

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: 151304 Period: From 01/01/2011 To 12/31/2011 Worksheet 5 Parts I-III Date/Time Prepared: 5/24/2012 4:36 pm

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. Date: 5/24/2012 Time: 4:36 pm

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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

Encryption Information

ECR: Date: 5/24/2012 Time: 4:36 pm
 .MGunhY07jIs4dnAcm7F4:cCgQ4gw0
 wyhQT0yoKZKwFUUHL1fCLa9iHN8Bvg
 upj70mp7pp0r5F38
 PI: Date: 5/24/2012 Time: 4:36 pm
 wzHVkld.Jocw4tQCwxe0kTcuoQRqL0
 a0ZZC0iewIujaBGzpuO:E:cCjF4Vwn
 QUDWylFEFc01Bmb6

(Signed) 
 Officer or Administrator of Provider(s)
 Title: VP of Finance & CFO
 Date: 5/25/12

	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	167,964	6,898	0	64,680	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	35,401	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	203,365	6,898	0	64,680	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: 151304		Period: From 01/01/2011 To 12/31/2011		Worksheet S-2 Part I Date/Time Prepared: 5/24/2012 10:14 am							
1.00		2.00		3.00		4.00							
Hospital and Hospital Health Care Complex Address:													
1.00	Street: 1300 NORTH MAIN STREET			PO Box:						1.00			
2.00	City: RUSHVILLE			State: IN		Zip Code: 46173-		County: RUSH		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		RUSH MEMORIAL HOSPITAL	151304	99915	1	08/01/2000	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		RUSH SWING BEDS	152304	99915		08/01/2000	N	O	N	7.00		
8.00	Swing Beds - NF							N		N	8.00		
9.00	Hospital-Based SNF										9.00		
10.00	Hospital-Based NF										10.00		
11.00	Hospital-Based OLTC										11.00		
12.00	Hospital-Based HHA										12.00		
13.00	Separately Certified ASC										13.00		
14.00	Hospital-Based Hospice										14.00		
15.00	Hospital-Based Health Clinic - RHC										15.00		
16.00	Hospital-Based Health Clinic - FQHC										16.00		
17.00	Hospital-based (CMHC) 1										17.00		
18.00	Renal Dialysis										18.00		
19.00	Other										19.00		
							From:	To:					
							1.00	2.00					
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2011	12/31/2011		20.00			
21.00	Type of Control (see instructions)						2				21.00		
Inpatient PPS Information													
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N				22.00		
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.						0				23.00		
		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days						
		1.00	2.00	3.00	4.00	5.00	6.00						
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.						0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.						0	0	0	0	0	0	25.00
							Urban/Rural S	Date of Geogr					
							1.00	2.00					
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.						2				26.00		
27.00	For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification (in column 2).						2				27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0				35.00		
							Beginning:	Ending:					
							1.00	2.00					
36.00	Enter applicable beginning and ending dates of SCH status. subscript line 36 for number of periods in excess of one and enter subsequent dates.										36.00		
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.						0				37.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151304	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/24/2012 10:14 am
---	--	----------------------	---	--

		Beginning: 1.00	Ending: 2.00	
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.				58.00
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00	
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01

Teaching Hospitals that Claim Residents in Non-Provider Settings					
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00	

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
--	--	----------------------	----------------------	--	-------------------------------------	---

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151304

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

Worksheet S-2
Part I
Date/Time Prepared:
5/24/2012 10:14 am

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151304	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/24/2012 10:14 am		
			1.00		2.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		N			140.00
		1.00		2.00		3.00
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name:	Contractor's Name:	Contractor's Number:			141.00
142.00	Street:	PO Box:				142.00
143.00	City:	State:	Zip Code:			143.00
					1.00	
144.00	Are provider based physicians' costs included in Worksheet A?				Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.				N	145.00
			1.00		2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N			146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N			147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N			148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N			149.00
			Part A		Part B	
			1.00		2.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital		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
					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
		0	1.00	2.00	3.00	4.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5					0.00
						1.00
Health Information Technology (HIT) Incentive in the American Recovery and Reinvestment Act						
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.				N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.00

Health Financial Systems		RUSH MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151304	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part II Date/Time Prepared: 5/24/2012 10:14 am	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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	03/14/2012		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	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	1.00	21.00
			N	
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		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.		X	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		X	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
			Y/N	Date
			1.00	2.00
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/14/2012	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151304

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

Worksheet S-3
Part I
Date/Time Prepared:
5/24/2012 10:14 am

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	
	Line Number				
	1.00	2.00	3.00	4.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	15	5,475	36,432.00	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)		15	5,475	36,432.00	7.00
8.00 INTENSIVE CARE UNIT					8.00
9.00 CORONARY CARE UNIT					9.00
10.00 BURN INTENSIVE CARE UNIT					10.00
11.00 SURGICAL INTENSIVE CARE UNIT					11.00
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00
13.00 NURSERY					13.00
14.00 Total (see instructions)		15	5,475	36,432.00	14.00
15.00 CAH visits					15.00
16.00 SUBPROVIDER - IPF					16.00
17.00 SUBPROVIDER - IRF					17.00
18.00 SUBPROVIDER					18.00
19.00 SKILLED NURSING FACILITY					19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE					21.00
22.00 HOME HEALTH AGENCY					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00 HOSPICE					24.00
25.00 CMHC - CMHC					25.00
26.00 RURAL HEALTH CLINIC					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25
27.00 Total (sum of lines 14-26)		15			27.00
28.00 Observation Bed Days					28.00
29.00 Ambulance Trips					29.00
30.00 Employee discount days (see instruction)					30.00
31.00 Employee discount days - IRF					31.00
32.00 Labor & delivery days (see instructions)					32.00
33.00 LTCH non-covered days					33.00

Cost Center Description	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	973	92	1,518	1.00	
2.00 HMO		176	9		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	409	0	417	5.00	
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	124	6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,382	92	2,059	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	1,382	92	2,059	14.00	
15.00 CAH visits	0	0	0	0	15.00	
16.00 SUBPROVIDER - IPF					16.00	
17.00 SUBPROVIDER - IRF					17.00	
18.00 SUBPROVIDER					18.00	
19.00 SKILLED NURSING FACILITY					19.00	
20.00 NURSING FACILITY					20.00	
21.00 OTHER LONG TERM CARE					21.00	
22.00 HOME HEALTH AGENCY					22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00	
24.00 HOSPICE					24.00	
25.00 CMHC - CMHC					25.00	
26.00 RURAL HEALTH CLINIC					26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25	
27.00 Total (sum of lines 14-26)					27.00	
28.00 Observation Bed Days	0		80	422	28.00	
29.00 Ambulance Trips		700			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		
	Total Interns & Residents	Employees On Payroll	Nonpaid workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	292	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	228.58	0.00	0	292	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	228.58	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

Cost Center Description	Discharges		
	Title XIX	Total All Patients	
	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	31	476	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)	31	476	14.00
15.00 CAH visits			15.00
16.00 SUBPROVIDER - IPF			16.00
17.00 SUBPROVIDER - IRF			17.00
18.00 SUBPROVIDER			18.00
19.00 SKILLED NURSING FACILITY			19.00
20.00 NURSING FACILITY			20.00
21.00 OTHER LONG TERM CARE			21.00
22.00 HOME HEALTH AGENCY			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)			23.00
24.00 HOSPICE			24.00
25.00 CMHC - CMHC			25.00
26.00 RURAL HEALTH CLINIC			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER			26.25
27.00 Total (sum of lines 14-26)			27.00
28.00 Observation Bed Days			28.00
29.00 Ambulance Trips			29.00
30.00 Employee discount days (see instruction)			30.00
31.00 Employee discount days - IRF			31.00
32.00 Labor & delivery days (see instructions)			32.00
33.00 LTCH non-covered days			33.00

				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)			0.358652	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			620,796	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			592,863	5.00
6.00	Medicaid charges			4,034,341	6.00
7.00	Medicaid cost (line 1 times line 6)			1,446,924	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)			233,265	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			504,896	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			233,265	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	576,147	0	576,147	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	206,636	0	206,636	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)	206,636	0	206,636	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)			3,271,400	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			545,526	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)			2,725,874	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)			977,640	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			1,184,276	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			1,417,541	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151304

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

Worksheet A

Date/Time Prepared:
5/24/2012 10:14 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		1,724,295	1,724,295	0	1,724,295	1.00
4.00 EMPLOYEE BENEFITS	285,221	2,245,131	2,530,352	0	2,530,352	4.00
5.00 ADMINISTRATIVE & GENERAL	1,720,788	626,533	2,347,321	0	2,347,321	5.00
7.00 OPERATION OF PLANT	179,268	512,307	691,575	1,796	693,371	7.00
8.00 LAUNDRY & LINEN SERVICE	0	0	0	61,032	61,032	8.00
9.00 HOUSEKEEPING	253,486	129,693	383,179	-61,032	322,147	9.00
10.00 DIETARY	334,228	234,582	568,810	-406,334	162,476	10.00
11.00 CAFETERIA	0	0	0	406,334	406,334	11.00
13.00 NURSING ADMINISTRATION	140,033	911	140,944	-200	140,744	13.00
14.00 CENTRAL SERVICES & SUPPLY	48,854	143,512	192,366	-103,706	88,660	14.00
15.00 PHARMACY	0	0	0	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	231,165	103,722	334,887	0	334,887	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	823,762	72,008	895,770	1,687	897,457	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	288,315	384,884	673,199	-31,994	641,205	50.00
51.00 RECOVERY ROOM	0	1,628	1,628	32,009	33,637	51.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	801,407	990,506	1,791,913	152	1,792,065	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00 LABORATORY	538,730	707,705	1,246,435	0	1,246,435	60.00
65.00 RESPIRATORY THERAPY	110,403	5,922	116,325	0	116,325	65.00
66.00 PHYSICAL THERAPY	288,178	147,027	435,205	5	435,210	66.00
67.00 OCCUPATIONAL THERAPY	218,388	610	218,998	0	218,998	67.00
68.00 SPEECH PATHOLOGY	3,046	9	3,055	0	3,055	68.00
69.00 ELECTROCARDIOLOGY	172,639	4,520	177,159	0	177,159	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,908	13,908	103,706	117,614	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	61,610	61,610	0	61,610	72.00
73.00 DRUGS CHARGED TO PATIENTS	321,875	1,368,794	1,690,669	0	1,690,669	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	81,409	11,159	92,568	0	92,568	90.00
91.00 EMERGENCY	792,875	524,773	1,317,648	6,324	1,323,972	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	564,503	76,145	640,648	-9,779	630,869	95.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	8,198,573	10,091,894	18,290,467	0	18,290,467	118.00
NONREIMBURSABLE COST CENTERS						
192.00 PHYSICIANS' PRIVATE OFFICES	2,389,264	556,541	2,945,805	0	2,945,805	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 FOUNDATION	52,207	284	52,491	0	52,491	193.01
193.02 OCCUPATIONAL MEDICINE	36,132	3,366	39,498	0	39,498	193.02
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00 TOTAL (SUM OF LINES 118-199)	10,676,176	10,652,085	21,328,261	0	21,328,261	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151304

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

Worksheet A

Date/Time Prepared:
5/24/2012 10:14 am

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	-50,108	1,674,187	1.00
4.00	EMPLOYEE BENEFITS	-3,037	2,527,315	4.00
5.00	ADMINISTRATIVE & GENERAL	-252,044	2,095,277	5.00
7.00	OPERATION OF PLANT	-448	692,923	7.00
8.00	LAUNDRY & LINEN SERVICE	0	61,032	8.00
9.00	HOUSEKEEPING	-252	321,895	9.00
10.00	DIETARY	-2,405	160,071	10.00
11.00	CAFETERIA	-178,143	228,191	11.00
13.00	NURSING ADMINISTRATION	-485	140,259	13.00
14.00	CENTRAL SERVICES & SUPPLY	-5,603	83,057	14.00
15.00	PHARMACY	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	-11,759	323,128	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-747	896,710	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	-311,685	329,520	50.00
51.00	RECOVERY ROOM	0	33,637	51.00
53.00	ANESTHESIOLOGY	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	-537,933	1,254,132	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00	LABORATORY	-1,210	1,245,225	60.00
65.00	RESPIRATORY THERAPY	0	116,325	65.00
66.00	PHYSICAL THERAPY	0	435,210	66.00
67.00	OCCUPATIONAL THERAPY	0	218,998	67.00
68.00	SPEECH PATHOLOGY	0	3,055	68.00
69.00	ELECTROCARDIOLOGY	-7	177,152	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	-717	116,897	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	61,610	72.00
73.00	DRUGS CHARGED TO PATIENTS	-5,673	1,684,996	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0	92,568	90.00
91.00	EMERGENCY	-1,515	1,322,457	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	-519	630,350	95.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	-1,364,290	16,926,177	118.00
NONREIMBURSABLE COST CENTERS				
192.00	PHYSICIANS' PRIVATE OFFICES	0	2,945,805	192.00
193.00	NONPAID WORKERS	0	0	193.00
193.01	FOUNDATION	0	52,491	193.01
193.02	OCCUPATIONAL MEDICINE	0	39,498	193.02
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
200.00	TOTAL (SUM OF LINES 118-199)	-1,364,290	19,963,971	200.00

		Increases			
Cost Center		Line #	Salary	other	
2.00		3.00	4.00	5.00	
A - SALARY RECLASS					
1.00	RECOVERY ROOM	51.00	32,009	0	1.00
2.00	EMERGENCY	91.00	200	0	2.00
	TOTALS		32,209	0	
B - LAUNDRY RECLASS					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	61,032	1.00
	TOTALS		0	61,032	
C - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	238,758	167,576	1.00
	TOTALS		238,758	167,576	
D - MED SUPPLY RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	103,706	1.00
	TOTALS		0	103,706	
E - AMBULANCE RECLASS					
1.00	OPERATION OF PLANT	7.00	1,796	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	1,687	0	2.00
3.00	OPERATING ROOM	50.00	15	0	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	152	0	4.00
5.00	PHYSICAL THERAPY	66.00	5	0	5.00
6.00	EMERGENCY	91.00	6,124	0	6.00
	TOTALS		9,779	0	
500.00	Grand Total: Increases		280,746	332,314	500.00

		Decreases				
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - SALARY RECLASS						
1.00	NURSING ADMINISTRATION	13.00	200	0	0	1.00
2.00	OPERATING ROOM	50.00	32,009	0	0	2.00
	TOTALS		32,209	0	0	
B - LAUNDRY RECLASS						
1.00	HOUSEKEEPING	9.00	0	61,032	0	1.00
	TOTALS		0	61,032	0	
C - CAFETERIA RECLASS						
1.00	DIETARY	10.00	238,758	167,576	0	1.00
	TOTALS		238,758	167,576	0	
D - MED SUPPLY RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	103,706	0	1.00
	TOTALS		0	103,706	0	
E - AMBULANCE RECLASS						
1.00	AMBULANCE SERVICES	95.00	9,779	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
	TOTALS		9,779	0	0	
500.00	Grand Total: Decreases		280,746	332,314		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151304

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/24/2012 10:14 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	164,978	0	0	0	0 1.00
2.00	Land Improvements	235,798	0	0	0	0 2.00
3.00	Buildings and Fixtures	12,000,217	46,683	0	46,683	0 3.00
4.00	Building Improvements	57,726	560,424	0	560,424	0 4.00
5.00	Fixed Equipment	685,390	60,543	0	60,543	0 5.00
6.00	Movable Equipment	10,515,924	296,621	0	296,621	0 6.00
7.00	HIT designated Assets	0	0	0	0	0 7.00
8.00	Subtotal (sum of lines 1-7)	23,660,033	964,271	0	964,271	0 8.00
9.00	Reconciling Items	0	0	0	0	0 9.00
10.00	Total (line 8 minus line 9)	23,660,033	964,271	0	964,271	0 10.00
SUMMARY OF CAPITAL						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,282,530	0	208,497	233,268	0 1.00
3.00	Total (sum of lines 1-2)	1,282,530	0	208,497	233,268	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	0 1.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0 3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151304

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/24/2012 10:14 am

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	164,978	0		1.00	
2.00	Land Improvements	235,798	0		2.00	
3.00	Buildings and Fixtures	12,046,900	0		3.00	
4.00	Building Improvements	618,150	0		4.00	
5.00	Fixed Equipment	745,933	0		5.00	
6.00	Movable Equipment	10,812,545	0		6.00	
7.00	HIT designated Assets	0	0		7.00	
8.00	Subtotal (sum of lines 1-7)	24,624,304	0		8.00	
9.00	Reconciling Items	0	0		9.00	
10.00	Total (line 8 minus line 9)	24,624,304	0		10.00	
SUMMARY OF CAPITAL						
Cost Center Description		Other Capital-Related costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,724,295		1.00	
3.00	Total (sum of lines 1-2)	0	1,724,295		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	1,232,422	0
3.00	Total (sum of lines 1-2)	0	0	0	1,232,422	0

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151304

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/24/2012 10:14 am

SUMMARY OF CAPITAL						
Cost Center Description	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	208,497	233,268	0	0	1,674,187 1.00
3.00	Total (sum of lines 1-2)	208,497	233,268	0	0	1,674,187 3.00

Line #	Cost Center Description	Basis/Code (2)		Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted	
		1.00	2.00		3.00	4.00
					Cost Center	Line #
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00	Investment income - 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		-847,048		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	RESPIRATORY THERAPY	65.00 23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00 24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00 25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0	*** Cost Center Deleted ***	2.00 27.00
28.00	Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00 28.00
29.00	Physicians' assistant			0		0.00 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00 30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00 31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A		0		0.00 32.00
33.00	CAFETERIA	B		-89,369	CAFETERIA	11.00 33.00
34.00	JAIL MEALS	B		-88,774	CAFETERIA	11.00 34.00
35.00	VENDING MACHINES	B		-578	ADMINISTRATIVE & GENERAL	5.00 35.00
36.00	SALE OF SUPPLIES	B		-717	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00 36.00
37.00	PHYSICIAN APPLICATION FEES	B		-11,250	ADMINISTRATIVE & GENERAL	5.00 37.00
38.00	NSF FEES	B		-393	EMPLOYEE BENEFITS	4.00 38.00
39.00	MEDICAL RECORDS TRANSCRIPTION FEES	B		-11,725	MEDICAL RECORDS & LIBRARY	16.00 39.00
40.00	COPIER FEES	B		-18,699	ADMINISTRATIVE & GENERAL	5.00 40.00
41.00	ATHLETIC TRAINER - SCHOOL REV	B		-16,000	ADMINISTRATIVE & GENERAL	5.00 41.00
42.00	INTEREST FUNDED DEPRECIATION	B		-4,741	NEW CAP REL COSTS-BLDG & FIXT	1.00 42.00
43.00	WELLNESS PROGRAM	B		-820	EMPLOYEE BENEFITS	4.00 43.00
44.00	INSURANCE REIMBURSEMENT	B		-59,395	ADMINISTRATIVE & GENERAL	5.00 44.00
45.00	SALE OF SCRAP	B		-5,603	CENTRAL SERVICES & SUPPLY	14.00 45.00
45.01	MISC. INCOME	B		-507	EMPLOYEE BENEFITS	4.00 45.01
45.02	MISC. INCOME	B		-6,214	ADMINISTRATIVE & GENERAL	5.00 45.02
45.03	MISC. INCOME	B		-300	DIETARY	10.00 45.03
45.04	MISC. INCOME	B		-25	MEDICAL RECORDS & LIBRARY	16.00 45.04
45.05	MISC. INCOME	B		-38	ADULTS & PEDIATRICS	30.00 45.05
45.06	MISC. INCOME	B		-400	RADIOLOGY-DIAGNOSTIC	54.00 45.06

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	
45.07 MISC. INCOME	B	-150	LABORATORY	60.00	45.07
45.08 MISC. INCOME	B	-500	EMERGENCY	91.00	45.08
45.09 INTEREST INCOME	B	-45,367	NEW CAP REL COSTS-BLDG & FIXT	1.00	45.09
45.10 TELEPHONE SALARY	A	-3,614	ADMINISTRATIVE & GENERAL	5.00	45.10
45.11 TELEPHONE OTHER	A	-816	ADMINISTRATIVE & GENERAL	5.00	45.11
45.12 TELEPHONE BENEFITS	A	-573	ADMINISTRATIVE & GENERAL	5.00	45.12
45.13 ADVERTISING	A	-126,265	ADMINISTRATIVE & GENERAL	5.00	45.13
45.14 IHA & AHA LOBBYING	A	-3,200	ADMINISTRATIVE & GENERAL	5.00	45.14
45.15 REBATES	B	-1,317	EMPLOYEE BENEFITS	4.00	45.15
45.16 REBATES	B	-5,440	ADMINISTRATIVE & GENERAL	5.00	45.16
45.17 REBATES	B	-448	OPERATION OF PLANT	7.00	45.17
45.18 REBATES	B	-252	HOUSEKEEPING	9.00	45.18
45.19 REBATES	B	-2,105	DIETARY	10.00	45.19
45.20 REBATES	B	-485	NURSING ADMINISTRATION	13.00	45.20
45.21 REBATES	B	-9	MEDICAL RECORDS & LIBRARY	16.00	45.21
45.22 REBATES	B	-709	ADULTS & PEDIATRICS	30.00	45.22
45.23 REBATES	B	-234	OPERATING ROOM	50.00	45.23
45.24 REBATES	B	-1,936	RADIOLOGY-DIAGNOSTIC	54.00	45.24
45.25 REBATES	B	-1,060	LABORATORY	60.00	45.25
45.26 REBATES	B	-7	ELECTROCARDIOLOGY	69.00	45.26
45.27 REBATES	B	-5,673	DRUGS CHARGED TO PATIENTS	73.00	45.27
45.28 REBATES	B	-1,015	EMERGENCY	91.00	45.28
45.29 REBATES	B	-519	AMBULANCE SERVICES	95.00	45.29
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-1,364,290			50.00

Cost Center Description	Wkst. A-7 Ref.		
	5.00		
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0		1.00
2.00 Investment income - 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 CAFETERIA	0		33.00
34.00 JAIL MEALS	0		34.00
35.00 VENDING MACHINES	0		35.00
36.00 SALE OF SUPPLIES	0		36.00
37.00 PHYSICIAN APPLICATION FEES	0		37.00
38.00 NSF FEES	0		38.00
39.00 MEDICAL RECORDS TRANSCRIPTION FEES	0		39.00
40.00 COPIER FEES	0		40.00
41.00 ATHLETIC TRAINER - SCHOOL REV	0		41.00
42.00 INTEREST FUNDED DEPRECIATION	9		42.00
43.00 WELLNESS PROGRAM	0		43.00
44.00 INSURANCE REIMBURSEMENT	0		44.00
45.00 SALE OF SCRAP	0		45.00
45.01 MISC. INCOME	0		45.01
45.02 MISC. INCOME	0		45.02
45.03 MISC. INCOME	0		45.03
45.04 MISC. INCOME	0		45.04
45.05 MISC. INCOME	0		45.05
45.06 MISC. INCOME	0		45.06
45.07 MISC. INCOME	0		45.07
45.08 MISC. INCOME	0		45.08
45.09 INTEREST INCOME	9		45.09
45.10 TELEPHONE SALARY	0		45.10
45.11 TELEPHONE OTHER	0		45.11
45.12 TELEPHONE BENEFITS	0		45.12
45.13 ADVERTISING	0		45.13
45.14 IHA & AHA LOBBYING	0		45.14
45.15 REBATES	0		45.15

Provider CCN: 151304

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

Worksheet A-8

Date/Time Prepared:
5/24/2012 10:14 am

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
45.16	REBATES	0	45.16
45.17	REBATES	0	45.17
45.18	REBATES	0	45.18
45.19	REBATES	0	45.19
45.20	REBATES	0	45.20
45.21	REBATES	0	45.21
45.22	REBATES	0	45.22
45.23	REBATES	0	45.23
45.24	REBATES	0	45.24
45.25	REBATES	0	45.25
45.26	REBATES	0	45.26
45.27	REBATES	0	45.27
45.28	REBATES	0	45.28
45.29	REBATES	0	45.29
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: 151304

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

Worksheet A-8-2

Date/Time Prepared:
5/24/2012 10:14 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	50.00	OPERATING ROOM	22,209	17,209	1.00
2.00	50.00	OPERATING ROOM	296,200	294,242	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	473,303	448,303	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	37,631	37,631	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	49,663	49,663	5.00
6.00	60.00	LABORATORY	36,000	0	6.00
7.00	91.00	EMERGENCY	460,256	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00			1,375,262	847,048	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151304

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

Worksheet A-8-2

Date/Time Prepared:
5/24/2012 10:14 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	5,000	0	0	0	0	1.00
2.00	1,958	0	0	0	0	2.00
3.00	25,000	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	36,000	0	0	0	0	6.00
7.00	460,256	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	528,214					200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151304

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

Worksheet A-8-2

Date/Time Prepared:
5/24/2012 10:14 am

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151304

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

Worksheet A-8-2
Date/Time Prepared:
5/24/2012 10:14 am

	RCE Disallowance	Adjustment	
	17.00	18.00	
1.00	0	17,209	1.00
2.00	0	294,242	2.00
3.00	0	448,303	3.00
4.00	0	37,631	4.00
5.00	0	49,663	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	847,048	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151304

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

Worksheet B
Part I
Date/Time Prepared:
5/24/2012 10:14 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	1,674,187	1,674,187			1.00
4.00	EMPLOYEE BENEFITS	2,527,315	15,534	2,542,849		4.00
5.00	ADMINISTRATIVE & GENERAL	2,095,277	320,339	421,108	2,836,724	5.00
7.00	OPERATION OF PLANT	692,923	162,791	44,310	900,024	7.00
8.00	LAUNDRY & LINEN SERVICE	61,032	6,894	0	67,926	8.00
9.00	HOUSEKEEPING	321,895	33,630	62,033	417,558	9.00
10.00	DIETARY	160,071	64,814	23,363	248,248	10.00
11.00	CAFETERIA	228,191	21,519	58,428	308,138	11.00
13.00	NURSING ADMINISTRATION	140,259	10,387	34,220	184,866	13.00
14.00	CENTRAL SERVICES & SUPPLY	83,057	46,043	11,955	141,055	14.00
15.00	PHARMACY	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	323,128	33,257	56,570	412,955	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	896,710	144,439	202,002	1,243,151	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	329,520	113,232	62,726	505,478	50.00
51.00	RECOVERY ROOM	33,637	14,556	7,833	56,026	51.00
53.00	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,254,132	190,645	196,156	1,640,933	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
60.00	LABORATORY	1,245,225	48,465	131,837	1,425,527	60.00
65.00	RESPIRATORY THERAPY	116,325	3,051	27,018	146,394	65.00
66.00	PHYSICAL THERAPY	435,210	84,866	70,524	590,600	66.00
67.00	OCCUPATIONAL THERAPY	218,998	25,874	53,443	298,315	67.00
68.00	SPEECH PATHOLOGY	3,055	606	745	4,406	68.00
69.00	ELECTROCARDIOLOGY	177,152	9,362	42,248	228,762	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	116,897	0	0	116,897	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	61,610	0	0	61,610	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,684,996	8,291	78,769	1,772,056	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	92,568	60,575	19,922	173,065	90.00
91.00	EMERGENCY	1,322,457	92,528	195,578	1,610,563	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	630,350	13,182	135,751	779,283	95.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	16,926,177	1,524,880	1,936,539	16,170,560	118.00
NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	2,945,805	139,851	584,692	3,670,348	192.00
193.00	NONPAID WORKERS	0	0	0	0	193.00
193.01	FOUNDATION	52,491	0	12,776	65,267	193.01
193.02	OCCUPATIONAL MEDICINE	39,498	3,610	8,842	51,950	193.02
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	5,846	0	5,846	194.00
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)	19,963,971	1,674,187	2,542,849	19,963,971	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151304

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

Worksheet B
Part I
Date/Time Prepared:
5/24/2012 10:14 am

Cost Center Description		OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	CAFETERIA 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	1,049,091					7.00
8.00	LAUNDRY & LINEN SERVICE	6,152	85,328				8.00
9.00	HOUSEKEEPING	30,013	5,989	522,718			9.00
10.00	DIETARY	57,843	2,455	29,850	379,512		10.00
11.00	CAFETERIA	19,205	0	9,911	0	388,290	11.00
13.00	NURSING ADMINISTRATION	9,270	0	4,784	0	4,460	13.00
14.00	CENTRAL SERVICES & SUPPLY	41,091	0	21,205	0	4,956	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	29,680	0	15,316	0	17,345	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	128,905	55,637	66,521	379,512	50,797	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	101,054	5,585	52,148	0	12,390	50.00
51.00	RECOVERY ROOM	12,990	0	6,704	0	2,230	51.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	170,141	3,608	87,800	0	40,142	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	LABORATORY	43,252	0	22,320	0	32,709	60.00
65.00	RESPIRATORY THERAPY	2,723	719	1,405	0	5,947	65.00
66.00	PHYSICAL THERAPY	75,738	1,680	39,085	0	15,115	66.00
67.00	OCCUPATIONAL THERAPY	23,091	773	11,916	0	7,186	67.00
68.00	SPEECH PATHOLOGY	540	33	279	0	0	68.00
69.00	ELECTROCARDIOLOGY	8,355	0	4,312	0	6,443	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	7,399	0	3,818	0	11,894	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	54,060	0	27,898	0	7,434	90.00
91.00	EMERGENCY	82,576	8,849	42,613	0	43,364	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	11,764	0	6,071	0	45,594	95.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	915,842	85,328	453,956	379,512	308,006	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	124,810	0	64,408	0	77,806	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	FOUNDATION	0	0	0	0	2,478	193.01
193.02	OCCUPATIONAL MEDICINE	3,222	0	1,662	0	0	193.02
194.00	OTHER NONREIMBURSABLE COST CENTERS	5,217	0	2,692	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,049,091	85,328	522,718	379,512	388,290	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151304

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

Worksheet B
Part I
Date/Time Prepared:
5/24/2012 10:14 am

Cost Center Description	NURSING	CENTRAL	PHARMACY	MEDICAL	Subtotal	
	ADMINISTRATION	SERVICES & SUPPLY		RECORDS & LIBRARY		
	13.00	14.00	15.00	16.00	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	233,999					13.00
14.00 CENTRAL SERVICES & SUPPLY	0	231,669				14.00
15.00 PHARMACY	0	0	0			15.00
16.00 MEDICAL RECORDS & LIBRARY	0	514	0	544,206		16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	73,035	14,356	0	233,824	2,451,636	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	17,995	12,788	0	51,423	842,581	50.00
51.00 RECOVERY ROOM	3,370	464	0	0	91,063	51.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	14,815	0	62,261	2,291,481	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00 LABORATORY	0	94,548	0	0	1,854,460	60.00
65.00 RESPIRATORY THERAPY	8,446	1,585	0	1,153	192,619	65.00
66.00 PHYSICAL THERAPY	0	2,471	0	0	822,508	66.00
67.00 OCCUPATIONAL THERAPY	0	148	0	0	390,838	67.00
68.00 SPEECH PATHOLOGY	0	3	0	0	5,991	68.00
69.00 ELECTROCARDIOLOGY	0	619	0	0	286,380	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	30,227	0	0	166,485	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	17,842	0	0	89,656	72.00
73.00 DRUGS CHARGED TO PATIENTS	2,627	2,030	0	0	2,093,323	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	2,011	0	0	293,132	90.00
91.00 EMERGENCY	62,758	15,726	0	195,545	2,328,745	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	65,768	8,536	0	0	1,046,086	95.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	233,999	218,683	0	544,206	15,246,984	118.00
NONREIMBURSABLE COST CENTERS						
192.00 PHYSICIANS' PRIVATE OFFICES	0	12,669	0	0	4,557,954	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 FOUNDATION	0	0	0	0	78,555	193.01
193.02 OCCUPATIONAL MEDICINE	0	317	0	0	65,755	193.02
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	14,723	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	233,999	231,669	0	544,206	19,963,971	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151304

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

Worksheet B
Part I
Date/Time Prepared:
5/24/2012 10:14 am

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
GENERAL SERVICE COST CENTERS		25.00	26.00	
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
14.00	CENTRAL SERVICES & SUPPLY			14.00
15.00	PHARMACY			15.00
16.00	MEDICAL RECORDS & LIBRARY			16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	2,451,636	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	842,581	50.00
51.00	RECOVERY ROOM	0	91,063	51.00
53.00	ANESTHESIOLOGY	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	2,291,481	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00	LABORATORY	0	1,854,460	60.00
65.00	RESPIRATORY THERAPY	0	192,619	65.00
66.00	PHYSICAL THERAPY	0	822,508	66.00
67.00	OCCUPATIONAL THERAPY	0	390,838	67.00
68.00	SPEECH PATHOLOGY	0	5,991	68.00
69.00	ELECTROCARDIOLOGY	0	286,380	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	166,485	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	89,656	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	2,093,323	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0	293,132	90.00
91.00	EMERGENCY	0	2,328,745	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	0	1,046,086	95.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	15,246,984	118.00
NONREIMBURSABLE COST CENTERS				
192.00	PHYSICIANS' PRIVATE OFFICES	0	4,557,954	192.00
193.00	NONPAID WORKERS	0	0	193.00
193.01	FOUNDATION	0	78,555	193.01
193.02	OCCUPATIONAL MEDICINE	0	65,755	193.02
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	14,723	194.00
200.00	Cross Foot Adjustments	0	0	200.00
201.00	Negative Cost Centers	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	19,963,971	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151304

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2012 10:14 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	0	15,534	15,534	15,534	1.00
4.00	EMPLOYEE BENEFITS	0	320,339	320,339	2,573	4.00
5.00	ADMINISTRATIVE & GENERAL	0	162,791	162,791	271	5.00
7.00	OPERATION OF PLANT	0	6,894	6,894	0	7.00
8.00	LAUNDRY & LINEN SERVICE	0	33,630	33,630	379	8.00
9.00	HOUSEKEEPING	0	64,814	64,814	143	9.00
10.00	DIETARY	0	21,519	21,519	357	10.00
11.00	CAFETERIA	0	10,387	10,387	209	11.00
13.00	NURSING ADMINISTRATION	0	46,043	46,043	73	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	PHARMACY	0	33,257	33,257	346	15.00
16.00	MEDICAL RECORDS & LIBRARY	0				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	144,439	144,439	1,234	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	113,232	113,232	383	50.00
51.00	RECOVERY ROOM	0	14,556	14,556	48	51.00
53.00	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	190,645	190,645	1,198	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
60.00	LABORATORY	0	48,465	48,465	805	60.00
65.00	RESPIRATORY THERAPY	0	3,051	3,051	165	65.00
66.00	PHYSICAL THERAPY	0	84,866	84,866	431	66.00
67.00	OCCUPATIONAL THERAPY	0	25,874	25,874	326	67.00
68.00	SPEECH PATHOLOGY	0	606	606	5	68.00
69.00	ELECTROCARDIOLOGY	0	9,362	9,362	258	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	8,291	8,291	481	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	60,575	60,575	122	90.00
91.00	EMERGENCY	0	92,528	92,528	1,195	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	13,182	13,182	829	95.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,524,880	1,524,880	11,831	118.00
NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	0	139,851	139,851	3,571	192.00
193.00	NONPAID WORKERS	0	0	0	0	193.00
193.01	FOUNDATION	0	0	0	78	193.01
193.02	OCCUPATIONAL MEDICINE	0	3,610	3,610	54	193.02
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	5,846	5,846	0	194.00
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	1,674,187	1,674,187	15,534	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151304

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2012 10:14 am

Cost Center Description	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	CAFETERIA 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	180,031					7.00
8.00 LAUNDRY & LINEN SERVICE	1,056	9,231				8.00
9.00 HOUSEKEEPING	5,150	648	47,680			9.00
10.00 DIETARY	9,926	266	2,723	82,552		10.00
11.00 CAFETERIA	3,296	0	904	0	31,886	11.00
13.00 NURSING ADMINISTRATION	1,591	0	436	0	366	13.00
14.00 CENTRAL SERVICES & SUPPLY	7,051	0	1,934	0	407	14.00
15.00 PHARMACY	0	0	0	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	5,093	0	1,397	0	1,424	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	22,121	6,018	6,068	82,552	4,171	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	17,341	604	4,757	0	1,017	50.00
51.00 RECOVERY ROOM	2,229	0	611	0	183	51.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	29,198	390	8,009	0	3,296	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00 LABORATORY	7,422	0	2,036	0	2,686	60.00
65.00 RESPIRATORY THERAPY	467	78	128	0	488	65.00
66.00 PHYSICAL THERAPY	12,997	182	3,565	0	1,241	66.00
67.00 OCCUPATIONAL THERAPY	3,963	84	1,087	0	590	67.00
68.00 SPEECH PATHOLOGY	93	4	25	0	0	68.00
69.00 ELECTROCARDIOLOGY	1,434	0	393	0	529	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	1,270	0	348	0	977	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	9,277	0	2,545	0	610	90.00
91.00 EMERGENCY	14,171	957	3,887	0	3,561	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	2,019	0	554	0	3,744	95.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	157,165	9,231	41,407	82,552	25,290	118.00
NONREIMBURSABLE COST CENTERS						
192.00 PHYSICIANS' PRIVATE OFFICES	21,418	0	5,875	0	6,393	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 FOUNDATION	0	0	0	0	203	193.01
193.02 OCCUPATIONAL MEDICINE	553	0	152	0	0	193.02
194.00 OTHER NONREIMBURSABLE COST CENTERS	895	0	246	0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	180,031	9,231	47,680	82,552	31,886	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151304

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2012 10:14 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
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	16,474					13.00
14.00	CENTRAL SERVICES & SUPPLY	0	58,167				14.00
15.00	PHARMACY	0	0	0			15.00
16.00	MEDICAL RECORDS & LIBRARY	0	129	0	49,432		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	5,142	3,604	0	21,239	320,026	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	1,267	3,211	0	4,671	156,013	50.00
51.00	RECOVERY ROOM	237	117	0	0	19,037	51.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	3,720	0	5,655	273,049	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	LABORATORY	0	23,738	0	0	112,029	60.00
65.00	RESPIRATORY THERAPY	595	398	0	105	8,235	65.00
66.00	PHYSICAL THERAPY	0	620	0	0	115,037	66.00
67.00	OCCUPATIONAL THERAPY	0	37	0	0	37,585	67.00
68.00	SPEECH PATHOLOGY	0	1	0	0	817	68.00
69.00	ELECTROCARDIOLOGY	0	156	0	0	16,445	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,589	0	0	9,793	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	4,480	0	0	5,642	72.00
73.00	DRUGS CHARGED TO PATIENTS	185	510	0	0	45,472	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	0	505	0	0	76,897	90.00
91.00	EMERGENCY	4,418	3,948	0	17,762	172,793	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	4,630	2,143	0	0	41,794	95.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	16,474	54,906	0	49,432	1,410,664	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	0	3,181	0	0	249,486	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	FOUNDATION	0	0	0	0	1,512	193.01
193.02	OCCUPATIONAL MEDICINE	0	80	0	0	5,428	193.02
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	7,097	194.00
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	16,474	58,167	0	49,432	1,674,187	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151304

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2012 10:14 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
14.00 CENTRAL SERVICES & SUPPLY			14.00
15.00 PHARMACY			15.00
16.00 MEDICAL RECORDS & LIBRARY			16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS	0	320,026	30.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	0	156,013	50.00
51.00 RECOVERY ROOM	0	19,037	51.00
53.00 ANESTHESIOLOGY	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	273,049	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	55.00
60.00 LABORATORY	0	112,029	60.00
65.00 RESPIRATORY THERAPY	0	8,235	65.00
66.00 PHYSICAL THERAPY	0	115,037	66.00
67.00 OCCUPATIONAL THERAPY	0	37,585	67.00
68.00 SPEECH PATHOLOGY	0	817	68.00
69.00 ELECTROCARDIOLOGY	0	16,445	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,793	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	5,642	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	45,472	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00 CLINIC	0	76,897	90.00
91.00 EMERGENCY	0	172,793	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS			
95.00 AMBULANCE SERVICES	0	41,794	95.00
SPECIAL PURPOSE COST CENTERS			
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	1,410,664	118.00
NONREIMBURSABLE COST CENTERS			
192.00 PHYSICIANS' PRIVATE OFFICES	0	249,486	192.00
193.00 NONPAID WORKERS	0	0	193.00
193.01 FOUNDATION	0	1,512	193.01
193.02 OCCUPATIONAL MEDICINE	0	5,428	193.02
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	7,097	194.00
200.00 Cross Foot Adjustments	0	0	200.00
201.00 Negative Cost Centers	0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	1,674,187	202.00

Cost Center Description	CAPITAL	EMPLOYEE	Reconciliation	ADMINISTRATIVE	OPERATION OF				
	RELATED COSTS						BENEFITS	& GENERAL	PLANT
	NEW BLDG & FIXT (SQUARE FEET)						(GROSS SALARIES)	(ACCUM. COST)	(SQUARE FEET)
	1.00	4.00	SA	5.00	7.00				
GENERAL SERVICE COST CENTERS									
1.00 NEW CAP REL COSTS-BLDG & FIXT	71,887					1.00			
4.00 EMPLOYEE BENEFITS	667	10,390,955				4.00			
5.00 ADMINISTRATIVE & GENERAL	13,755	1,720,788	-2,836,724	17,127,247		5.00			
7.00 OPERATION OF PLANT	6,990	181,064	0	900,024	50,475	7.00			
8.00 LAUNDRY & LINEN SERVICE	296	0	0	67,926	296	8.00			
9.00 HOUSEKEEPING	1,444	253,486	0	417,558	1,444	9.00			
10.00 DIETARY	2,783	95,470	0	248,248	2,783	10.00			
11.00 CAFETERIA	924	238,758	0	308,138	924	11.00			
13.00 NURSING ADMINISTRATION	446	139,833	0	184,866	446	13.00			
14.00 CENTRAL SERVICES & SUPPLY	1,977	48,854	0	141,055	1,977	14.00			
15.00 PHARMACY	0	0	0	0	0	15.00			
16.00 MEDICAL RECORDS & LIBRARY	1,428	231,165	0	412,955	1,428	16.00			
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00 ADULTS & PEDIATRICS	6,202	825,449	0	1,243,151	6,202	30.00			
ANCILLARY SERVICE COST CENTERS									
50.00 OPERATING ROOM	4,862	256,321	0	505,478	4,862	50.00			
51.00 RECOVERY ROOM	625	32,009	0	56,026	625	51.00			
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00			
54.00 RADIOLOGY-DIAGNOSTIC	8,186	801,559	0	1,640,933	8,186	54.00			
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00			
60.00 LABORATORY	2,081	538,730	0	1,425,527	2,081	60.00			
65.00 RESPIRATORY THERAPY	131	110,403	0	146,394	131	65.00			
66.00 PHYSICAL THERAPY	3,644	288,183	0	590,600	3,644	66.00			
67.00 OCCUPATIONAL THERAPY	1,111	218,388	0	298,315	1,111	67.00			
68.00 SPEECH PATHOLOGY	26	3,046	0	4,406	26	68.00			
69.00 ELECTROCARDIOLOGY	402	172,639	0	228,762	402	69.00			
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00			
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	116,897	0	71.00			
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	61,610	0	72.00			
73.00 DRUGS CHARGED TO PATIENTS	356	321,875	0	1,772,056	356	73.00			
OUTPATIENT SERVICE COST CENTERS									
90.00 CLINIC	2,601	81,409	0	173,065	2,601	90.00			
91.00 EMERGENCY	3,973	799,199	0	1,610,563	3,973	91.00			
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00			
OTHER REIMBURSABLE COST CENTERS									
95.00 AMBULANCE SERVICES	566	554,724	0	779,283	566	95.00			
SPECIAL PURPOSE COST CENTERS									
118.00 SUBTOTALS (SUM OF LINES 1-117)	65,476	7,913,352	-2,836,724	13,333,836	44,064	118.00			
NONREIMBURSABLE COST CENTERS									
192.00 PHYSICIANS' PRIVATE OFFICES	6,005	2,389,264	0	3,670,348	6,005	192.00			
193.00 NONPAID WORKERS	0	0	0	0	0	193.00			
193.01 FOUNDATION	0	52,207	0	65,267	0	193.01			
193.02 OCCUPATIONAL MEDICINE	155	36,132	0	51,950	155	193.02			
194.00 OTHER NONREIMBURSABLE COST CENTERS	251	0	0	5,846	251	194.00			
200.00 Cross Foot Adjustments						200.00			
201.00 Negative Cost Centers						201.00			
202.00 Cost to be allocated (per wkst. B, Part I)	1,674,187	2,542,849		2,836,724	1,049,091	202.00			
203.00 Unit cost multiplier (wkst. B, Part I)	23.289148	0.244718		0.165626	20.784368	203.00			
204.00 Cost to be allocated (per wkst. B, Part II)		15,534		322,912	180,031	204.00			
205.00 Unit cost multiplier (wkst. B, Part II)		0.001495		0.018854	3.566736	205.00			

Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	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	28,495				8.00
9.00	HOUSEKEEPING	2,000	48,735			9.00
10.00	DIETARY	820	2,783	100		10.00
11.00	CAFETERIA	0	924	0	1,567	11.00
13.00	NURSING ADMINISTRATION	0	446	0	18	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	1,977	0	20	14.00
15.00	PHARMACY	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	1,428	0	70	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	18,580	6,202	100	205	42,477
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,865	4,862	0	50	10,466
51.00	RECOVERY ROOM	0	625	0	9	1,960
53.00	ANESTHESIOLOGY	0	0	0	0	0
54.00	RADIOLOGY-DIAGNOSTIC	1,205	8,186	0	162	0
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
60.00	LABORATORY	0	2,081	0	132	0
65.00	RESPIRATORY THERAPY	240	131	0	24	4,912
66.00	PHYSICAL THERAPY	561	3,644	0	61	0
67.00	OCCUPATIONAL THERAPY	258	1,111	0	29	0
68.00	SPEECH PATHOLOGY	11	26	0	0	0
69.00	ELECTROCARDIOLOGY	0	402	0	26	0
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	DRUGS CHARGED TO PATIENTS	0	356	0	48	1,528
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	2,601	0	30	0
91.00	EMERGENCY	2,955	3,973	0	175	36,500
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	566	0	184	38,251
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	28,495	42,324	100	1,243	136,094
NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	0	6,005	0	314	0
193.00	NONPAID WORKERS	0	0	0	0	0
193.01	FOUNDATION	0	0	0	10	0
193.02	OCCUPATIONAL MEDICINE	0	155	0	0	0
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	251	0	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per wkst. B, Part I)	85,328	522,718	379,512	388,290	233,999
203.00	Unit cost multiplier (wkst. B, Part I)	2.994490	10.725721	3.795.120000	247.791959	1.719392
204.00	Cost to be allocated (per wkst. B, Part II)	9,231	47,680	82,552	31,886	16,474
205.00	Unit cost multiplier (wkst. B, Part II)	0.323952	0.978352	825.520000	20.348437	0.121049

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151304

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

Worksheet B-1

Date/Time Prepared:
5/24/2012 10:14 am

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		14.00	15.00	16.00	
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
14.00	CENTRAL SERVICES & SUPPLY	794,833			14.00
15.00	PHARMACY	0	100		15.00
16.00	MEDICAL RECORDS & LIBRARY	1,765	0	94,400	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	49,253	0	40,560	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	43,874	0	8,920	50.00
51.00	RECOVERY ROOM	1,592	0	0	51.00
53.00	ANESTHESIOLOGY	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	50,830	0	10,800	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
60.00	LABORATORY	324,380	0	0	60.00
65.00	RESPIRATORY THERAPY	5,438	0	200	65.00
66.00	PHYSICAL THERAPY	8,477	0	0	66.00
67.00	OCCUPATIONAL THERAPY	508	0	0	67.00
68.00	SPEECH PATHOLOGY	9	0	0	68.00
69.00	ELECTROCARDIOLOGY	2,125	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	103,706	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	61,214	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	6,966	100	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	6,901	0	0	90.00
91.00	EMERGENCY	53,953	0	33,920	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES	29,286	0	0	95.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1-117)	750,277	100	94,400	118.00
NONREIMBURSABLE COST CENTERS					
192.00	PHYSICIANS' PRIVATE OFFICES	43,467	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	193.00
193.01	FOUNDATION	0	0	0	193.01
193.02	OCCUPATIONAL MEDICINE	1,089	0	0	193.02
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.00
200.00	Cross Foot Adjustments				200.00
201.00	Negative Cost Centers				201.00
202.00	Cost to be allocated (per wkst. B, Part I)	231,669	0	544,206	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	0.291469	0.000000	5.764894	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	58,167	0	49,432	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	0.073181	0.000000	0.523644	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151304

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2012 10:14 am

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		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	2,451,636		2,451,636	0		0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	842,581		842,581	0		0	50.00
51.00 RECOVERY ROOM	91,063		91,063	0		0	51.00
53.00 ANESTHESIOLOGY	0		0	0		0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	2,291,481		2,291,481	0		0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0		0	0		0	55.00
60.00 LABORATORY	1,854,460		1,854,460	0		0	60.00
65.00 RESPIRATORY THERAPY	192,619	0	192,619	0		0	65.00
66.00 PHYSICAL THERAPY	822,508	0	822,508	0		0	66.00
67.00 OCCUPATIONAL THERAPY	390,838	0	390,838	0		0	67.00
68.00 SPEECH PATHOLOGY	5,991	0	5,991	0		0	68.00
69.00 ELECTROCARDIOLOGY	286,380		286,380	0		0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0		0	0		0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	166,485		166,485	0		0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	89,656		89,656	0		0	72.00
73.00 DRUGS CHARGED TO PATIENTS	2,093,323		2,093,323	0		0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00 CLINIC	293,132		293,132	0		0	90.00
91.00 EMERGENCY	2,328,745		2,328,745	0		0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	438,943		438,943	0		0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 AMBULANCE SERVICES	1,046,086		1,046,086	0		0	95.00
200.00 Subtotal (see instructions)	15,685,927	0	15,685,927	0		0	200.00
201.00 Less Observation Beds	438,943		438,943	0		0	201.00
202.00 Total (see instructions)	15,246,984	0	15,246,984	0		0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151304

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2012 10:14 am

		Title XVIII			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,198,871		2,198,871			30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	59,366	1,930,597	1,989,963	0.423415	0.000000	50.00
51.00	RECOVERY ROOM	3,026	391,145	394,171	0.231024	0.000000	51.00
53.00	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	682,732	12,659,419	13,342,151	0.171747	0.000000	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
60.00	LABORATORY	734,613	7,857,553	8,592,166	0.215831	0.000000	60.00
65.00	RESPIRATORY THERAPY	260,153	263,545	523,698	0.367805	0.000000	65.00
66.00	PHYSICAL THERAPY	243,529	1,580,197	1,823,726	0.451004	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	110,234	687,717	797,951	0.489802	0.000000	67.00
68.00	SPEECH PATHOLOGY	6,099	12,781	18,880	0.317320	0.000000	68.00
69.00	ELECTROCARDIOLOGY	131,267	1,690,111	1,821,378	0.157233	0.000000	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	77,122	1,562,588	1,639,710	0.101533	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	295,921	295,921	0.302973	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	958,933	4,143,911	5,102,844	0.410227	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	EMERGENCY	59,583	3,759,230	3,818,813	0.609809	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	446,404	446,404	0.983286	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	0	929,107	929,107	1.125905	0.000000	95.00
200.00	Subtotal (see instructions)	5,525,528	38,210,226	43,735,754			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	5,525,528	38,210,226	43,735,754			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151304

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2012 10:14 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000			50.00
51.00	RECOVERY ROOM	0.000000			51.00
53.00	ANESTHESIOLOGY	0.000000			53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	RADIOLOGY-THERAPEUTIC	0.000000			55.00
60.00	LABORATORY	0.000000			60.00
65.00	RESPIRATORY THERAPY	0.000000			65.00
66.00	PHYSICAL THERAPY	0.000000			66.00
67.00	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	SPEECH PATHOLOGY	0.000000			68.00
69.00	ELECTROCARDIOLOGY	0.000000			69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
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					
95.00	AMBULANCE SERVICES	0.000000			95.00
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: 151304

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2012 10:14 am

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		Cost
			Total Costs	RCE Disallowance	Total Costs	Total Costs	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	2,451,636					0	0 30.00
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	842,581			842,581		0	0 50.00
51.00 RECOVERY ROOM	91,063			91,063		0	0 51.00
53.00 ANESTHESIOLOGY	0			0		0	0 53.00
54.00 RADIOLOGY-DIAGNOSTIC	2,291,481			2,291,481		0	0 54.00
55.00 RADIOLOGY-THERAPEUTIC	0			0		0	0 55.00
60.00 LABORATORY	1,854,460			1,854,460		0	0 60.00
65.00 RESPIRATORY THERAPY	192,619	0		192,619		0	0 65.00
66.00 PHYSICAL THERAPY	822,508	0		822,508		0	0 66.00
67.00 OCCUPATIONAL THERAPY	390,838	0		390,838		0	0 67.00
68.00 SPEECH PATHOLOGY	5,991	0		5,991		0	0 68.00
69.00 ELECTROCARDIOLOGY	286,380			286,380		0	0 69.00
70.00 ELECTROENCEPHALOGRAPHY	0			0		0	0 70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	166,485			166,485		0	0 71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	89,656			89,656		0	0 72.00
73.00 DRUGS CHARGED TO PATIENTS	2,093,323			2,093,323		0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
90.00 CLINIC	293,132			293,132		0	0 90.00
91.00 EMERGENCY	2,328,745			2,328,745		0	0 91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	438,943			438,943		0	0 92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 AMBULANCE SERVICES	1,046,086			1,046,086		0	0 95.00
200.00 Subtotal (see instructions)	15,685,927	0		15,685,927		0	0 200.00
201.00 Less Observation Beds	438,943			438,943		0	0 201.00
202.00 Total (see instructions)	15,246,984	0		15,246,984		0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151304

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2012 10:14 am

Cost Center Description	Charges			Hospital	Cost	
	Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,198,871		2,198,871			30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	59,366	1,930,597	1,989,963	0.423415	0.000000	50.00
51.00 RECOVERY ROOM	3,026	391,145	394,171	0.231024	0.000000	51.00
53.00 ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00 RADIOLOGY-DIAGNOSTIC	682,732	12,659,419	13,342,151	0.171747	0.000000	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
60.00 LABORATORY	734,613	7,857,553	8,592,166	0.215831	0.000000	60.00
65.00 RESPIRATORY THERAPY	260,153	263,545	523,698	0.367805	0.000000	65.00
66.00 PHYSICAL THERAPY	243,529	1,580,197	1,823,726	0.451004	0.000000	66.00
67.00 OCCUPATIONAL THERAPY	110,234	687,717	797,951	0.489802	0.000000	67.00
68.00 SPEECH PATHOLOGY	6,099	12,781	18,880	0.317320	0.000000	68.00
69.00 ELECTROCARDIOLOGY	131,267	1,690,111	1,821,378	0.157233	0.000000	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	77,122	1,562,588	1,639,710	0.101533	0.000000	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	295,921	295,921	0.302973	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	958,933	4,143,911	5,102,844	0.410227	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	0	0	0.000000	0.000000	90.00
91.00 EMERGENCY	59,583	3,759,230	3,818,813	0.609809	0.000000	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	446,404	446,404	0.983286	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	0	929,107	929,107	1.125905	0.000000	95.00
200.00 Subtotal (see instructions)	5,525,528	38,210,226	43,735,754			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	5,525,528	38,210,226	43,735,754			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151304

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2012 10:14 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000			50.00
51.00	RECOVERY ROOM	0.000000			51.00
53.00	ANESTHESIOLOGY	0.000000			53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	RADIOLOGY-THERAPEUTIC	0.000000			55.00
60.00	LABORATORY	0.000000			60.00
65.00	RESPIRATORY THERAPY	0.000000			65.00
66.00	PHYSICAL THERAPY	0.000000			66.00
67.00	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	SPEECH PATHOLOGY	0.000000			68.00
69.00	ELECTROCARDIOLOGY	0.000000			69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
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					
95.00	AMBULANCE SERVICES	0.000000			95.00
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: 151304

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

Worksheet D
Part II
Date/Time Prepared:
5/24/2012 10:14 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	156,013	1,989,963	0.078400	20,763	1,628	50.00
51.00 RECOVERY ROOM	19,037	394,171	0.048296	0	0	51.00
53.00 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	273,049	13,342,151	0.020465	323,131	6,613	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
60.00 LABORATORY	112,029	8,592,166	0.013039	382,242	4,984	60.00
65.00 RESPIRATORY THERAPY	8,235	523,698	0.015725	135,415	2,129	65.00
66.00 PHYSICAL THERAPY	115,037	1,823,726	0.063078	77,175	4,868	66.00
67.00 OCCUPATIONAL THERAPY	37,585	797,951	0.047102	34,807	1,639	67.00
68.00 SPEECH PATHOLOGY	817	18,880	0.043273	1,715	74	68.00
69.00 ELECTROCARDIOLOGY	16,445	1,821,378	0.009029	90,310	815	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	9,793	1,639,710	0.005972	19,112	114	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	5,642	295,921	0.019066	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	45,472	5,102,844	0.008911	479,505	4,273	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	76,897	0	0.000000	0	0	90.00
91.00 EMERGENCY	172,793	3,818,813	0.045248	3,967	179	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	446,404	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	1,048,844	40,607,776		1,568,142	27,316	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151304

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2012 10:14 am

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	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00 LABORATORY	0	0	0	0	0	60.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
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
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES						95.00
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: 151304

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2012 10:14 am

Cost Center Description	Title XVIII			Hospital	Cost	
	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (From Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	1,989,963	0.000000	0.000000	20,763	50.00
51.00 RECOVERY ROOM	0	394,171	0.000000	0.000000	0	51.00
53.00 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	13,342,151	0.000000	0.000000	323,131	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
60.00 LABORATORY	0	8,592,166	0.000000	0.000000	382,242	60.00
65.00 RESPIRATORY THERAPY	0	523,698	0.000000	0.000000	135,415	65.00
66.00 PHYSICAL THERAPY	0	1,823,726	0.000000	0.000000	77,175	66.00
67.00 OCCUPATIONAL THERAPY	0	797,951	0.000000	0.000000	34,807	67.00
68.00 SPEECH PATHOLOGY	0	18,880	0.000000	0.000000	1,715	68.00
69.00 ELECTROCARDIOLOGY	0	1,821,378	0.000000	0.000000	90,310	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,639,710	0.000000	0.000000	19,112	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	295,921	0.000000	0.000000	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	5,102,844	0.000000	0.000000	479,505	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00 EMERGENCY	0	3,818,813	0.000000	0.000000	3,967	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	446,404	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	40,607,776			1,568,142	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS
 Provider CCN: 151304
 Period: From 01/01/2011 To 12/31/2011
 Worksheet D Part IV
 Date/Time Prepared: 5/24/2012 10:14 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
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00 LABORATORY	0	0	0	0	0	60.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
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
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES						95.00
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: 151304

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2012 10:14 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
53.00 ANESTHESIOLOGY	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0		55.00
60.00 LABORATORY	0	0		60.00
65.00 RESPIRATORY THERAPY	0	0		65.00
66.00 PHYSICAL THERAPY	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0		68.00
69.00 ELECTROCARDIOLOGY	0	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0		73.00
OUTPATIENT SERVICE COST CENTERS				
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
OTHER REIMBURSABLE COST CENTERS				
95.00 AMBULANCE SERVICES				95.00
200.00 Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151304

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

worksheet D
Part V
Date/Time Prepared:
5/24/2012 10:14 am

Cost Center Description		Cost to Charge	PPS Reimbursed	Charges		Cost
		Ratio From	Services (see	Cost	Cost	
		Worksheet C,	instructions)	Reimbursed	Reimbursed	
		Part I, col. 9		Services	Services Not	
				Subject To	Subject To	
				Bed. & Coins.	Bed. & Coins.	
				(see	(see	
				instructions)	instructions)	
		1.00	2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.423415	0	1,076,661	0	50.00
51.00	RECOVERY ROOM	0.231024	0	106,408	0	51.00
53.00	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.171747	0	4,339,742	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	55.00
60.00	LABORATORY	0.215831	0	2,347,655	0	60.00
65.00	RESPIRATORY THERAPY	0.367805	0	68,997	0	65.00
66.00	PHYSICAL THERAPY	0.451004	0	384,793	0	66.00
67.00	OCCUPATIONAL THERAPY	0.489802	0	203,531	0	67.00
68.00	SPEECH PATHOLOGY	0.317320	0	3,704	0	68.00
69.00	ELECTROCARDIOLOGY	0.157233	0	921,395	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.101533	0	111,552	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.302973	0	63,418	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.410227	0	2,346,733	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0.000000	0	0	0	90.00
91.00	EMERGENCY	0.609809	0	700,312	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.983286	0	229,969	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	1.125905	0	0	0	95.00
200.00	Subtotal (see instructions)		0	12,904,870	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	12,904,870	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151304	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/24/2012 10:14 am
	Title XVIII	Hospital	Cost

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	455,874	0		50.00
51.00 RECOVERY ROOM	0	24,583	0		51.00
53.00 ANESTHESIOLOGY	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	745,338	0		54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0		55.00
60.00 LABORATORY	0	506,697	0		60.00
65.00 RESPIRATORY THERAPY	0	25,377	0		65.00
66.00 PHYSICAL THERAPY	0	173,543	0		66.00
67.00 OCCUPATIONAL THERAPY	0	99,690	0		67.00
68.00 SPEECH PATHOLOGY	0	1,175	0		68.00
69.00 ELECTROCARDIOLOGY	0	144,874	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,326	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	19,214	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	962,693	0		73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	0	0	0		90.00
91.00 EMERGENCY	0	427,057	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	226,125	0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES		0			95.00
200.00 Subtotal (see instructions)	0	3,823,566	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	3,823,566	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151304

Period: From 01/01/2011

Worksheet D

Component CCN: 152304

To 12/31/2011

Part V

Date/Time Prepared: 5/24/2012 10:14 am

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	0.423415	0	0	0	50.00
51.00 RECOVERY ROOM	0.231024	0	0	0	51.00
53.00 ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.171747	0	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	55.00
60.00 LABORATORY	0.215831	0	0	0	60.00
65.00 RESPIRATORY THERAPY	0.367805	0	0	0	65.00
66.00 PHYSICAL THERAPY	0.451004	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0.489802	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0.317320	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0.157233	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.101533	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.302973	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.410227	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	0.000000	0	0	0	90.00
91.00 EMERGENCY	0.609809	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.983286	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES	1.125905		0	0	95.00
200.00 Subtotal (see instructions)		0	0	0	200.00
201.00 Less PBP Clinic Lab. services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151304	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/time Prepared: 5/24/2012 10:14 am
	Component CCN: 152304		

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
53.00 ANESTHESIOLOGY	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0		55.00
60.00 LABORATORY	0	0	0		60.00
65.00 RESPIRATORY THERAPY	0	0	0		65.00
66.00 PHYSICAL THERAPY	0	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	0	0	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS					
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
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES		0			95.00
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: 151304	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/24/2012 10:14 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)		2,481	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,940	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)		1,940	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		417	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		132	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)		973	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)		409	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		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)		2,451,636	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)		433,743	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,017,893	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,198,871	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,198,871	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.917695	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,133.44	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)		2,017,893	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,040.15	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,012,066	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)		1,012,066	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151304	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1		
		Title XVIII		Hospital	Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
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)				464,258	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				1,476,324	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)				425,421	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)				425,421	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)				422	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 + line 2)				1,040.15	88.00
89.00	observation bed cost (line 87 x line 88) (see instructions)				438,943	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151304

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

Worksheet D-1

Date/Time Prepared:
5/24/2012 10:14 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: 151304

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

Worksheet D-1

Date/Time Prepared:
5/24/2012 10:14 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)			2,481 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,940 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)			1,940 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			417 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			124 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)			92 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			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)			2,451,636 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)			433,743 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,017,893 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			2,198,871 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			2,198,871 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.917695 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			1,133.44 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)			2,017,893 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,040.15 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			95,694 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)			95,694 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151304

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

Worksheet D-1

Date/Time Prepared:
5/24/2012 10:14 am

Cost Center Description	Title XIX			Hospital Program Days	Program Cost (col. 3 x col. 4)	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)			
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT						43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					66,632	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					162,326	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 XVII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					422	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,040.15	88.00
89.00 observation bed cost (line 87 x line 88) (see instructions)					438,943	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151304

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

Worksheet D-1

Date/Time Prepared:
5/24/2012 10:14 am

Cost Center Description	Title XIX		Hospital		Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)		
	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: 151304

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

Worksheet D-3

Date/Time Prepared:
5/24/2012 10:14 am

Cost Center Description		Title XVIII	Hospital	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		974,290		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.423415	20,763	8,791	50.00
51.00	RECOVERY ROOM	0.231024	0	0	51.00
53.00	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.171747	323,131	55,497	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	LABORATORY	0.215831	382,242	82,500	60.00
65.00	RESPIRATORY THERAPY	0.367805	135,415	49,806	65.00
66.00	PHYSICAL THERAPY	0.451004	77,175	34,806	66.00
67.00	OCCUPATIONAL THERAPY	0.489802	34,807	17,049	67.00
68.00	SPEECH PATHOLOGY	0.317320	1,715	544	68.00
69.00	ELECTROCARDIOLOGY	0.157233	90,310	14,200	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.101533	19,112	1,940	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.302973	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.410227	479,505	196,706	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0.000000	0	0	90.00
91.00	EMERGENCY	0.609809	3,967	2,419	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.983286	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		1,568,142	464,258	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		1,568,142		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151304 Period: From 01/01/2011 To 12/31/2011 Worksheet D-3
 Component CCN: 152304 Date/Time Prepared: 5/24/2012 10:14 am

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.423415	4,406	1,866	50.00
51.00	RECOVERY ROOM	0.231024	0	0	51.00
53.00	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.171747	31,946	5,487	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	LABORATORY	0.215831	25,870	5,584	60.00
65.00	RESPIRATORY THERAPY	0.367805	19,764	7,269	65.00
66.00	PHYSICAL THERAPY	0.451004	104,881	47,302	66.00
67.00	OCCUPATIONAL THERAPY	0.489802	51,464	25,207	67.00
68.00	SPEECH PATHOLOGY	0.317320	2,692	854	68.00
69.00	ELECTROCARDIOLOGY	0.157233	12,030	1,892	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.101533	4,763	484	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.302973	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.410227	69,414	28,475	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0.000000	0	0	90.00
91.00	EMERGENCY	0.609809	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.983286	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		327,230	124,420	200.00
201.00	Less P&P Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		327,230		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151304

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

Worksheet D-3

Date/Time Prepared:
5/24/2012 10:14 am

Cost Center Description	Title XIX		Hospital		Cost
	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)		
			1.00	2.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		124,897		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.423415	7,702	3,261	50.00
51.00	RECOVERY ROOM	0.231024	441	102	51.00
53.00	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.171747	47,725	8,197	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
60.00	LABORATORY	0.215831	55,509	11,981	60.00
65.00	RESPIRATORY THERAPY	0.367805	18,604	6,843	65.00
66.00	PHYSICAL THERAPY	0.451004	1,805	814	66.00
67.00	OCCUPATIONAL THERAPY	0.489802	1,128	552	67.00
68.00	SPEECH PATHOLOGY	0.317320	213	68	68.00
69.00	ELECTROCARDIOLOGY	0.157233	1,930	303	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.101533	3,424	348	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.302973	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.410227	67,436	27,664	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0.000000	0	0	90.00
91.00	EMERGENCY	0.609809	10,657	6,499	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.983286	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		216,574	66,632	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)		216,574		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 151304

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

Worksheet E
Part B
Date/Time Prepared:
5/24/2012 10:14 am

		Title XVIII	Hospital	Cost	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			3,823,566	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)			3,823,566	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)			3,861,802	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)			22,082	25.00
26.00	Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)			2,088,607	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			1,751,113	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0	29.00
30.00	Subtotal (sum of lines 27 through 29)			1,751,113	30.00
31.00	Primary payer payments			1,393	31.00
32.00	Subtotal (line 30 minus line 31)			1,749,720	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)			492,785	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			492,785	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			399,845	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			2,242,505	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)			2,242,505	40.00
41.00	Interim payments			2,235,607	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)			6,898	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

Health Financial Systems

RUSH MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 151304

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

Worksheet E
Part 8
Date/Time Prepared:
5/24/2012 10:14 am

Title XVIII

Hospital

Cost

Overrides
1.00

WORKSHEET OVERRIDE VALUES

112.00 override of Ancillary service charges (line 12)

0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151304

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

Worksheet E-1
Part 1
Date/Time Prepared:
5/24/2012 10:14 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		1,262,744		2,209,470	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	09/30/2011	21,158	09/30/2011	214,305	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	09/20/2011	126,617	09/20/2011	162,075	3.50
3.51		12/08/2011	16,936	12/08/2011	26,093	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)		-122,395		26,137	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)		1,140,349		2,235,607	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		167,964		6,898	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,308,313		2,242,505	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: 151304	Period: From 01/01/2011 To 12/31/2011	Worksheet E-1 Part I Date/Time Prepared: 5/24/2012 10:14 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		562,150		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)				
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		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	09/20/2011	34,811		0
3.51		12/08/2011	7,967		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)		-42,778		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)		519,372		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)				
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)				
6.01	SETTLEMENT TO PROVIDER		35,401		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		554,773		0
				Contractor Number	Date (Mo/Day/Yr)
			0	1.00	2.00
8.00	Name of Contractor				

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 151304	Period: From 01/01/2011 To 12/31/2011	Worksheet E-2
		Component CCN: 152304		Date/Time Prepared: 5/24/2012 10:14 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)		429,675	0
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)		125,664	0
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00
5.00	Program days		409	0
6.00	Interns and residents not in approved teaching program (see instructions)			0
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)		555,339	0
9.00	Primary payer payments (see instructions)		0	0
10.00	Subtotal (line 8 minus line 9)		555,339	0
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0
12.00	Subtotal (line 10 minus line 11)		555,339	0
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		566	0
14.00	80% of Part B costs (line 12 x 80%)			0
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		554,773	0
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
17.00	Reimbursable bad debts (see instructions)		0	0
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
19.00	Total (sum of lines 15 and 17, plus/minus line 16)		554,773	0
20.00	Interim payments		519,372	0
21.00	Tentative settlement (for contractor use only)		0	0
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)		35,401	0
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	0

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151304	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part V Date/Time Prepared: 5/24/2012 10:14 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		1,476,324	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)		1,476,324	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5) . For CAH (see instructions)		1,491,087	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)		1,491,087	19.00
20.00	Deductibles (exclude professional component)		235,515	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		1,255,572	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,255,572	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		52,741	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		52,741	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		37,952	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26)		1,308,313	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)		1,308,313	30.00
31.00	Interim payments		1,140,349	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)		167,964	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: 151304	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part VII Date/Time Prepared: 5/24/2012 10:14 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		162,326	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)		162,326	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)		162,326	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		124,897	8.00
9.00	Ancillary service charges		216,574	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)		341,471	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)		341,471	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		179,145	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)		162,326	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.		162,326	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)		162,326	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)		162,326	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		162,326	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)		162,326	40.00
41.00	Interim payments		97,646	41.00
42.00	Balance due provider/program (line 40 minus 41)		64,680	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	43.00

Health Financial Systems

RUSH MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

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

Provider CCN: 151304

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

Worksheet G

Date/Time Prepared:
5/24/2012 10:14 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	1,609,177	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	4,099,562	0	0	0	4.00
5.00 Other receivable	0	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	1,118,429	0	0	0	7.00
8.00 Prepaid expenses	0	0	0	0	8.00
9.00 Other current assets	0	0	0	0	9.00
10.00 Due from other funds	0	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	6,827,168	0	0	0	11.00
FIXED ASSETS					
12.00 Land	164,978	0	0	0	12.00
13.00 Land improvements	235,799	0	0	0	13.00
14.00 Accumulated depreciation	0	0	0	0	14.00
15.00 Buildings	12,665,051	0	0	0	15.00
16.00 Accumulated depreciation	-31,952	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	745,933	0	0	0	19.00
20.00 Accumulated depreciation	-56,706	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	10,812,544	0	0	0	23.00
24.00 Accumulated depreciation	-15,172,407	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)	9,363,240	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	1,683,048	0	0	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	0	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	1,683,048	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	17,873,456	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	2,754,335	0	0	0	37.00
38.00 Salaries, wages, and fees payable	0	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	1,125,411	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	200,000	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	4,079,746	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	2,974,524	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	0	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	2,974,524	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	7,054,270	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	10,819,186	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)	10,819,186	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	17,873,456	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151304

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

Worksheet G-1

Date/Time Prepared:
5/24/2012 10:14 am

	General Fund		Special Purpose Fund			
	1.00	2.00	3.00	4.00		
1.00 Fund balances at beginning of period		11,059,531			0	1.00
2.00 Net income (loss) (from wkst. G-3, line 29)		-240,345				2.00
3.00 Total (sum of line 1 and line 2)		10,819,186			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)		10,819,186			0	11.00
12.00 Deductions (debit adjustments) (specify)	0		0			12.00
13.00	0		0			13.00
14.00	0		0			14.00
15.00	0		0			15.00
16.00	0		0			16.00
17.00	0		0			17.00
18.00 Total deductions (sum of lines 12-17)		0			0	18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		10,819,186			0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151304

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

Worksheet G-1

Date/Time Prepared:
5/24/2012 10:14 am

	Endowment Fund		Plant Fund		
	5.00	6.00	7.00	8.00	
1.00 Fund balances at beginning of period		0		0	1.00
2.00 Net income (loss) (from wkst. G-3, line 29)					2.00
3.00 Total (sum of line 1 and line 2)		0		0	3.00
4.00 Additions (credit adjustments) (specify)	0		0		4.00
5.00	0		0		5.00
6.00	0		0		6.00
7.00	0		0		7.00
8.00	0		0		8.00
9.00	0		0		9.00
10.00 Total additions (sum of line 4-9)		0		0	10.00
11.00 Subtotal (line 3 plus line 10)		0		0	11.00
12.00 Deductions (debit adjustments) (specify)	0		0		12.00
13.00	0		0		13.00
14.00	0		0		14.00
15.00	0		0		15.00
16.00	0		0		16.00
17.00	0		0		17.00
18.00 Total deductions (sum of lines 12-17)		0		0	18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151304

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

Worksheet G-2 Parts

Date/Time Prepared:
5/24/2012 10:14 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,645,275		2,645,275	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,645,275		2,645,275	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,645,275		2,645,275	17.00
18.00	Ancillary services	3,396,601	35,397,756	38,794,357	18.00
19.00	Outpatient services	59,583	3,759,112	3,818,695	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	0	929,107	929,107	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	4,458,882	4,458,882	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line I)	6,101,459	44,544,857	50,646,316	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		21,328,261		29.00
30.00	BAD DEBT EXPENSE	3,271,400			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)		3,271,400		36.00
37.00	MISC. ADJUSTMENT	576			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)		576		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		24,599,085		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151304

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

Worksheet G-3

Date/Time Prepared:

5/24/2012 10:14 am

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	50,646,316	1.00
2.00	Less contractual allowances and discounts on patients' accounts	27,624,273	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,022,043	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	24,599,085	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,577,042	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	1,173,121	24.00
24.01	NON-OPERATING REVENUE	163,576	24.01
25.00	Total other income (sum of lines 6-24)	1,336,697	25.00
26.00	Total (line 5 plus line 25)	-240,345	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)	-240,345	29.00