7.00
8.00	Optional travel expense rate per mile						0.00 8.00
9.00	Total hours worked	0.00	3,951.00	1,985.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	71.67	53.75	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	35.83	35.83	26.88			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
1.00							
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)						0 14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						283,168 15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)						106,694 16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						389,862 17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						0 18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)						0 19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						389,862 20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						0.00 21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						0 22.00
23.00	Total salary equivalency (see instructions)						389,862 23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)						18,632 24.00
25.00	Assistants (line 4 times column 3, line 11)						0 25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						18,632 26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						1,794 27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						20,426 28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						0 29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0 30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						0 31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0 32.00
33.00	Standard travel allowance and standard travel expense (line 28)						20,426 33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						1,794 34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0 35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)						0 36.00
37.00	Assistants (line 6 times column 3, line 11)						0 37.00
38.00	Subtotal (sum of lines 36 and 37)						0 38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0 39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0 40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0 41.00
42.00	Subtotal (sum of lines 40 and 41)						0 42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0 43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0 44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0 45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151333	Period: From 01/01/2011 To 12/31/2011	Worksheet A-8-3 Par Date/Time Prepared: 5/29/2012 9:04 am
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	Physical Therapy	Cost
		1.00

46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0	46.00
		1.00	

	Therapists	Assistants	Aides	Trainees	Total	
	1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	49.00

CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	51.00

DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	71.67	53.75	0.00	0.00	52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	56.00

					1.00	
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Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT						
57.00	Salary equivalency amount (from line 23)				389,862	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))				20,426	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)				0	59.00
60.00	Overtime allowance (from column 5, line 56)				0	60.00
61.00	Equipment cost (see instructions)				0	61.00
62.00	Supplies (see instructions)				0	62.00
63.00	Total allowance (sum of lines 57-62)				410,288	63.00
64.00	Total cost of outside supplier services (from your records)				384,419	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)				0	65.00

LINE 33 CALCULATION						
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others				18,632	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others				1,794	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27				20,426	100.02

LINE 34 CALCULATION						
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others				1,794	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others				0	101.01
101.02	Line 34 = sum of lines 27 and 31				1,794	101.02

LINE 35 CALCULATION						
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others				0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others				0	102.01
102.02	Line 35 = sum of lines 31 and 32				0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151333	Period: From 01/01/2011 To 12/31/2011	Worksheet A-8-3 Par Date/Time Prepared: 5/29/2012 9:04 am
		Occupational Therapy	Cost

			1.00	
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PART I - GENERAL INFORMATION

1.00	Total number of weeks worked (excluding aides) (see instructions)			52	1.00
2.00	Line 1 multiplied by 15 hours per week			780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)			238	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)			0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)			0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)			0	6.00
7.00	Standard travel expense rate			3.45	7.00
8.00	Optional travel expense rate per mile			0.00	8.00

	Supervisors 1.00	Therapists 2.00	Assistants 3.00	Aides 4.00	Trainees 5.00	
9.00	0.00	1,779.00	0.00	0.00	0.00	9.00
10.00	0.00	52.56	0.00	0.00	0.00	10.00
11.00	26.28	26.28	0.00			11.00
12.00	0	0	0			12.00
12.01	0	0	0			12.01
13.00	0	0	0			13.00
13.01	0	0	0			13.01

Part II - SALARY EQUIVALENCY COMPUTATION

14.00	Supervisors (column 1, line 9 times column 1, line 10)			0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)			93,504	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)			0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)			93,504	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)			0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)			0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)			93,504	20.00

If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.

21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)			0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)			0	22.00
23.00	Total salary equivalency (see instructions)			93,504	23.00

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

Standard Travel Allowance

24.00	Therapists (line 3 times column 2, line 11)			6,255	24.00
25.00	Assistants (line 4 times column 3, line 11)			0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)			6,255	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)			821	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)			7,076	28.00

Optional Travel Allowance and Optional Travel Expense

29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)			0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)			0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)			0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)			0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)			7,076	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)			821	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)			0	35.00

Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

Standard Travel Expense

36.00	Therapists (line 5 times column 2, line 11)			0	36.00
37.00	Assistants (line 6 times column 3, line 11)			0	37.00
38.00	Subtotal (sum of lines 36 and 37)			0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)			0	39.00

Optional Travel Allowance and Optional Travel Expense

40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)			0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)			0	41.00
42.00	Subtotal (sum of lines 40 and 41)			0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)			0	43.00

Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.

44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)			0	44.00
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151333	Period: From 01/01/2011 To 12/31/2011	worksheet A-8-3 Par Date/Time Prepared: 5/29/2012 9:04 am
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	Occupational Therapy	Cost
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		1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0	46.00
	Therapists	Assistants	Aides
	1.00	2.00	3.00
	Trainees	Total	
	4.00	5.00	

PART V - OVERTIME COMPUTATION

47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00

CALCULATION OF LIMIT

50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00

DETERMINATION OF OVERTIME ALLOWANCE

52.00	Adjusted hourly salary equivalency amount (see instructions)	52.56	0.00	0.00	0.00	0.00	52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0	54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0	55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

1.00

Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57.00	Salary equivalency amount (from line 23)	93,504	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	7,076	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	100,580	63.00
64.00	Total cost of outside supplier services (from your records)	99,374	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00

LINE 33 CALCULATION

100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	6,255	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	821	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	7,076	100.02

LINE 34 CALCULATION

101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	821	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	821	101.02

LINE 35 CALCULATION

102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151333	Period: From 01/01/2011 To 12/31/2011	Worksheet A-8-3 Par
			Date/Time Prepared: 5/29/2012 9:04 am
			Speech Pathology
			Cost

						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					74	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					3.45	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	140.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	65.30	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	32.65	32.65	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					9,142	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					9,142	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					9,142	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					65.30	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					50,934	22.00
23.00	Total salary equivalency (see instructions)					50,934	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					2,416	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					2,416	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					255	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					2,671	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					2,671	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					255	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151333	Period: From 01/01/2011 To 12/31/2011	Worksheet A-8-3 Par Date/Time Prepared: 5/29/2012 9:04 am
		Speech Pathology	Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	

PART V - OVERTIME COMPUTATION

47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00

CALCULATION OF LIMIT

50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00

DETERMINATION OF OVERTIME ALLOWANCE

52.00	Adjusted hourly salary equivalency amount (see instructions)	65.30	0.00	0.00	0.00	0.00	52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0	54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0	55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

1.00

Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57.00	Salary equivalency amount (from line 23)	50,934	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	2,671	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	53,605	63.00
64.00	Total cost of outside supplier services (from your records)	8,921	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00

LINE 33 CALCULATION

100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	2,416	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	255	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	2,671	100.02

LINE 34 CALCULATION

101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	255	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	255	101.02

LINE 35 CALCULATION

102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151333

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2012 9:04 am

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT				
	0	1.00	4.00	4A	5.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT	2,508,818	2,508,818				1.00
4.00 EMPLOYEE BENEFITS	4,221,796	0	4,221,796			4.00
5.00 ADMINISTRATIVE & GENERAL	3,494,840	341,589	680,764	4,517,193	4,517,193	5.00
7.00 OPERATION OF PLANT	1,103,526	311,690	60,443	1,475,659	258,360	7.00
8.00 LAUNDRY & LINEN SERVICE	114,653	16,758	6,867	138,278	24,210	8.00
9.00 HOUSEKEEPING	383,128	13,932	102,542	499,602	87,471	9.00
10.00 DIETARY	119,917	73,206	23,094	216,217	37,855	10.00
11.00 CAFETERIA	384,094	39,764	81,877	505,735	88,545	11.00
13.00 NURSING ADMINISTRATION	516,386	16,486	165,659	698,531	122,300	13.00
16.00 MEDICAL RECORDS & LIBRARY	433,210	103,624	109,549	646,383	113,169	16.00
17.00 SOCIAL SERVICE	0	5,702	0	5,702	998	17.00
17.01 UTILIZATION REVIEW	124,280	4,462	40,071	168,813	29,556	17.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1,261,817	216,396	388,600	1,866,813	326,843	30.00
31.00 INTENSIVE CARE UNIT	807,959	70,430	257,086	1,135,475	198,800	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	74,284	8,404	24,322	107,010	18,735	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	696,518	231,394	164,526	1,092,438	191,265	50.00
51.00 RECOVERY ROOM	87,713	56,894	27,060	171,667	30,056	51.00
52.00 DELIVERY ROOM & LABOR ROOM	51,867	29,773	16,236	97,876	17,136	52.00
53.00 ANESTHESIOLOGY	193,405	0	190,096	383,501	67,144	53.00
54.00 RADIOLOGY-DIAGNOSTIC	806,182	77,817	188,614	1,072,613	187,794	54.00
54.01 NUCLEAR MEDICINE-DIAGNOSTIC	139,422	3,471	0	142,893	25,018	54.01
57.00 CT SCAN	468,962	32,723	43,396	545,081	95,433	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	1,736,916	61,282	184,152	1,982,350	347,072	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	397,437	11,230	102,086	510,753	89,423	65.00
66.00 PHYSICAL THERAPY	395,508	79,701	0	475,209	83,200	66.00
67.00 OCCUPATIONAL THERAPY	99,826	0	0	99,826	17,478	67.00
68.00 SPEECH PATHOLOGY	9,003	0	0	9,003	1,576	68.00
69.00 ELECTROCARDIOLOGY	135,434	2,479	14,839	152,752	26,744	69.00
69.01 CARDIAC REHAB	59,043	17,923	19,718	96,684	16,928	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	868,129	0	3,113	871,242	152,538	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	206,054	0	0	206,054	36,076	72.00
73.00 DRUGS CHARGED TO PATIENTS	3,417,960	19,237	38,331	3,475,528	608,499	73.00
73.01 ONCOLOGY	268,603	120,853	86,054	475,510	83,253	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	-1,725	4,016	0	2,291	401	90.00
91.00 EMERGENCY	1,274,566	148,842	303,966	1,727,374	302,430	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	26,859,531	2,120,078	3,323,061	25,572,056	3,686,306	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,825	0	11,825	2,070	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	3,458,203	317,814	898,735	4,674,752	818,469	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 DME	0	0	0	0	0	193.01
193.02 LACTATION CONSULTING	0	0	0	0	0	193.02
193.03 DIABETIC COUNSELING	0	0	0	0	0	193.03
194.00 VACANT SPACE	0	38,351	0	38,351	6,715	194.00
194.01 BOARD OF HEALTH	0	20,750	0	20,750	3,633	194.01
200.00 Cross Foot Adjustments	0	0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	30,317,734	2,508,818	4,221,796	30,317,734	4,517,193	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151333

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2012 9:04 am

Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
	7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT	1,734,019					7.00
8.00 LAUNDRY & LINEN SERVICE	15,961	178,449				8.00
9.00 HOUSEKEEPING	13,269	11,540	611,882			9.00
10.00 DIETARY	69,723	10,904	25,921	360,620		10.00
11.00 CAFETERIA	37,872	0	14,080	0	646,232	11.00
13.00 NURSING ADMINISTRATION	15,701	0	5,837	0	30,208	13.00
16.00 MEDICAL RECORDS & LIBRARY	98,694	0	36,691	0	35,334	16.00
17.00 SOCIAL SERVICE	5,431	0	2,019	0	0	17.00
17.01 UTILIZATION REVIEW	4,250	0	1,580	0	0	17.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	206,101	48,305	76,621	295,291	101,335	30.00
31.00 INTENSIVE CARE UNIT	67,079	21,470	24,938	65,329	62,679	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	8,004	0	2,976	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	220,386	30,238	81,932	0	48,763	50.00
51.00 RECOVERY ROOM	54,187	0	20,145	0	13,801	51.00
52.00 DELIVERY ROOM & LABOR ROOM	28,357	0	10,542	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	74,115	5,355	27,553	0	59,758	54.00
54.01 NUCLEAR MEDICINE-DIAGNOSTIC	3,306	0	1,229	0	0	54.01
57.00 CT SCAN	31,167	0	11,587	0	14,632	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	58,367	0	21,699	0	76,538	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	10,696	0	3,976	0	31,268	65.00
66.00 PHYSICAL THERAPY	75,910	1,280	28,221	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	2,361	0	878	0	4,839	69.00
69.01 CARDIAC REHAB	17,071	0	6,346	0	4,696	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	16,693	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	18,322	0	6,812	0	12,713	73.00
73.01 ONCOLOGY	115,104	1,933	42,792	0	25,742	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	3,825	0	1,422	0	630	90.00
91.00 EMERGENCY	141,761	35,263	52,702	0	77,053	91.00
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						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE						113.00
114.00 UTILIZATION REVIEW-SNF						114.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1,397,020	166,288	508,499	360,620	616,682	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,262	0	4,187	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	302,693	12,161	90,629	0	29,550	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 DME	0	0	0	0	0	193.01
193.02 LACTATION CONSULTING	0	0	0	0	0	193.02
193.03 DIABETIC COUNSELING	0	0	0	0	0	193.03
194.00 VACANT SPACE	3,282	0	1,220	0	0	194.00
194.01 BOARD OF HEALTH	19,762	0	7,347	0	0	194.01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	1,734,019	178,449	611,882	360,620	646,232	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151333

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2012 9:04 am

Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	UTILIZATION REVIEW	Subtotal	
		13.00	16.00	17.00	17.01	24.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION	872,577					13.00
16.00	MEDICAL RECORDS & LIBRARY	0	930,271				16.00
17.00	SOCIAL SERVICE	0	0	14,150			17.00
17.01	UTILIZATION REVIEW	0	0	0	204,199		17.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	264,183	479,789	11,587	167,207	3,844,075	30.00
31.00	INTENSIVE CARE UNIT	163,408	0	2,563	36,992	1,778,733	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	0	0	0	0	136,725	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	127,128	184,092	0	0	1,976,242	50.00
51.00	RECOVERY ROOM	35,981	18,506	0	0	344,343	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	153,911	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	450,645	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	49,731	0	0	1,476,919	54.00
54.01	NUCLEAR MEDICINE-DIAGNOSTIC	0	440	0	0	172,886	54.01
57.00	CT SCAN	0	3,659	0	0	701,559	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	2,985	0	0	2,489,011	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	2,007	0	0	648,123	65.00
66.00	PHYSICAL THERAPY	0	2,340	0	0	666,160	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	117,304	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	10,579	68.00
69.00	ELECTROCARDIOLOGY	0	645	0	0	188,219	69.00
69.01	CARDIAC REHAB	12,243	0	0	0	153,968	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,040,473	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	242,130	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,121,874	73.00
73.01	ONCOLOGY	67,110	39,082	0	0	850,526	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	1,642	0	0	0	10,211	90.00
91.00	EMERGENCY	200,882	146,052	0	0	2,683,517	91.00
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							
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE						113.00
114.00	UTILIZATION REVIEW-SNF						114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	872,577	929,328	14,150	204,199	24,258,133	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	29,344	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	943	0	0	5,929,197	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	DME	0	0	0	0	0	193.01
193.02	LACTATION CONSULTING	0	0	0	0	0	193.02
193.03	DIABETIC COUNSELING	0	0	0	0	0	193.03
194.00	VACANT SPACE	0	0	0	0	49,568	194.00
194.01	BOARD OF HEALTH	0	0	0	0	51,492	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	872,577	930,271	14,150	204,199	30,317,734	202.00

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
4.00	EMPLOYEE BENEFITS			4.00
5.00	ADMINISTRATIVE & GENERAL			5.00
7.00	OPERATION OF PLANT			7.00
8.00	LAUNDRY & LINEN SERVICE			8.00
9.00	HOUSEKEEPING			9.00
10.00	DIETARY			10.00
11.00	CAFETERIA			11.00
13.00	NURSING ADMINISTRATION			13.00
16.00	MEDICAL RECORDS & LIBRARY			16.00
17.00	SOCIAL SERVICE			17.00
17.01	UTILIZATION REVIEW			17.01
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	3,844,075	30.00
31.00	INTENSIVE CARE UNIT	0	1,778,733	31.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	136,725	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	1,976,242	50.00
51.00	RECOVERY ROOM	0	344,343	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	153,911	52.00
53.00	ANESTHESIOLOGY	0	450,645	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	1,476,919	54.00
54.01	NUCLEAR MEDICINE-DIAGNOSTIC	0	172,886	54.01
57.00	CT SCAN	0	701,559	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	0	2,489,011	60.00
60.01	BLOOD LABORATORY	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	64.00
65.00	RESPIRATORY THERAPY	0	648,123	65.00
66.00	PHYSICAL THERAPY	0	666,160	66.00
67.00	OCCUPATIONAL THERAPY	0	117,304	67.00
68.00	SPEECH PATHOLOGY	0	10,579	68.00
69.00	ELECTROCARDIOLOGY	0	188,219	69.00
69.01	CARDIAC REHAB	0	153,968	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,040,473	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	242,130	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	4,121,874	73.00
73.01	ONCOLOGY	0	850,526	73.01
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	CLINIC	0	10,211	90.00
91.00	EMERGENCY	0	2,683,517	91.00
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				
109.00	PANCREAS ACQUISITION	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	110.00
111.00	ISLET ACQUISITION	0	0	111.00
113.00	INTEREST EXPENSE			113.00
114.00	UTILIZATION REVIEW-SNF			114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	24,258,133	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29,344	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	5,929,197	192.00
193.00	NONPAID WORKERS	0	0	193.00
193.01	DME	0	0	193.01
193.02	LACTATION CONSULTING	0	0	193.02
193.03	DIABETIC COUNSELING	0	0	193.03
194.00	VACANT SPACE	0	49,568	194.00
194.01	BOARD OF HEALTH	0	51,492	194.01
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	30,317,734	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151333

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2012 9:04 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS	Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT				
	0	1.00	2A	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	EMPLOYEE BENEFITS	0	0	0	0	4.00
5.00	ADMINISTRATIVE & GENERAL	0	341,589	341,589	0	5.00
7.00	OPERATION OF PLANT	0	311,690	311,690	0	7.00
8.00	LAUNDRY & LINEN SERVICE	0	16,758	16,758	0	8.00
9.00	HOUSEKEEPING	0	13,932	13,932	0	9.00
10.00	DIETARY	0	73,206	73,206	0	10.00
11.00	CAFETERIA	0	39,764	39,764	0	11.00
13.00	NURSING ADMINISTRATION	0	16,486	16,486	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	0	103,624	103,624	0	16.00
17.00	SOCIAL SERVICE	0	5,702	5,702	0	17.00
17.01	UTILIZATION REVIEW	0	4,462	4,462	0	17.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	216,396	216,396	0	30.00
31.00	INTENSIVE CARE UNIT	0	70,430	70,430	0	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	42.00
43.00	NURSERY	0	8,404	8,404	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	231,394	231,394	0	50.00
51.00	RECOVERY ROOM	0	56,894	56,894	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	29,773	29,773	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	77,817	77,817	0	54.00
54.01	NUCLEAR MEDICINE-DIAGNOSTIC	0	3,471	3,471	0	54.01
57.00	CT SCAN	0	32,723	32,723	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	LABORATORY	0	61,282	61,282	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	11,230	11,230	0	65.00
66.00	PHYSICAL THERAPY	0	79,701	79,701	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	2,479	2,479	0	69.00
69.01	CARDIAC REHAB	0	17,923	17,923	0	69.01
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	19,237	19,237	0	73.00
73.01	ONCOLOGY	0	120,853	120,853	0	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	CLINIC	0	4,016	4,016	0	90.00
91.00	EMERGENCY	0	148,842	148,842	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	22,870	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	113.00
114.00	UTILIZATION REVIEW-SNF	0	0	0	0	114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,120,078	2,120,078	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,825	11,825	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	317,814	317,814	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	193.00
193.01	DME	0	0	0	0	193.01
193.02	LACTATION CONSULTING	0	0	0	0	193.02
193.03	DIABETIC COUNSELING	0	0	0	0	193.03
194.00	VACANT SPACE	0	38,351	38,351	0	194.00
194.01	BOARD OF HEALTH	0	20,750	20,750	0	194.01
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	2,508,818	2,508,818	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151333

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2012 9:04 am

Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
	7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT	331,228					7.00
8.00 LAUNDRY & LINEN SERVICE	3,049	21,638				8.00
9.00 HOUSEKEEPING	2,535	1,399	24,481			9.00
10.00 DIETARY	13,318	1,322	1,037	91,746		10.00
11.00 CAFETERIA	7,234	0	563	0	54,257	11.00
13.00 NURSING ADMINISTRATION	2,999	0	234	0	2,536	13.00
16.00 MEDICAL RECORDS & LIBRARY	18,852	0	1,468	0	2,967	16.00
17.00 SOCIAL SERVICE	1,037	0	81	0	0	17.00
17.01 UTILIZATION REVIEW	812	0	63	0	0	17.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	39,369	5,859	3,066	75,126	8,510	30.00
31.00 INTENSIVE CARE UNIT	12,813	2,603	998	16,620	5,262	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	1,529	0	119	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	42,097	3,666	3,278	0	4,094	50.00
51.00 RECOVERY ROOM	10,351	0	806	0	1,159	51.00
52.00 DELIVERY ROOM & LABOR ROOM	5,417	0	422	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	14,157	649	1,102	0	5,017	54.00
54.01 NUCLEAR MEDICINE-DIAGNOSTIC	631	0	49	0	0	54.01
57.00 CT SCAN	5,953	0	464	0	1,228	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	11,149	0	868	0	6,426	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	2,043	0	159	0	2,625	65.00
66.00 PHYSICAL THERAPY	14,500	155	1,129	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	451	0	35	0	406	69.00
69.01 CARDIAC REHAB	3,261	0	254	0	394	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,402	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	3,500	0	273	0	1,067	73.00
73.01 ONCOLOGY	21,987	234	1,712	0	2,161	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	731	0	57	0	53	90.00
91.00 EMERGENCY	27,079	4,276	2,109	0	6,469	91.00
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						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE						113.00
114.00 UTILIZATION REVIEW-SNF						114.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	266,854	20,163	20,346	91,746	51,776	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,151	0	168	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	57,821	1,475	3,624	0	2,481	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 DME	0	0	0	0	0	193.01
193.02 LACTATION CONSULTING	0	0	0	0	0	193.02
193.03 DIABETIC COUNSELING	0	0	0	0	0	193.03
194.00 VACANT SPACE	627	0	49	0	0	194.00
194.01 BOARD OF HEALTH	3,775	0	294	0	0	194.01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	331,228	21,638	24,481	91,746	54,257	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151333		Period: From 01/01/2011 To 12/31/2011		Worksheet B Part II Date/Time Prepared: 5/29/2012 9:04 am	
Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	UTILIZATION REVIEW	Subtotal	
		13.00	16.00	17.00	17.01	24.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION	31,504					13.00
16.00	MEDICAL RECORDS & LIBRARY	0	135,469				16.00
17.00	SOCIAL SERVICE	0	0	6,895			17.00
17.01	UTILIZATION REVIEW	0	0	0	7,572		17.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	9,538	69,868	5,646	6,200	464,295	30.00
31.00	INTENSIVE CARE UNIT	5,900	0	1,249	1,372	132,281	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	0	0	0	0	11,469	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	4,590	26,808	0	0	330,391	50.00
51.00	RECOVERY ROOM	1,299	2,695	0	0	75,477	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	36,908	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	5,078	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	7,242	0	0	120,185	54.00
54.01	NUCLEAR MEDICINE-DIAGNOSTIC	0	64	0	0	6,107	54.01
57.00	CT SCAN	0	533	0	0	48,118	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	435	0	0	106,406	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	292	0	0	23,111	65.00
66.00	PHYSICAL THERAPY	0	341	0	0	102,118	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	1,322	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	119	68.00
69.00	ELECTROCARDIOLOGY	0	94	0	0	5,487	69.00
69.01	CARDIAC REHAB	442	0	0	0	23,554	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	12,937	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	2,728	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	70,093	73.00
73.01	ONCOLOGY	2,423	5,691	0	0	161,357	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	59	0	0	0	4,946	90.00
91.00	EMERGENCY	7,253	21,269	0	0	240,167	91.00
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							
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE						113.00
114.00	UTILIZATION REVIEW-SNF						114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	31,504	135,332	6,895	7,572	1,984,654	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	14,301	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	137	0	0	445,234	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	DME	0	0	0	0	0	193.01
193.02	LACTATION CONSULTING	0	0	0	0	0	193.02
193.03	DIABETIC COUNSELING	0	0	0	0	0	193.03
194.00	VACANT SPACE	0	0	0	0	39,535	194.00
194.01	BOARD OF HEALTH	0	0	0	0	25,094	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	31,504	135,469	6,895	7,572	2,508,818	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151333

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2012 9:04 am

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
4.00	EMPLOYEE BENEFITS			4.00
5.00	ADMINISTRATIVE & GENERAL			5.00
7.00	OPERATION OF PLANT			7.00
8.00	LAUNDRY & LINEN SERVICE			8.00
9.00	HOUSEKEEPING			9.00
10.00	DIETARY			10.00
11.00	CAFETERIA			11.00
13.00	NURSING ADMINISTRATION			13.00
16.00	MEDICAL RECORDS & LIBRARY			16.00
17.00	SOCIAL SERVICE			17.00
17.01	UTILIZATION REVIEW			17.01
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	464,295	30.00
31.00	INTENSIVE CARE UNIT	0	132,281	31.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	11,469	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	330,391	50.00
51.00	RECOVERY ROOM	0	75,477	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	36,908	52.00
53.00	ANESTHESIOLOGY	0	5,078	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	120,185	54.00
54.01	NUCLEAR MEDICINE-DIAGNOSTIC	0	6,107	54.01
57.00	CT SCAN	0	48,118	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	0	106,406	60.00
60.01	BLOOD LABORATORY	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	64.00
65.00	RESPIRATORY THERAPY	0	23,111	65.00
66.00	PHYSICAL THERAPY	0	102,118	66.00
67.00	OCCUPATIONAL THERAPY	0	1,322	67.00
68.00	SPEECH PATHOLOGY	0	119	68.00
69.00	ELECTROCARDIOLOGY	0	5,487	69.00
69.01	CARDIAC REHAB	0	23,554	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,937	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	2,728	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	70,093	73.00
73.01	ONCOLOGY	0	161,357	73.01
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	CLINIC	0	4,946	90.00
91.00	EMERGENCY	0	240,167	91.00
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				
109.00	PANCREAS ACQUISITION	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	110.00
111.00	ISLET ACQUISITION	0	0	111.00
113.00	INTEREST EXPENSE			113.00
114.00	UTILIZATION REVIEW-SNF			114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,984,654	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,301	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	445,234	192.00
193.00	NONPAID WORKERS	0	0	193.00
193.01	DME	0	0	193.01
193.02	LACTATION CONSULTING	0	0	193.02
193.03	DIABETIC COUNSELING	0	0	193.03
194.00	VACANT SPACE	0	39,535	194.00
194.01	BOARD OF HEALTH	0	25,094	194.01
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	2,508,818	202.00

Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)					
	1.00					
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT	101,201					1.00
4.00 EMPLOYEE BENEFITS	0	12,777,533				4.00
5.00 ADMINISTRATIVE & GENERAL	13,779	2,060,375	-4,517,193	25,800,541		5.00
7.00 OPERATION OF PLANT	12,573	182,933	0	1,475,659	73,441	7.00
8.00 LAUNDRY & LINEN SERVICE	676	20,783	0	138,278	676	8.00
9.00 HOUSEKEEPING	562	310,350	0	499,602	562	9.00
10.00 DIETARY	2,953	69,896	0	216,217	2,953	10.00
11.00 CAFETERIA	1,604	247,807	0	505,735	1,604	11.00
13.00 NURSING ADMINISTRATION	665	501,376	0	698,531	665	13.00
16.00 MEDICAL RECORDS & LIBRARY	4,180	331,557	0	646,383	4,180	16.00
17.00 SOCIAL SERVICE	230	0	0	5,702	230	17.00
17.01 UTILIZATION REVIEW	180	121,277	0	168,813	180	17.01
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	8,729	1,176,121	0	1,866,813	8,729	30.00
31.00 INTENSIVE CARE UNIT	2,841	778,088	0	1,135,475	2,841	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	339	73,613	0	107,010	339	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	9,334	497,949	0	1,092,438	9,334	50.00
51.00 RECOVERY ROOM	2,295	81,900	0	171,667	2,295	51.00
52.00 DELIVERY ROOM & LABOR ROOM	1,201	49,138	0	97,876	1,201	52.00
53.00 ANESTHESIOLOGY	0	575,338	0	383,501	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	3,139	570,853	0	1,072,613	3,139	54.00
54.01 NUCLEAR MEDICINE-DIAGNOSTIC	140	0	0	142,893	140	54.01
57.00 CT SCAN	1,320	131,342	0	545,081	1,320	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	2,472	557,347	0	1,982,350	2,472	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	453	308,969	0	510,753	453	65.00
66.00 PHYSICAL THERAPY	3,215	0	0	475,209	3,215	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	99,826	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	9,003	0	68.00
69.00 ELECTROCARDIOLOGY	100	44,910	0	152,752	100	69.00
69.01 CARDIAC REHAB	723	59,677	0	96,684	723	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,423	0	871,242	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	206,054	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	776	116,012	0	3,475,528	776	73.00
73.01 ONCOLOGY	4,875	260,449	0	475,510	4,875	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	162	0	0	2,291	162	90.00
91.00 EMERGENCY	6,004	919,973	0	1,727,374	6,004	91.00
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						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE						113.00
114.00 UTILIZATION REVIEW-SNF						114.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	85,520	10,057,456	-4,517,193	21,054,863	59,168	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	477	0	0	11,825	477	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	12,820	2,720,077	0	4,674,752	12,820	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 DME	0	0	0	0	0	193.01
193.02 LACTATION CONSULTING	0	0	0	0	0	193.02
193.03 DIABETIC COUNSELING	0	0	0	0	0	193.03
194.00 VACANT SPACE	1,547	0	0	38,351	139	194.00
194.01 BOARD OF HEALTH	837	0	0	20,750	837	194.01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 cost to be allocated (per wkst. B, Part I)	2,508,818	4,221,796		4,517,193	1,734,019	202.00
203.00 Unit cost multiplier (wkst. B, Part I)	24.790447	0.330408		0.175081	23.611048	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151333

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

Worksheet B-1

Date/Time Prepared:
5/29/2012 9:04 am

Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)					
204.00 Cost to be allocated (per wkst. B, Part II)	1.00	4.00	5A	5.00	7.00	
205.00 Unit cost multiplier (wkst. B, Part II)		0.000000		341,589 0.013240	331,228 4.510124	204.00 205.00

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE	38,490					8.00
9.00	HOUSEKEEPING	2,489	69,708				9.00
10.00	DIETARY	2,352	2,953	4,267			10.00
11.00	CAFETERIA	0	1,604	0	22,569		11.00
13.00	NURSING ADMINISTRATION	0	665	0	1,055	11,689	13.00
16.00	MEDICAL RECORDS & LIBRARY	0	4,180	0	1,234	0	16.00
17.00	SOCIAL SERVICE	0	230	0	0	0	17.00
17.01	UTILIZATION REVIEW	0	180	0	0	0	17.01
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	10,419	8,729	3,494	3,539	3,539	30.00
31.00	INTENSIVE CARE UNIT	4,631	2,841	773	2,189	2,189	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	0	339	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	6,522	9,334	0	1,703	1,703	50.00
51.00	RECOVERY ROOM	0	2,295	0	482	482	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	1,201	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,155	3,139	0	2,087	0	54.00
54.01	NUCLEAR MEDICINE-DIAGNOSTIC	0	140	0	0	0	54.01
57.00	CT SCAN	0	1,320	0	511	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	2,472	0	2,673	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	453	0	1,092	0	65.00
66.00	PHYSICAL THERAPY	276	3,215	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	100	0	169	0	69.00
69.01	CARDIAC REHAB	0	723	0	164	164	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	583	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	776	0	444	0	73.00
73.01	ONCOLOGY	417	4,875	0	899	899	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	162	0	22	22	90.00
91.00	EMERGENCY	7,606	6,004	0	2,691	2,691	91.00
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							
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE						113.00
114.00	UTILIZATION REVIEW-SNF						114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	35,867	57,930	4,267	21,537	11,689	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	477	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	2,623	10,325	0	1,032	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	DME	0	0	0	0	0	193.01
193.02	LACTATION CONSULTING	0	0	0	0	0	193.02
193.03	DIABETIC COUNSELING	0	0	0	0	0	193.03
194.00	VACANT SPACE	0	139	0	0	0	194.00
194.01	BOARD OF HEALTH	0	837	0	0	0	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per wkst. B, Part I)	178,449	611,882	360,620	646,232	872,577	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	4.636243	8.777787	84.513710	28.633612	74.649414	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	21,638	24,481	91,746	54,257	31,504	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151333

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

Worksheet B-1

Date/Time Prepared:
5/29/2012 9:04 am

Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
	8.00	9.00	10.00	11.00	13.00	
205.00 Unit cost multiplier (wkst. B, Part II)	0.562172	0.351194	21.501289	2.404050	2.695184	205.00

Cost Center Description		MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	UTILIZATION REVIEW (PATIENT DAYS)	
		16.00	17.00	17.01	
GENERAL SERVICE COST CENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	EMPLOYEE BENEFITS				4.00
5.00	ADMINISTRATIVE & GENERAL				5.00
7.00	OPERATION OF PLANT				7.00
8.00	LAUNDRY & LINEN SERVICE				8.00
9.00	HOUSEKEEPING				9.00
10.00	DIETARY				10.00
11.00	CAFETERIA				11.00
13.00	NURSING ADMINISTRATION				13.00
16.00	MEDICAL RECORDS & LIBRARY	131,204			16.00
17.00	SOCIAL SERVICE	0	4,267		17.00
17.01	UTILIZATION REVIEW	0	0	4,267	17.01
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	67,669	3,494	3,494	30.00
31.00	INTENSIVE CARE UNIT	0	773	773	31.00
41.00	SUBPROVIDER - IRF	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	42.00
43.00	NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	25,964	0	0	50.00
51.00	RECOVERY ROOM	2,610	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	7,014	0	0	54.00
54.01	NUCLEAR MEDICINE-DIAGNOSTIC	62	0	0	54.01
57.00	CT SCAN	516	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	LABORATORY	421	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	RESPIRATORY THERAPY	283	0	0	65.00
66.00	PHYSICAL THERAPY	330	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	91	0	0	69.00
69.01	CARDIAC REHAB	0	0	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
73.01	ONCOLOGY	5,512	0	0	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	CLINIC	0	0	0	90.00
91.00	EMERGENCY	20,599	0	0	91.00
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					
109.00	PANCREAS ACQUISITION	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	111.00
113.00	INTEREST EXPENSE				113.00
114.00	UTILIZATION REVIEW-SNF				114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	131,071	4,267	4,267	118.00
NONREIMBURSABLE COST CENTERS					
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	133	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	193.00
193.01	DME	0	0	0	193.01
193.02	LACTATION CONSULTING	0	0	0	193.02
193.03	DIABETIC COUNSELING	0	0	0	193.03
194.00	VACANT SPACE	0	0	0	194.00
194.01	BOARD OF HEALTH	0	0	0	194.01
200.00	Cross Foot Adjustments				200.00
201.00	Negative Cost Centers				201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	930,271	14,150	204,199	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	7.090264	3.316147	47.855402	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	135,469	6,895	7,572	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.032507	1.615889	1.774549	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151333

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2012 9:04 am

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Hospital		Cost
			Total Costs	RCE Disallowance	Total Costs		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,844,075		3,844,075	0	0	30.00
31.00	INTENSIVE CARE UNIT	1,778,733		1,778,733	0	0	31.00
41.00	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	SUBPROVIDER	0		0	0	0	42.00
43.00	NURSERY	136,725		136,725	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	1,976,242		1,976,242	0	0	50.00
51.00	RECOVERY ROOM	344,343		344,343	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	153,911		153,911	0	0	52.00
53.00	ANESTHESIOLOGY	450,645		450,645	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,476,919		1,476,919	0	0	54.00
54.01	NUCLEAR MEDICINE-DIAGNOSTIC	172,886		172,886	0	0	54.01
57.00	CT SCAN	701,559		701,559	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	LABORATORY	2,489,011		2,489,011	0	0	60.00
60.01	BLOOD LABORATORY	0		0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	RESPIRATORY THERAPY	648,123	0	648,123	0	0	65.00
66.00	PHYSICAL THERAPY	666,160	0	666,160	0	0	66.00
67.00	OCCUPATIONAL THERAPY	117,304	0	117,304	0	0	67.00
68.00	SPEECH PATHOLOGY	10,579	0	10,579	0	0	68.00
69.00	ELECTROCARDIOLOGY	188,219		188,219	0	0	69.00
69.01	CARDIAC REHAB	153,968		153,968	0	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,040,473		1,040,473	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	242,130		242,130	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	4,121,874		4,121,874	0	0	73.00
73.01	ONCOLOGY	850,526		850,526	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	CLINIC	10,211		10,211	0	0	90.00
91.00	EMERGENCY	2,683,517		2,683,517	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	670,203		670,203	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0		0			99.10
SPECIAL PURPOSE COST CENTERS							
109.00	PANCREAS ACQUISITION	0		0			109.00
110.00	INTESTINAL ACQUISITION	0		0			110.00
111.00	ISLET ACQUISITION	0		0			111.00
113.00	INTEREST EXPENSE						113.00
114.00	UTILIZATION REVIEW-SNF						114.00
200.00	Subtotal (see instructions)	24,928,336	0	24,928,336	0	0	200.00
201.00	Less Observation Beds	670,203		670,203			201.00
202.00	Total (see instructions)	24,258,133	0	24,258,133	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151333

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2012 9:04 am

Cost Center Description	Title XVIII			Hospital	Cost	
	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,343,266		2,343,266		30.00
31.00	INTENSIVE CARE UNIT	1,252,985		1,252,985		31.00
41.00	SUBPROVIDER - IRF	0		0		41.00
42.00	SUBPROVIDER	0		0		42.00
43.00	NURSERY	170,524		170,524		43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	478,201	2,770,662	3,248,863	0.608287	50.00
51.00	RECOVERY ROOM	70,111	433,028	503,139	0.684389	51.00
52.00	DELIVERY ROOM & LABOR ROOM	287,877	174,375	462,252	0.332959	52.00
53.00	ANESTHESIOLOGY	66,944	205,981	272,925	1.651168	53.00
54.00	RADIOLOGY-DIAGNOSTIC	599,697	4,303,672	4,903,369	0.301205	54.00
54.01	NUCLEAR MEDICINE-DIAGNOSTIC	32,246	475,365	507,611	0.340588	54.01
57.00	CT SCAN	697,846	8,642,491	9,340,337	0.075111	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	LABORATORY	1,953,666	8,564,968	10,518,634	0.236629	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	60.01
64.00	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	RESPIRATORY THERAPY	1,030,824	337,360	1,368,184	0.473710	65.00
66.00	PHYSICAL THERAPY	447,399	1,145,348	1,592,747	0.418246	66.00
67.00	OCCUPATIONAL THERAPY	141,662	254,136	395,798	0.296373	67.00
68.00	SPEECH PATHOLOGY	13,988	37,426	51,414	0.205761	68.00
69.00	ELECTROCARDIOLOGY	51,360	838,374	889,734	0.211545	69.00
69.01	CARDIAC REHAB	0	144,512	144,512	1.065434	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	904,550	1,124,154	2,028,704	0.512876	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	236,862	268,283	505,145	0.479328	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,245,243	6,293,459	8,538,702	0.482728	73.00
73.01	ONCOLOGY	10,375	663,734	674,109	1.261704	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	CLINIC	61	6,367	6,428	1.588519	90.00
91.00	EMERGENCY	167,116	4,903,443	5,070,559	0.529235	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	21,424	1,105,434	1,126,858	0.594754	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0		109.00
110.00	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	ISLET ACQUISITION	0	0	0		111.00
113.00	INTEREST EXPENSE					113.00
114.00	UTILIZATION REVIEW-SNF					114.00
200.00	Subtotal (see instructions)	13,224,227	42,692,572	55,916,799		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	13,224,227	42,692,572	55,916,799		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151333

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

worksheet C
Part I
Date/Time Prepared:
5/29/2012 9:04 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
31.00	INTENSIVE CARE UNIT				31.00
41.00	SUBPROVIDER - IRF				41.00
42.00	SUBPROVIDER				42.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000			50.00
51.00	RECOVERY ROOM	0.000000			51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	ANESTHESIOLOGY	0.000000			53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000			54.01
57.00	CT SCAN	0.000000			57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	LABORATORY	0.000000			60.00
60.01	BLOOD LABORATORY	0.000000			60.01
64.00	INTRAVENOUS THERAPY	0.000000			64.00
65.00	RESPIRATORY THERAPY	0.000000			65.00
66.00	PHYSICAL THERAPY	0.000000			66.00
67.00	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	SPEECH PATHOLOGY	0.000000			68.00
69.00	ELECTROCARDIOLOGY	0.000000			69.00
69.01	CARDIAC REHAB	0.000000			69.01
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
73.01	ONCOLOGY	0.000000			73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC				88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	CLINIC	0.000000			90.00
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	CORF				99.10
SPECIAL PURPOSE COST CENTERS					
109.00	PANCREAS ACQUISITION				109.00
110.00	INTESTINAL ACQUISITION				110.00
111.00	ISLET ACQUISITION				111.00
113.00	INTEREST EXPENSE				113.00
114.00	UTILIZATION REVIEW-SNF				114.00
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: 151333

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2012 9:04 am

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		Total Costs
			Total Costs	RCE Disallowance	Total Costs	Cost	
			1.00	2.00	3.00	4.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,844,075		3,844,075	0	0	30.00
31.00	INTENSIVE CARE UNIT	1,778,733		1,778,733	0	0	31.00
41.00	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	SUBPROVIDER	0		0	0	0	42.00
43.00	NURSERY	136,725		136,725	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	1,976,242		1,976,242	0	0	50.00
51.00	RECOVERY ROOM	344,343		344,343	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	153,911		153,911	0	0	52.00
53.00	ANESTHESIOLOGY	450,645		450,645	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,476,919		1,476,919	0	0	54.00
54.01	NUCLEAR MEDICINE-DIAGNOSTIC	172,886		172,886	0	0	54.01
57.00	CT SCAN	701,559		701,559	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	LABORATORY	2,489,011		2,489,011	0	0	60.00
60.01	BLOOD LABORATORY	0		0	0	0	60.01
64.00	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	RESPIRATORY THERAPY	648,123	0	648,123	0	0	65.00
66.00	PHYSICAL THERAPY	666,160	0	666,160	0	0	66.00
67.00	OCCUPATIONAL THERAPY	117,304	0	117,304	0	0	67.00
68.00	SPEECH PATHOLOGY	10,579	0	10,579	0	0	68.00
69.00	ELECTROCARDIOLOGY	188,219		188,219	0	0	69.00
69.01	CARDIAC REHAB	153,968		153,968	0	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,040,473		1,040,473	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	242,130		242,130	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	4,121,874		4,121,874	0	0	73.00
73.01	ONCOLOGY	850,526		850,526	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	CLINIC	10,211		10,211	0	0	90.00
91.00	EMERGENCY	2,683,517		2,683,517	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	670,203		670,203	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0		0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	ISLET ACQUISITION	0		0	0	0	111.00
113.00	INTEREST EXPENSE						113.00
114.00	UTILIZATION REVIEW-SNF						114.00
200.00	Subtotal (see instructions)	24,928,336	0	24,928,336	0	0	200.00
201.00	Less Observation Beds	670,203		670,203	0	0	201.00
202.00	Total (see instructions)	24,258,133	0	24,258,133	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151333	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/29/2012 9:04 am
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Cost Center Description	Charges			Hospital	Cost	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	10.00		
	6.00	7.00	8.00	9.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,343,266		2,343,266			30.00
31.00	INTENSIVE CARE UNIT	1,252,985		1,252,985			31.00
41.00	SUBPROVIDER - IRF	0		0			41.00
42.00	SUBPROVIDER	0		0			42.00
43.00	NURSERY	170,524		170,524			43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	478,201	2,770,662	3,248,863	0.608287	0.000000	50.00
51.00	RECOVERY ROOM	70,111	433,028	503,139	0.684389	0.000000	51.00
52.00	DELIVERY ROOM & LABOR ROOM	287,877	174,375	462,252	0.332959	0.000000	52.00
53.00	ANESTHESIOLOGY	66,944	205,981	272,925	1.651168	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	599,697	4,303,672	4,903,369	0.301205	0.000000	54.00
54.01	NUCLEAR MEDICINE-DIAGNOSTIC	32,246	475,365	507,611	0.340588	0.000000	54.01
57.00	CT SCAN	697,846	8,642,491	9,340,337	0.075111	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	LABORATORY	1,953,666	8,564,968	10,518,634	0.236629	0.000000	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
64.00	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	RESPIRATORY THERAPY	1,030,824	337,360	1,368,184	0.473710	0.000000	65.00
66.00	PHYSICAL THERAPY	447,399	1,145,348	1,592,747	0.418246	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	141,662	254,136	395,798	0.296373	0.000000	67.00
68.00	SPEECH PATHOLOGY	13,988	37,426	51,414	0.205761	0.000000	68.00
69.00	ELECTROCARDIOLOGY	51,360	838,374	889,734	0.211545	0.000000	69.00
69.01	CARDIAC REHAB	0	144,512	144,512	1.065434	0.000000	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	904,550	1,124,154	2,028,704	0.512876	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	236,862	268,283	505,145	0.479328	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,245,243	6,293,459	8,538,702	0.482728	0.000000	73.00
73.01	ONCOLOGY	10,375	663,734	674,109	1.261704	0.000000	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	CLINIC	61	6,367	6,428	1.588519	0.000000	90.00
91.00	EMERGENCY	167,116	4,903,443	5,070,559	0.529235	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	21,424	1,105,434	1,126,858	0.594754	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0			99.10
SPECIAL PURPOSE COST CENTERS							
109.00	PANCREAS ACQUISITION	0	0	0			109.00
110.00	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	ISLET ACQUISITION	0	0	0			111.00
113.00	INTEREST EXPENSE						113.00
114.00	UTILIZATION REVIEW-SNF						114.00
200.00	Subtotal (see instructions)	13,224,227	42,692,572	55,916,799			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	13,224,227	42,692,572	55,916,799			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151333

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2012 9:04 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
31.00	INTENSIVE CARE UNIT				31.00
41.00	SUBPROVIDER - IRF				41.00
42.00	SUBPROVIDER				42.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000			50.00
51.00	RECOVERY ROOM	0.000000			51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	ANESTHESIOLOGY	0.000000			53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000			54.01
57.00	CT SCAN	0.000000			57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	LABORATORY	0.000000			60.00
60.01	BLOOD LABORATORY	0.000000			60.01
64.00	INTRAVENOUS THERAPY	0.000000			64.00
65.00	RESPIRATORY THERAPY	0.000000			65.00
66.00	PHYSICAL THERAPY	0.000000			66.00
67.00	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	SPEECH PATHOLOGY	0.000000			68.00
69.00	ELECTROCARDIOLOGY	0.000000			69.00
69.01	CARDIAC REHAB	0.000000			69.01
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
73.01	ONCOLOGY	0.000000			73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
90.00	CLINIC	0.000000			90.00
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	CORF				99.10
SPECIAL PURPOSE COST CENTERS					
109.00	PANCREAS ACQUISITION				109.00
110.00	INTESTINAL ACQUISITION				110.00
111.00	ISLET ACQUISITION				111.00
113.00	INTEREST EXPENSE				113.00
114.00	UTILIZATION REVIEW-SNF				114.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151333

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

Worksheet D
Part II
Date/Time Prepared:
5/29/2012 9:04 am

Cost Center Description	Title XVIII			Hospital	Cost	
	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	330,391	3,248,863	0.101694	223,294	22,708	50.00
51.00 RECOVERY ROOM	75,477	503,139	0.150012	36,512	5,477	51.00
52.00 DELIVERY ROOM & LABOR ROOM	36,908	462,252	0.079844	1,881	150	52.00
53.00 ANESTHESIOLOGY	5,078	272,925	0.018606	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	120,185	4,903,369	0.024511	319,122	7,822	54.00
54.01 NUCLEAR MEDICINE-DIAGNOSTIC	6,107	507,611	0.012031	15,658	188	54.01
57.00 CT SCAN	48,118	9,340,337	0.005152	292,657	1,508	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00 LABORATORY	106,406	10,518,634	0.010116	1,090,425	11,031	60.00
60.01 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
64.00 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00 RESPIRATORY THERAPY	23,111	1,368,184	0.016892	426,698	7,208	65.00
66.00 PHYSICAL THERAPY	102,118	1,592,747	0.064114	171,851	11,018	66.00
67.00 OCCUPATIONAL THERAPY	1,322	395,798	0.003340	43,068	144	67.00
68.00 SPEECH PATHOLOGY	119	51,414	0.002315	6,148	14	68.00
69.00 ELECTROCARDIOLOGY	5,487	889,734	0.006167	29,519	182	69.00
69.01 CARDIAC REHAB	23,554	144,512	0.162990	0	0	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	12,937	2,028,704	0.006377	555,798	3,544	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	2,728	505,145	0.005400	236,862	1,279	72.00
73.00 DRUGS CHARGED TO PATIENTS	70,093	8,538,702	0.008209	1,281,839	10,523	73.00
73.01 ONCOLOGY	161,357	674,109	0.239363	1,886	451	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00 CLINIC	4,946	6,428	0.769446	0	0	90.00
91.00 EMERGENCY	240,167	5,070,559	0.047365	4,505	213	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,126,858	0.000000	0	0	92.00
200.00 Total (lines 50-199)	1,376,609	52,150,024		4,737,723	83,460	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151333	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/29/2012 9:04 am
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Cost Center Description	Title XVIII				Hospital	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
54.01 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	0	54.01
57.00 CT SCAN	0	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	0	60.01
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
69.01 CARDIAC REHAB	0	0	0	0	0	0	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
73.01 ONCOLOGY	0	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151333

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2012 9:04 am

Cost Center Description	Title XVIII			Hospital		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)	Cost		
	6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0	3,248,863	0.000000	0.000000	223,294		50.00
51.00 RECOVERY ROOM	0	503,139	0.000000	0.000000	36,512		51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	462,252	0.000000	0.000000	1,881		52.00
53.00 ANESTHESIOLOGY	0	272,925	0.000000	0.000000	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	4,903,369	0.000000	0.000000	319,122		54.00
54.01 NUCLEAR MEDICINE-DIAGNOSTIC	0	507,611	0.000000	0.000000	15,658		54.01
57.00 CT SCAN	0	9,340,337	0.000000	0.000000	292,657		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0		58.00
59.00 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0		59.00
60.00 LABORATORY	0	10,518,634	0.000000	0.000000	1,090,425		60.00
60.01 BLOOD LABORATORY	0	0	0.000000	0.000000	0		60.01
64.00 INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0		64.00
65.00 RESPIRATORY THERAPY	0	1,368,184	0.000000	0.000000	426,698		65.00
66.00 PHYSICAL THERAPY	0	1,592,747	0.000000	0.000000	171,851		66.00
67.00 OCCUPATIONAL THERAPY	0	395,798	0.000000	0.000000	43,068		67.00
68.00 SPEECH PATHOLOGY	0	51,414	0.000000	0.000000	6,148		68.00
69.00 ELECTROCARDIOLOGY	0	889,734	0.000000	0.000000	29,519		69.00
69.01 CARDIAC REHAB	0	144,512	0.000000	0.000000	0		69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,028,704	0.000000	0.000000	555,798		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	505,145	0.000000	0.000000	236,862		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	8,538,702	0.000000	0.000000	1,281,839		73.00
73.01 ONCOLOGY	0	674,109	0.000000	0.000000	1,886		73.01
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0		89.00
90.00 CLINIC	0	6,428	0.000000	0.000000	0		90.00
91.00 EMERGENCY	0	5,070,559	0.000000	0.000000	4,505		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,126,858	0.000000	0.000000	0		92.00
200.00 Total (lines 50-199)	0	52,150,024			4,737,723		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151333

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2012 9:04 am

Cost Center Description	Title XVIII			Hospital		Cost
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.01
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01 CARDIAC REHAB	0	0	0	0	0	69.01
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
73.01 ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151333

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2012 9:04 am

Cost Center Description		Title XVIII		Hospital	Cost
		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
		23.00	24.00		
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0		50.00
51.00	RECOVERY ROOM	0	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	ANESTHESIOLOGY	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	NUCLEAR MEDICINE-DIAGNOSTIC	0	0		54.01
57.00	CT SCAN	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0		59.00
60.00	LABORATORY	0	0		60.00
60.01	BLOOD LABORATORY	0	0		60.01
64.00	INTRAVENOUS THERAPY	0	0		64.00
65.00	RESPIRATORY THERAPY	0	0		65.00
66.00	PHYSICAL THERAPY	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0	0		67.00
68.00	SPEECH PATHOLOGY	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	0		69.00
69.01	CARDIAC REHAB	0	0		69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01	ONCOLOGY	0	0		73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	CLINIC	0	0		90.00
91.00	EMERGENCY	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151333	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/29/2012 9:04 am
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Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Hospital	Cost
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0.608287	0	1,000,571	0		50.00
51.00 RECOVERY ROOM	0.684389	0	121,974	0		51.00
52.00 DELIVERY ROOM & LABOR ROOM	0.332959	0	885	0		52.00
53.00 ANESTHESIOLOGY	1.651168	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.301205	0	1,041,094	0		54.00
54.01 NUCLEAR MEDICINE-DIAGNOSTIC	0.340588	0	137,647	0		54.01
57.00 CT SCAN	0.075111	0	2,507,658	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0.000000	0	0	0		59.00
60.00 LABORATORY	0.236629	0	3,052,304	0		60.00
60.01 BLOOD LABORATORY	0.000000	0	0	0		60.01
64.00 INTRAVENOUS THERAPY	0.000000	0	0	0		64.00
65.00 RESPIRATORY THERAPY	0.473710	0	212,056	0		65.00
66.00 PHYSICAL THERAPY	0.418246	0	364,990	0		66.00
67.00 OCCUPATIONAL THERAPY	0.296373	0	83,162	0		67.00
68.00 SPEECH PATHOLOGY	0.205761	0	17,345	0		68.00
69.00 ELECTROCARDIOLOGY	0.211545	0	293,471	0		69.00
69.01 CARDIAC REHAB	1.065434	0	35,121	0		69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.512876	0	411,630	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.479328	0	64,216	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.482728	0	2,668,088	834		73.00
73.01 ONCOLOGY	1.261704	0	304,942	55		73.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0.000000					88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00 CLINIC	1.588519	0	0	0		90.00
91.00 EMERGENCY	0.529235	0	1,191,055	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.594754	0	448,961	0		92.00
200.00 Subtotal (see instructions)		0	13,957,170	889		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	13,957,170	889		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151333	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/29/2012 9:04 am
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Cost Center Description	Costs			Hospital	Cost
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	608,634	0		50.00
51.00 RECOVERY ROOM	0	83,478	0		51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	295	0		52.00
53.00 ANESTHESIOLOGY	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	313,583	0		54.00
54.01 NUCLEAR MEDICINE-DIAGNOSTIC	0	46,881	0		54.01
57.00 CT SCAN	0	188,353	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00 LABORATORY	0	722,264	0		60.00
60.01 BLOOD LABORATORY	0	0	0		60.01
64.00 INTRAVENOUS THERAPY	0	0	0		64.00
65.00 RESPIRATORY THERAPY	0	100,453	0		65.00
66.00 PHYSICAL THERAPY	0	152,656	0		66.00
67.00 OCCUPATIONAL THERAPY	0	24,647	0		67.00
68.00 SPEECH PATHOLOGY	0	3,569	0		68.00
69.00 ELECTROCARDIOLOGY	0	62,082	0		69.00
69.01 CARDIAC REHAB	0	37,419	0		69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	211,115	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	30,781	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	1,287,961	403		73.00
73.01 ONCOLOGY	0	384,747	69		73.01
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00 CLINIC	0	0	0		90.00
91.00 EMERGENCY	0	630,348	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	267,021	0		92.00
200.00 Subtotal (see instructions)	0	5,156,287	472		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	5,156,287	472		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151333 Component CCN:152333	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/29/2012 9:04 am
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Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.608287	0	0	0	50.00
51.00 RECOVERY ROOM	0.684389	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0.332959	0	0	0	52.00
53.00 ANESTHESIOLOGY	1.651168	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.301205	0	0	0	54.00
54.01 NUCLEAR MEDICINE-DIAGNOSTIC	0.340588	0	0	0	54.01
57.00 CT SCAN	0.075111	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00 LABORATORY	0.236629	0	0	0	60.00
60.01 BLOOD LABORATORY	0.000000	0	0	0	60.01
64.00 INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0.473710	0	0	0	65.00
66.00 PHYSICAL THERAPY	0.418246	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0.296373	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0.205761	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0.211545	0	0	0	69.00
69.01 CARDIAC REHAB	1.065434	0	0	0	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.512876	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.479328	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.482728	0	0	0	73.00
73.01 ONCOLOGY	1.261704	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0.000000				88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00 CLINIC	1.588519	0	0	0	90.00
91.00 EMERGENCY	0.529235	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.594754	0	0	0	92.00
200.00 Subtotal (see instructions)		0	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151333 Component CCN: 152333	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/29/2012 9:04 am
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Cost Center Description	Costs			Swing Beds - SNF	Cost
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	0	0		50.00
51.00 RECOVERY ROOM	0	0	0		51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00 ANESTHESIOLOGY	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0		54.01
57.00 CT SCAN	0	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00 LABORATORY	0	0	0		60.00
60.01 BLOOD LABORATORY	0	0	0		60.01
64.00 INTRAVENOUS THERAPY	0	0	0		64.00
65.00 RESPIRATORY THERAPY	0	0	0		65.00
66.00 PHYSICAL THERAPY	0	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	0	0	0		69.00
69.01 CARDIAC REHAB	0	0	0		69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
73.01 ONCOLOGY	0	0	0		73.01
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00 CLINIC	0	0	0		90.00
91.00 EMERGENCY	0	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00 Subtotal (see instructions)	0	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151333

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

Worksheet D-1

Date/Time Prepared:
5/29/2012 9:04 am

Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			4,212 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,461 2.00
3.00	Private room days (excluding swing-bed and observation bed days)			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			3,461 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			640 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			111 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			1,796 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)			640 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		145.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,844,075	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)		16,095	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)		613,490	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,230,585	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,361,068	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,361,068	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.368273	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)		682.19	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,230,585	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)		933.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,676,440	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,676,440	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151333

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

Worksheet D-1

Date/Time Prepared:
5/29/2012 9:04 am

Cost Center Description	Title XVIII			Hospital Program Days	Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)		Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00			
42.00 NURSERY (title v & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	1,778,733	773	2,301.08	514	1,182,755	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1,859,318	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,718,513	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					597,395	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)					597,395	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)					718	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					933.43	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					670,203	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151333

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

Worksheet D-1

Date/Time Prepared:
5/29/2012 9:04 am

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

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151333	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
			Date/Time Prepared: 5/29/2012 9:04 am

Cost Center Description	Title XIX	Hospital	Cost
			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,212 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,461 2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,461 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		640 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		111 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)		187 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)		640 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)		225 15.00
16.00	Nursery days (title V or XIX only)		0 16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)		3,844,075 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)		599,904 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,244,171 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,361,068 28.00
29.00	Private room charges (excluding swing-bed charges)		0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,361,068 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.374027 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)		682.19 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,244,171 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)		937.35 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		175,284 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)		175,284 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151333

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

Worksheet D-1

Date/Time Prepared:
5/29/2012 9:04 am

Cost Center Description	Title XIX			Hospital	Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	136,725	225	607.67	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	1,778,733	773	2,301.08	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					216,776	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					392,060	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					599,904	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)					599,904	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)					718	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					937.35	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					673,017	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151333

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

worksheet D-1

Date/Time Prepared:
5/29/2012 9:04 am

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151333	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/29/2012 9:04 am
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Cost Center Description	Ratio of Cost To Charges	Hospital Cost		
		Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS		1,361,754		30.00
31.00 INTENSIVE CARE UNIT		760,862		31.00
41.00 SUBPROVIDER - IRF		0		41.00
42.00 SUBPROVIDER		0		42.00
43.00 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0.608287	223,294	135,827	50.00
51.00 RECOVERY ROOM	0.684389	36,512	24,988	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0.332959	1,881	626	52.00
53.00 ANESTHESIOLOGY	1.651168	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.301205	319,122	96,121	54.00
54.01 NUCLEAR MEDICINE-DIAGNOSTIC	0.340588	15,658	5,333	54.01
57.00 CT SCAN	0.075111	292,657	21,982	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00 LABORATORY	0.236629	1,090,425	258,026	60.00
60.01 BLOOD LABORATORY	0.000000	0	0	60.01
64.00 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00 RESPIRATORY THERAPY	0.473710	426,698	202,131	65.00
66.00 PHYSICAL THERAPY	0.418246	171,851	71,876	66.00
67.00 OCCUPATIONAL THERAPY	0.296373	43,068	12,764	67.00
68.00 SPEECH PATHOLOGY	0.205761	6,148	1,265	68.00
69.00 ELECTROCARDIOLOGY	0.211545	29,519	6,245	69.00
69.01 CARDIAC REHAB	1.065434	0	0	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.512876	555,798	285,055	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.479328	236,862	113,535	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.482728	1,281,839	618,780	73.00
73.01 ONCOLOGY	1.261704	1,886	2,380	73.01
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00 CLINIC	1.588519	0	0	90.00
91.00 EMERGENCY	0.529235	4,505	2,384	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.594754	0	0	92.00
200.00 Total (sum of lines 50-94 and 96-98)		4,737,723	1,859,318	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)		4,737,723		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151333 Component CCN: 152333	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/29/2012 9:04 am
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Cost Center Description	Title XVIII			Cost
	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		206,191		30.00
31.00 INTENSIVE CARE UNIT		0		31.00
41.00 SUBPROVIDER - IRF		0		41.00
42.00 SUBPROVIDER		0		42.00
43.00 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0.608287	777	473	50.00
51.00 RECOVERY ROOM	0.684389	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0.332959	0	0	52.00
53.00 ANESTHESIOLOGY	1.651168	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.301205	11,248	3,388	54.00
54.01 NUCLEAR MEDICINE-DIAGNOSTIC	0.340588	0	0	54.01
57.00 CT SCAN	0.075111	9,366	703	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00 LABORATORY	0.236629	80,674	19,090	60.00
60.01 BLOOD LABORATORY	0.000000	0	0	60.01
64.00 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00 RESPIRATORY THERAPY	0.473710	56,381	26,708	65.00
66.00 PHYSICAL THERAPY	0.418246	194,828	81,486	66.00
67.00 OCCUPATIONAL THERAPY	0.296373	79,298	23,502	67.00
68.00 SPEECH PATHOLOGY	0.205761	4,417	909	68.00
69.00 ELECTROCARDIOLOGY	0.211545	783	166	69.00
69.01 CARDIAC REHAB	1.065434	0	0	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.512876	26,997	13,846	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.479328	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.482728	143,984	69,505	73.00
73.01 ONCOLOGY	1.261704	0	0	73.01
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00 CLINIC	1.588519	0	0	90.00
91.00 EMERGENCY	0.529235	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.594754	0	0	92.00
200.00 Total (sum of lines 50-94 and 96-98)		608,753	239,776	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)		608,753		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151333	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/29/2012 9:04 am
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Cost Center Description	Title XIX		Hospital		Cost
	Ratio of Cost To Charges	Inpatient Program 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		114,696		30.00
31.00	INTENSIVE CARE UNIT		22,898		31.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY		59,515		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.608287	47,506	28,897	50.00
51.00	RECOVERY ROOM	0.684389	2,765	1,892	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.332959	65,866	21,931	52.00
53.00	ANESTHESIOLOGY	1.651168	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.301205	19,165	5,773	54.00
54.01	NUCLEAR MEDICINE-DIAGNOSTIC	0.340588	754	257	54.01
57.00	CT SCAN	0.075111	38,408	2,885	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.236629	113,112	26,766	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
64.00	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	0.473710	13,484	6,388	65.00
66.00	PHYSICAL THERAPY	0.418246	2,381	996	66.00
67.00	OCCUPATIONAL THERAPY	0.296373	316	94	67.00
68.00	SPEECH PATHOLOGY	0.205761	3,423	704	68.00
69.00	ELECTROCARDIOLOGY	0.211545	1,945	411	69.00
69.01	CARDIAC REHAB	1.065434	0	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.512876	69,054	35,416	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.479328	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.482728	129,914	62,713	73.00
73.01	ONCOLOGY	1.261704	0	0	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	CLINIC	1.588519	61	97	90.00
91.00	EMERGENCY	0.529235	16,654	8,814	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.594754	21,424	12,742	92.00
200.00	Total (sum of lines 50-94 and 96-98)		546,232	216,776	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)		546,232	216,776	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151333	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/29/2012 9:04 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,156,759	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		5,156,759	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		5,208,327	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		48,269	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,173,992	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)		2,986,066	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)		2,986,066	30.00
31.00	Primary payer payments		1,756	31.00
32.00	Subtotal (line 30 minus line 31)		2,984,310	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)		363,851	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		363,851	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		332,300	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		3,348,161	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		3,348,161	40.00
41.00	Interim payments		3,847,093	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)		-498,932	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151333	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/29/2012 9:04 am
Title XVIII		Hospital	Cost
WORKSHEET OVERRIDE VALUES			Overrides
112.00 Override of Ancillary service charges (line 12)			1.00
			0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151333

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2012 9:04 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		4,273,800		3,599,266	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	01/01/2011	85,469	01/01/2011	235,443	3.01	
3.02		09/19/2011	17,654	09/19/2011	86,912	3.02	
3.03			0	09/19/2011	91,345	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	09/19/2011	71,661		0	3.50	
3.51		12/05/2011	8,769	12/05/2011	165,873	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)		22,693		247,827	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)		4,296,493		3,847,093	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		80,821		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		498,932	6.02	
7.00	Total Medicare program liability (see instructions)		4,377,314		3,348,161	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
			0	1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151333
Component CCN: 15Z333

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2012 9:04 am

		Title XVIII		Swing Beds - SNF	Cost
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider		1,032,479		0
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
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	09/19/2011	51,613		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	12/05/2011	182,486		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-130,873		0
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)		901,606		0
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
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER		0		0
6.02	SETTLEMENT TO PROGRAM		68,657		0
7.00	Total Medicare program liability (see instructions)		832,949		0
				Contractor Number	Date (Mo/Day/Yr)
				1.00	2.00
8.00	Name of Contractor		0		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 151333	Period: From 01/01/2011 To 12/31/2011	Worksheet E-2	
		Component CCN: 15Z333			Date/Time Prepared: 5/29/2012 9:04 am
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		603,369	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from wkst. D-3, column 3, line 200 for Part A, and sum of wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)		242,174	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		640	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		845,543	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		845,543	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		845,543	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		12,594	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		832,949	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
17.00	Reimbursable bad debts (see instructions)		0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)		832,949	0	19.00
20.00	Interim payments		901,606	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)		-68,657	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151333	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part V Date/Time Prepared: 5/29/2012 9:04 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHS)				
1.00	Inpatient services		4,718,513	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 thru 3)		4,718,513	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5) . For CAH (see instructions)		4,765,698	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		4,765,698	19.00
20.00	Deductibles (exclude professional component)		461,656	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		4,304,042	22.00
23.00	Coinsurance		6,509	23.00
24.00	Subtotal (line 22 minus line 23)		4,297,533	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		79,781	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		79,781	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		68,395	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26)		4,377,314	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		4,377,314	30.00
31.00	Interim payments		4,296,493	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)		80,821	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151333	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2012 9:04 am
		Title XIX	Hospital	Cost
				1.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		392,060	1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		392,060	4.00
5.00	Inpatient primary payer payments		0	5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		392,060	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		197,109	8.00
9.00	Ancillary service charges		546,232	9.00
10.00	Organ acquisition charges, net of revenue		0	10.00
11.00	Incentive from target amount computation		0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		743,341	12.00
CUSTOMARY CHRGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		743,341	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		351,281	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		392,060	21.00
PROSPECTIVE PAYMENT AMOUNT				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		0	23.00
24.00	Program capital payments		0	24.00
25.00	Capital exception payments (see instructions)		0	25.00
26.00	Routine and Ancillary service other pass through costs		0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title v or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX enter the sum of lines 27 and 21.		392,060	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		392,060	31.00
32.00	Deductibles		0	32.00
33.00	Coinsurance		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Utilization review		0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		392,060	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		392,060	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		392,060	40.00
41.00	Interim payments		264,641	41.00
42.00	Balance due provider/program (line 40 minus 41)		127,419	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	43.00

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

Provider CCN: 151333

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

Worksheet G

Date/Time Prepared:
5/29/2012 9:04 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	205,903	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	10,468,557	0	0	0	4.00
5.00 Other receivable	0	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-6,241,022	0	0	0	6.00
7.00 Inventory	1,071,908	0	0	0	7.00
8.00 Prepaid expenses	302,042	0	0	0	8.00
9.00 Other current assets	629,074	0	0	0	9.00
10.00 Due from other funds	0	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	6,436,462	0	0	0	11.00
FIXED ASSETS					
12.00 Land	159,364	0	0	0	12.00
13.00 Land improvements	297,478	0	0	0	13.00
14.00 Accumulated depreciation	-228,783	0	0	0	14.00
15.00 Buildings	28,416,530	0	0	0	15.00
16.00 Accumulated depreciation	-15,610,340	0	0	0	16.00
17.00 Leasehold improvements	189,178	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	0	0	0	0	19.00
20.00 Accumulated depreciation	0	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	15,730,128	0	0	0	23.00
24.00 Accumulated depreciation	-12,150,060	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	0	0	0	0	27.00
28.00 Accumulated depreciation	0	0	0	0	28.00
29.00 Minor equipment-nondepreciable	0	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	16,803,495	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	2,978,032	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	3,198,361	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	6,176,393	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	29,416,350	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	765,839	0	0	0	37.00
38.00 Salaries, wages, and fees payable	1,146,041	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	0	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	1,276,128	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	3,188,008	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	13,629,983	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	13,629,983	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	16,817,991	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	12,598,359	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	12,598,359	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	29,416,350	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151333

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

Worksheet G-1

Date/Time Prepared:
5/29/2012 9:04 am

	General Fund		Special Purpose Fund			
	1.00	2.00	3.00	4.00		
1.00 Fund balances at beginning of period		14,693,936		0		1.00
2.00 Net income (loss) (from wkst. G-3, line 29)		-1,563,994				2.00
3.00 Total (sum of line 1 and line 2)		13,129,942		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)		13,129,942		0		11.00
12.00 Deductions (debit adjustments) (specify)	531,583		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)		531,583		0		18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		12,598,359		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151333

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

Worksheet G-1

Date/Time Prepared:
5/29/2012 9:04 am

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151333

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

Worksheet G-2 Parts

Date/Time Prepared:
5/29/2012 9:04 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,361,068		2,361,068	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	238,205		238,205	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,599,273		2,599,273	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	2,294,361		2,294,361	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)	2,294,361		2,294,361	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,893,634		4,893,634	17.00
18.00	Ancillary services	9,672,522	47,158,884	56,831,406	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	PHYSICIAN OFFICES	380,802	5,156,209	5,537,011	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	14,946,958	52,315,093	67,262,051	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		32,755,046		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		32,755,046		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151333

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

Worksheet G-3

Date/Time Prepared:
5/29/2012 9:04 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	67,262,051	1.00
2.00	Less contractual allowances and discounts on patients' accounts	36,922,550	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,339,501	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	32,755,046	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,415,545	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	254,719	24.00
24.01	NON OPERATING INCOME	596,832	24.01
24.02		0	24.02
25.00	Total other income (sum of lines 6-24)	851,551	25.00
26.00	Total (line 5 plus line 25)	-1,563,994	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)	-1,563,994	29.00