

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: 153039	Period: From 01/01/2011 To 12/31/2011	Worksheet S Parts I-III Date/Time Prepared: 5/23/2012 4:21 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/23/2012 Time: 4:21 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 04 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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

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

Title

Date

Cost Center Description	Title XVIII		HIT	Title XIX	
	Title V	Part A			
	1.00	2.00	3.00	4.00	5.00
PART III - SETTLEMENT SUMMARY					
1.00 Hospital	0	50,917	31,105	0	0
2.00 Subprovider - IPF	0	0	0	0	0
3.00 Subprovider - IRF	0	0	0	0	0
4.00 SUBPROVIDER I	0	0	0	0	0
5.00 Swing bed - SNF	0	0	0	0	0
6.00 Swing bed - NF	0	0	0	0	0
7.00 SKILLED NURSING FACILITY	0	0	0	0	0
8.00 NURSING FACILITY	0	0	0	0	0
9.00 HOME HEALTH AGENCY I	0	0	0	0	0
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0
12.00 CMHC I	0	0	0	0	0
200.00 Total	0	50,917	31,105	0	0

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: 153039		Period: From 01/01/2011 To 12/31/2011		Worksheet S-2 Part I Date/Time Prepared: 5/23/2012 3:47 pm				
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IN		4.00 Zip Code: 46901- County: HOWARD				
1.00 Street: 829 N. DIXON ROAD		2.00 City: KOKOMO								
Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
3.00 Hospital and Hospital-Based Component Identification:										
3.00	Hospital	HRHS SPECIALTY HOSPITAL	153039	99915	5	04/01/2004	N	P	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						N	N	N	7.00
8.00	Swing Beds - NF						N	N	N	8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC						N	N	N	15.00
16.00	Hospital-Based Health Clinic - FQHC						N	N	N	16.00
17.00	Hospital-Based (CMHC) 1									17.00
17.10	Hospital-Based (CORF) 1						N	N	N	17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00
					From:		To:			
					1.00		2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)				01/01/2011		12/31/2011		20.00	
21.00	Type of Control (see instructions)						6		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		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.				3		N		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.	154	54	0	0	0	0		25.00	
					Urban/Rural	S	Date of Geogr			
					1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.				1			26.00		
27.00	For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification (in column 2).				1			27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.				0			35.00		
					Beginning:	Ending:				
					1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscriber line 36 for number of periods in excess of one and enter subsequent dates.								36.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 153039	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/23/2012 3:47 pm		
		Beginning:	Ending:			
		1.00	2.00			
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00		
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	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	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		
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 153039

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

Worksheet S-2
Part I
Date/Time Prepared:
5/23/2012 3:47 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 153039	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/23/2012 3:47 pm	
			1.00	2.00	3.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.		Y		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)		N	N 0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.			N	80.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(i)? Enter "Y" for yes and "N" for no.			N	86.00
			V	XIX	
			1.00	2.00	
Title V or XIX Inpatient Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
			Physical	Occupational	Speech
			1.00	2.00	3.00
			Respiratory		4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		Y	Y	109.00
			1.00		2.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.		N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1	118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.		250,000	5,000,000	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00

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			1.00	2.00					
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.								126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.								127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.								128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.								129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.								130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.								131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.								132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.								133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.								134.00
All Providers									
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)						Y		140.00
	1.00	2.00	3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: HOWARD REGIONAL HEALTH SYSTEM		Contractor's Name: NGS		Contractor's Number: 00130			141.00	
142.00	Street: 3500 S. LAFOUNTAIN		PO Box:					142.00	
143.00	City: KOKOMO		State:		Zip Code: 46902			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
161.10	CORF							N	161.10
							1.00		
Multi campus									
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N		165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5							0.00	166.00
							1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N		167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								0168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 153039	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part II Date/Time Prepared: 5/23/2012 3:47 pm
		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	Y	07/01/2011	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.			14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		
		Description	Y/N	Date
		0	1.00	2.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/14/2012	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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 153039

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

Worksheet S-2
Part II
Date/Time Prepared:
5/23/2012 3:47 pm

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/14/2012	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: 153039

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

Worksheet S-3
Part I
Date/Time Prepared:
5/23/2012 3:47 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours		
	Line Number					
	1.00	2.00	3.00	4.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	30	10,950	0.00		1.00
2.00 HMO						2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		30	10,950	0.00		7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		30	10,950	0.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10					25.10
26.00 RURAL HEALTH CLINIC	88.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00					26.25
27.00 Total (sum of lines 14-26)		30				27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 153039

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

Worksheet S-3
Part I
Date/Time Prepared:
5/23/2012 3:47 pm

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	5,684	154	6,638		1.00
2.00 HMO		134	54			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	5,684	154	6,638		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	5,684	154	6,638		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0		25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0		26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	0		28.00
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				0		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			0	0		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 153039

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

Worksheet S-3
Part I
Date/Time Prepared:
5/23/2012 3:47 pm

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	562	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	151.73	0.00	0	562	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00	0.00	0.00			25.10
26.00 RURAL HEALTH CLINIC	0.00	0.00	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00 Total (sum of lines 14-26)	0.00	151.73	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 153039

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

Worksheet S-3
Part I
Date/Time Prepared:
5/23/2012 3:47 pm

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	11	625		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)	11	625		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
25.10 CMHC - CORF				25.10
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 153039		Period: From 01/01/2011 To 12/31/2011		Worksheet A	
Date/Time Prepared: 5/23/2012 3:47 pm							
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)		
	1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS							
1.00 CAP REL COSTS-BLDG & FIXT		219,190	219,190	13,619	232,809	1.00	
1.01 CAP REL COSTS-BLDG & FIXT		33,338	33,338	0	33,338	1.01	
4.00 EMPLOYEE BENEFITS	-114,145	1,041,438	927,293	-1,620	925,673	4.00	
5.00 ADMINISTRATIVE & GENERAL	1,117,735	1,082,435	2,200,170	-14,310	2,185,860	5.00	
7.00 OPERATION OF PLANT	358,655	1,342,351	1,701,006	-65	1,700,941	7.00	
8.00 LAUNDRY & LINEN SERVICE	0	41,836	41,836	-15	41,821	8.00	
9.00 HOUSEKEEPING	77,172	39,349	116,521	-450	116,071	9.00	
10.00 DIETARY	187,365	136,646	324,011	-1,470	322,541	10.00	
11.00 CAFETERIA	0	0	0	1,468	1,468	11.00	
13.00 NURSING ADMINISTRATION	0	0	0	69,741	69,741	13.00	
16.00 MEDICAL RECORDS & LIBRARY	222,616	29,639	252,255	-4	252,251	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	1,165,527	606,369	1,771,896	-406,844	1,365,052	30.00	
ANCILLARY SERVICE COST CENTERS							
54.00 RADIOLOGY-DIAGNOSTIC	4,568	1,220	5,788	12,397	18,185	54.00	
54.02 IMAGING CENTER	0	0	0	0	0	54.02	
57.00 CT SCAN	0	0	0	5,742	5,742	57.00	
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	1,720	1,720	58.00	
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00 LABORATORY	0	1,918	1,918	201,889	203,807	60.00	
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01	
65.00 RESPIRATORY THERAPY	245,054	80,406	325,460	-41,054	284,406	65.00	
66.00 PHYSICAL THERAPY	3,046,571	818,909	3,865,480	-20,009	3,845,471	66.00	
69.00 ELECTROCARDIOLOGY	0	0	0	963	963	69.00	
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	39,712	7,806	47,518	207,896	255,414	71.00	
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00	
73.00 DRUGS CHARGED TO PATIENTS	296,487	424,742	721,229	26	721,255	73.00	
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00	
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00	
91.00 EMERGENCY	0	0	0	0	0	91.00	
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00	
93.02 NEUROPSYCH OFFICE	76,515	7,800	84,315	0	84,315	93.02	
93.03 SLEEP LAB	370,705	135,701	506,406	-29,568	476,838	93.03	
93.04 PHYSICIANS OFFICE	23,259	4,325	27,584	-52	27,532	93.04	
OTHER REIMBURSABLE COST CENTERS							
99.10 CORF	0	0	0	0	0	99.10	
SPECIAL PURPOSE COST CENTERS							
118.00 SUBTOTALS (SUM OF LINES 1-117)	7,117,796	6,055,418	13,173,214	0	13,173,214	118.00	
NONREIMBURSABLE COST CENTERS							
200.00 TOTAL (SUM OF LINES 118-199)	7,117,796	6,055,418	13,173,214	0	13,173,214	200.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 153039

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

Worksheet A
Date/Time Prepared:
5/23/2012 3:47 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	232,809	1.00
1.01	CAP REL COSTS-BLDG & FIXT	0	33,338	1.01
4.00	EMPLOYEE BENEFITS	0	925,673	4.00
5.00	ADMINISTRATIVE & GENERAL	331,228	2,517,088	5.00
7.00	OPERATION OF PLANT	0	1,700,941	7.00
8.00	LAUNDRY & LINEN SERVICE	0	41,821	8.00
9.00	HOUSEKEEPING	0	116,071	9.00
10.00	DIETARY	-272	322,269	10.00
11.00	CAFETERIA	0	1,468	11.00
13.00	NURSING ADMINISTRATION	0	69,741	13.00
16.00	MEDICAL RECORDS & LIBRARY	-1,304	250,947	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-2,052	1,363,000	30.00
ANCILLARY SERVICE COST CENTERS				
54.00	RADIOLOGY-DIAGNOSTIC	-10,101	8,084	54.00
54.02	IMAGING CENTER	0	0	54.02
57.00	CT SCAN	-4,871	871	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	-1,639	81	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	-190,326	13,481	60.00
60.01	BLOOD LABORATORY	0	0	60.01
65.00	RESPIRATORY THERAPY	-6,806	277,600	65.00
66.00	PHYSICAL THERAPY	-21,006	3,824,465	66.00
69.00	ELECTROCARDIOLOGY	-662	301	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	-5,370	250,044	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	-469	720,786	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	EMERGENCY	0	0	91.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
93.02	NEUROPSYCH OFFICE	0	84,315	93.02
93.03	SLEEP LAB	-28,682	448,156	93.03
93.04	PHYSICIANS OFFICE	-2,424	25,108	93.04
OTHER REIMBURSABLE COST CENTERS				
99.10	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	55,244	13,228,458	118.00
NONREIMBURSABLE COST CENTERS				
200.00	TOTAL (SUM OF LINES 118-199)	55,244	13,228,458	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - SUPPLY RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	170,195	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
	TOTALS		0	170,195	
B - PHARMACY RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00		1,278	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	TOTALS		0	1,278	
C - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	849	619	1.00
	TOTALS		849	619	
D - NURSING ADMIN RECLASS					
1.00	NURSING ADMINISTRATION	13.00	69,741		1.00
	TOTALS		69,741	0	
E - INSURANCE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	13,619	1.00
	TOTALS		0	13,619	
F - PURCHASED SERVICES RECLASS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	12,397	1.00
2.00	CT SCAN	57.00	0	5,742	2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,720	3.00
4.00	LABORATORY	60.00	0	201,889	4.00
5.00	RESPIRATORY THERAPY	65.00	0	8,005	5.00
6.00	PHYSICAL THERAPY	66.00	0	5,950	6.00
7.00	ELECTROCARDIOLOGY	69.00	0	963	7.00
8.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	37,701	8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,001	9.00
	TOTALS		0	275,368	
500.00	Grand Total: Increases		70,590	461,079	500.00

RECLASSIFICATIONS

Provider CCN: 153039

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

Worksheet A-6

Date/Time Prepared:
5/23/2012 3:47 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - SUPPLY RECLASS							
1.00	EMPLOYEE BENEFITS	4.00	0	1,022	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	691	0		2.00
3.00	OPERATION OF PLANT	7.00	0	65	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	15	0		4.00
5.00	HOUSEKEEPING	9.00	0	450	0		5.00
6.00	DIETARY	10.00	0	2	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	4	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	61,593	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	49,059	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	25,439	0		10.00
11.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,253	0		11.00
12.00	SLEEP LAB	93.03	0	29,568	0		12.00
13.00	PHYSICIANS OFFICE	93.04	0	34	0		13.00
	TOTALS		0	170,195			
B - PHARMACY RECLASS							
1.00	EMPLOYEE BENEFITS	4.00		598	0		1.00
2.00		30.00		142	0		2.00
3.00		66.00		520	0		3.00
4.00		71.00		0	0		4.00
5.00		93.04		18	0		5.00
	TOTALS		0	1,278			
C - CAFETERIA RECLASS							
1.00		10.00	849	619	0		1.00
	TOTALS		849	619			
D - NURSING ADMIN RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	69,741	0	0		1.00
	TOTALS		69,741	0			
E - INSURANCE RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	13,619	12		1.00
	TOTALS		0	13,619			
F - PURCHASED SERVICES RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	0	275,368	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
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
	TOTALS		0	275,368			
500.00	Grand Total: Decreases		70,590	461,079			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 153039

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/23/2012 3:47 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	16,570	38,463	0	38,463	16,571	2.00
3.00	Buildings and Fixtures	211,020	73,567	0	73,567	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	119,112	58,483	0	58,483	0	5.00
6.00	Movable Equipment	1,229,578	55,899	0	55,899	1,245	6.00
7.00	HIT designated Assets	69,041	534,680	0	534,680	0	7.00
8.00	Subtotal (sum of lines 1-7)	1,645,321	761,092	0	761,092	17,816	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	1,645,321	761,092	0	761,092	17,816	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	CAP REL COSTS-BLDG & FIXT	219,190	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT	33,338	0	0	0	0	1.01
3.00	Total (sum of lines 1-2)	252,528	0	0	0	0	3.00
COMPUTATION OF RATIOS							
Cost Center Description		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
		PART III - RECONCILIATION OF CAPITAL COSTS CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.01
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 153039

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/23/2012 3:47 pm

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0		1.00	
2.00	Land Improvements	38,462	0		2.00	
3.00	Buildings and Fixtures	284,587	0		3.00	
4.00	Building Improvements	0	0		4.00	
5.00	Fixed Equipment	177,595	0		5.00	
6.00	Movable Equipment	1,284,232	0		6.00	
7.00	HIT designated Assets	603,721	0		7.00	
8.00	Subtotal (sum of lines 1-7)	2,388,597	0		8.00	
9.00	Reconciling Items	0	0		9.00	
10.00	Total (line 8 minus line 9)	2,388,597	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	CAP REL COSTS-BLDG & FIXT	0	219,190		1.00	
1.01	CAP REL COSTS-BLDG & FIXT	0	33,338		1.01	
3.00	Total (sum of lines 1-2)	0	252,528		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	CAP REL COSTS-BLDG & FIXT	0	0	0	219,190	0
1.01	CAP REL COSTS-BLDG & FIXT	0	0	0	33,338	0
3.00	Total (sum of lines 1-2)	0	0	0	252,528	0

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 153039

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/23/2012 3:47 pm

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	13,619	0	0	232,809	1.00
1.01	CAP REL COSTS-BLDG & FIXT	0	0	0	0	33,338	1.01
3.00	Total (sum of lines 1-2)	0	13,619	0	0	266,147	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 153039

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

Worksheet A-8

Date/Time Prepared:
5/23/2012 3:47 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center		Line #	
			1.00	2.00	3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	1.00
1.01 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.01	1.01
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	-27,882				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	225,192				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	B		-93	ADMINISTRATIVE & GENERAL	5.00	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 - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	26.00
26.01 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.01	26.01
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	*** Cost Center Deleted ***	67.00	30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A		0		0.00	32.00
33.00 HRSC GENERAL ACCT MISCELLANEOUS REVE	B	-55		ADMINISTRATIVE & GENERAL	5.00	33.00
34.00 HRSC REPLAY OTHER RE REPLAY AFTER CA	B	-12,810		ADMINISTRATIVE & GENERAL	5.00	34.00
35.00 HRSC REPLAY OTHER RE OTHER OPERATING	B	-63,087		ADMINISTRATIVE & GENERAL	5.00	35.00
36.00 HRSC OTHER OPER. REV MISC REVENUE	B	-8,504		ADMINISTRATIVE & GENERAL	5.00	36.00
37.00 HRSC OTHER OPER. REV OTHER OPERATING	B	-14,614		ADMINISTRATIVE & GENERAL	5.00	37.00
38.00 HRSC DIETARY NON-FOO SALES	B	-272		DIETARY	10.00	38.00
39.00 HRSC MEDREC SALES MISC REVENUE	B	-1,304		MEDICAL RECORDS & LIBRARY	16.00	39.00
40.00 HRSC OCCUPATIONAL TH MISCELLANEOUS R	B	-3,084		PHYSICAL THERAPY	66.00	40.00
41.00 HRSC REPLAY OTHER RE REPLAY DME REVE	B	-12,408		PHYSICAL THERAPY	66.00	41.00
42.00 HRSC REPLAY OTHER RE PHYS OFF & OTH	B	-2,424		PHYSICIANS OFFICE	93.04	42.00
43.00 CHARITABLE DONATIONS	A	-725		ADMINISTRATIVE & GENERAL	5.00	43.00
44.00 ADVERTISING & PROMOTION	A	-19,303		ADMINISTRATIVE & GENERAL	5.00	44.00
45.00 ADVERTISING & PROMOTION	A	-2,583		PHYSICAL THERAPY	66.00	45.00
45.01 ADVERTISING & PROMOTION	A	-800		SLEEP LAB	93.03	45.01
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		55,244				50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 153039

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

Worksheet A-8

Date/Time Prepared:
5/23/2012 3:47 pm

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.01
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 - CAP REL COSTS-BLDG & FIXT	0	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT	0	26.01
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	HRSC GENERAL ACCT MISCELLANEOUS REVE	0	33.00
34.00	HRSC REPLAY OTHER RE REPLAY AFTER CA	0	34.00
35.00	HRSC REPLAY OTHER RE OTHER OPERATING	0	35.00
36.00	HRSC OTHER OPER. REV MISC REVENUE	0	36.00
37.00	HRSC OTHER OPER. REV OTHER OPERATING	0	37.00
38.00	HRSC DIETARY NON-FOO SALES	0	38.00
39.00	HRSC MEDREC SALES MISC REVENUE	0	39.00
40.00	HRSC OCCUPATIONAL TH MISCELLANEOUS R	0	40.00
41.00	HRSC REPLAY OTHER RE REPLAY DME REVE	0	41.00
42.00	HRSC REPLAY OTHER RE PHYS OFF & OTH	0	42.00
43.00	CHARITABLE DONATIONS	0	43.00
44.00	ADVERTISING & PROMOTION	0	44.00
45.00	ADVERTISING & PROMOTION	0	45.00
45.01	ADVERTISING & PROMOTION	0	45.01
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

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

Provider CCN: 153039

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

Worksheet A-8-1

Date/Time Prepared:
5/23/2012 3:47 pm

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE & GENERAL	1.00
2.00	30.00	ADULTS & PEDIATRICS	A&P	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	RADIOLOGY	3.00
4.00	57.00	CT SCAN	CT SCAN	4.00
4.01	58.00	MAGNETIC RESONANCE IMAGING (MRI)	MRI	4.01
4.02	60.00	LABORATORY	LAB	4.02
4.03	65.00	RESPIRATORY THERAPY	RT	4.03
4.04	66.00	PHYSICAL THERAPY	PT	4.04
4.05	69.00	ELECTROCARDIOLOGY	EKG	4.05
4.06	71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	MED SUPPLIES	4.06
4.07	73.00	DRUGS CHARGED TO PATIENTS	DRUGS	4.07
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5.00

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

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

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

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

6.00	G	HOWARD REGIONAL	60.00	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:	MISC SERVICES		100.00

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

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

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

Provider CCN: 153039

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

Worksheet A-8-1

Date/Time Prepared: 5/23/2012 3:47 pm

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	4.00	5.00	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	641,915	191,496	450,419	0	1.00
2.00	759	2,811	-2,052	0	2.00
3.00	1,245	11,346	-10,101	0	3.00
4.00	547	5,418	-4,871	0	4.00
4.01	81	1,720	-1,639	0	4.01
4.02	11,419	201,745	-190,326	0	4.02
4.03	1,199	8,005	-6,806	0	4.03
4.04	3,019	5,950	-2,931	0	4.04
4.05	76	738	-662	0	4.05
4.06	5,220	10,590	-5,370	0	4.06
4.07	532	1,001	-469	0	4.07
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	666,012	440,820	225,192	5.00

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

Related Organization(s) and/or Home Office			
Name	Percentage of Ownership	Type of Business	
4.00	5.00	6.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:			

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 153039

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

Worksheet A-8-2

Date/Time Prepared:
5/23/2012 3:47 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	93.03	SLEEP LAB	47,000	0	1.00
2.00	0.00		0	0	2.00
3.00	0.00		0	0	3.00
4.00	0.00		0	0	4.00
5.00	0.00		0	0	5.00
6.00	0.00		0	0	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00			47,000	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 153039

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

Worksheet A-8-2

Date/Time Prepared:
5/23/2012 3:47 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	47,000	171,400	232	19,118	956	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	47,000		232	19,118	956	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 153039

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

Worksheet A-8-2

Date/Time Prepared:
5/23/2012 3:47 pm

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 16.00	
1.00	0	0	0	0	19,118	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	19,118	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 153039

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

Worksheet A-8-2

Date/Time Prepared:
5/23/2012 3:47 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	27,882	27,882	1.00
2.00	0	0	2.00
3.00	0	0	3.00
4.00	0	0	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	27,882	27,882	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153039

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

Worksheet B
Part I
Date/Time Prepared:
5/23/2012 3:47 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	BLDG & FIXT			
	0	1.00	1.01	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	232,809	232,809			1.00
1.01	CAP REL COSTS-BLDG & FIXT	33,338	0	33,338		1.01
4.00	EMPLOYEE BENEFITS	925,673	803	0	926,476	4.00
5.00	ADMINISTRATIVE & GENERAL	2,517,088	19,222	0	143,192	5.00
7.00	OPERATION OF PLANT	1,700,941	89,908	0	45,947	7.00
8.00	LAUNDRY & LINEN SERVICE	41,821	2,932	0	0	8.00
9.00	HOUSEKEEPING	116,071	1,848	0	9,886	9.00
10.00	DIETARY	322,269	23,774	0	23,894	10.00
11.00	CAFETERIA	1,468	0	0	109	11.00
13.00	NURSING ADMINISTRATION	69,741	1,342	0	8,934	13.00
16.00	MEDICAL RECORDS & LIBRARY	250,947	1,427	0	28,519	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,363,000	43,126	0	140,380	30.00
ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	8,084	277	0	585	54.00
54.02	IMAGING CENTER	0	0	0	0	54.02
57.00	CT SCAN	871	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	81	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	LABORATORY	13,481	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	277,600	392	0	31,394	65.00
66.00	PHYSICAL THERAPY	3,824,465	30,968	33,338	390,293	66.00
69.00	ELECTROCARDIOLOGY	301	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	250,044	4,437	0	5,087	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	720,786	2,855	0	37,983	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00	EMERGENCY	0	0	0	0	91.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
93.02	NEUROPSYCH OFFICE	84,315	1,888	0	9,802	93.02
93.03	SLEEP LAB	448,156	2,259	0	47,491	93.03
93.04	PHYSICIANS OFFICE	25,108	5,351	0	2,980	93.04
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	13,228,458	232,809	33,338	926,476	118.00
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	13,228,458	232,809	33,338	926,476	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153039

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

Worksheet B
Part I
Date/Time Prepared:
5/23/2012 3:47 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BLDG & FIXT						1.01
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	2,679,502					5.00
7.00	OPERATION OF PLANT	466,557	2,303,353				7.00
8.00	LAUNDRY & LINEN SERVICE	11,368	54,969	111,090			8.00
9.00	HOUSEKEEPING	32,463	34,633	0	194,901		9.00
10.00	DIETARY	93,966	445,640	0	39,235	948,778	10.00
11.00	CAFETERIA	401	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	20,325	25,153	0	2,214	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	71,349	26,758	0	2,356	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	392,822	808,406	111,090	71,173	948,778	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	RADIOLOGY-DIAGNOSTIC	2,272	5,199	0	458	0	54.00
54.02	IMAGING CENTER	0	0	0	0	0	54.02
57.00	CT SCAN	221	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	21	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	3,424	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	78,586	7,339	0	646	0	65.00
66.00	PHYSICAL THERAPY	1,086,911	580,502	0	51,108	0	66.00
69.00	ELECTROCARDIOLOGY	76	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	65,932	83,180	0	7,323	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	193,457	53,517	0	4,712	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	0	0	0	0	0	91.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.02	NEUROPSYCH OFFICE	24,386	35,397	0	3,116	0	93.02
93.03	SLEEP LAB	126,471	42,355	0	3,729	0	93.03
93.04	PHYSICIANS OFFICE	8,494	100,305	0	8,831	0	93.04
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,679,502	2,303,353	111,090	194,901	948,778	118.00
NONREIMBURSABLE COST CENTERS							
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	2,679,502	2,303,353	111,090	194,901	948,778	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153039

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

Worksheet B
Part I
Date/Time Prepared:
5/23/2012 3:47 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		11.00	13.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BLDG & FIXT						1.01
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	1,978					11.00
13.00	NURSING ADMINISTRATION	32	127,741				13.00
16.00	MEDICAL RECORDS & LIBRARY	137	0	381,493			16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	533	76,645	114,448	4,070,401	0	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	RADIOLOGY-DIAGNOSTIC	1	6,387	0	23,263	0	54.00
54.02	IMAGING CENTER	0	0	0	0	0	54.02
57.00	CT SCAN	0	0	0	1,092	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	102	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	6,387	0	23,292	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	86	12,774	19,075	427,892	0	65.00
66.00	PHYSICAL THERAPY	919	19,161	209,821	6,227,486	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	0	377	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	18	0	0	416,021	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	72	0	0	1,013,382	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	0	0	0	0	0	91.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.02	NEUROPSYCH OFFICE	23	6,387	38,149	203,463	0	93.02
93.03	SLEEP LAB	147	0	0	670,608	0	93.03
93.04	PHYSICIANS OFFICE	10	0	0	151,079	0	93.04
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,978	127,741	381,493	13,228,458	0	118.00
NONREIMBURSABLE COST CENTERS							
200.00	Cross Foot Adjustments				0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,978	127,741	381,493	13,228,458	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153039

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

Worksheet B
Part I
Date/Time Prepared:
5/23/2012 3:47 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT		1.00
1.01	CAP REL COSTS-BLDG & FIXT		1.01
4.00	EMPLOYEE BENEFITS		4.00
5.00	ADMINISTRATIVE & GENERAL		5.00
7.00	OPERATION OF PLANT		7.00
8.00	LAUNDRY & LINEN SERVICE		8.00
9.00	HOUSEKEEPING		9.00
10.00	DIETARY		10.00
11.00	CAFETERIA		11.00
13.00	NURSING ADMINISTRATION		13.00
16.00	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	4,070,401	30.00
ANCILLARY SERVICE COST CENTERS			
54.00	RADIOLOGY-DIAGNOSTIC	23,263	54.00
54.02	IMAGING CENTER	0	54.02
57.00	CT SCAN	1,092	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	102	58.00
59.00	CARDIAC CATHETERIZATION	0	59.00
60.00	LABORATORY	23,292	60.00
60.01	BLOOD LABORATORY	0	60.01
65.00	RESPIRATORY THERAPY	427,892	65.00
66.00	PHYSICAL THERAPY	6,227,486	66.00
69.00	ELECTROCARDIOLOGY	377	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	416,021	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,013,382	73.00
OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
91.00	EMERGENCY	0	91.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	93.00
93.02	NEUROPSYCH OFFICE	203,463	93.02
93.03	SLEEP LAB	670,608	93.03
93.04	PHYSICIANS OFFICE	151,079	93.04
OTHER REIMBURSABLE COST CENTERS			
99.10	CORF	0	99.10
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	13,228,458	118.00
NONREIMBURSABLE COST CENTERS			
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	13,228,458	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 153039

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

Worksheet B
Part II
Date/Time Prepared:
5/23/2012 3:47 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	BLDG & FIXT			
		0	1.01			
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
1.01	CAP REL COSTS-BLDG & FIXT					1.01
4.00	EMPLOYEE BENEFITS	0	803	0	803	4.00
5.00	ADMINISTRATIVE & GENERAL	0	19,222	0	19,222	124 5.00
7.00	OPERATION OF PLANT	0	89,908	0	89,908	40 7.00
8.00	LAUNDRY & LINEN SERVICE	0	2,932	0	2,932	0 8.00
9.00	HOUSEKEEPING	0	1,848	0	1,848	9 9.00
10.00	DIETARY	0	23,774	0	23,774	21 10.00
11.00	CAFETERIA	0	0	0	0	0 11.00
13.00	NURSING ADMINISTRATION	0	1,342	0	1,342	8 13.00
16.00	MEDICAL RECORDS & LIBRARY	0	1,427	0	1,427	25 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	43,126	0	43,126	122 30.00
ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	277	0	277	1 54.00
54.02	IMAGING CENTER	0	0	0	0	0 54.02
57.00	CT SCAN	0	0	0	0	0 57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00	LABORATORY	0	0	0	0	0 60.00
60.01	BLOOD LABORATORY	0	0	0	0	0 60.01
65.00	RESPIRATORY THERAPY	0	392	0	392	27 65.00
66.00	PHYSICAL THERAPY	0	30,968	33,338	64,306	337 66.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,437	0	4,437	4 71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	DRUGS CHARGED TO PATIENTS	0	2,855	0	2,855	33 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
91.00	EMERGENCY	0	0	0	0	0 91.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0 93.00
93.02	NEUROPSYCH OFFICE	0	1,888	0	1,888	8 93.02
93.03	SLEEP LAB	0	2,259	0	2,259	41 93.03
93.04	PHYSICIANS OFFICE	0	5,351	0	5,351	3 93.04
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF	0	0	0	0	0 99.10
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	232,809	33,338	266,147	803 118.00
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	232,809	33,338	266,147	803 202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
1.01	CAP REL COSTS-BLDG & FIXT						1.01
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	19,346					5.00
7.00	OPERATION OF PLANT	3,369	93,317				7.00
8.00	LAUNDRY & LINEN SERVICE	82	2,227	5,241			8.00
9.00	HOUSEKEEPING	234	1,403	0	3,494		9.00
10.00	DIETARY	678	18,054	0	703	43,230	10.00
11.00	CAFETERIA	3	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	147	1,019	0	40	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	515	1,084	0	42	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,836	32,752	5,241	1,277	43,230	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	RADIOLOGY-DIAGNOSTIC	16	211	0	8	0	54.00
54.02	IMAGING CENTER	0	0	0	0	0	54.02
57.00	CT SCAN	2	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	25	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	567	297	0	12	0	65.00
66.00	PHYSICAL THERAPY	7,848	23,518	0	916	0	66.00
69.00	ELECTROCARDIOLOGY	1	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	476	3,370	0	131	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,397	2,168	0	84	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	0	0	0	0	0	91.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.02	NEUROPSYCH OFFICE	176	1,434	0	56	0	93.02
93.03	SLEEP LAB	913	1,716	0	67	0	93.03
93.04	PHYSICIANS OFFICE	61	4,064	0	158	0	93.04
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	19,346	93,317	5,241	3,494	43,230	118.00
NONREIMBURSABLE COST CENTERS							
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)	19,346	93,317	5,241	3,494	43,230	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	11.00	13.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
1.01 CAP REL COSTS-BLDG & FIXT						1.01
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	3					11.00
13.00 NURSING ADMINISTRATION	0	2,556				13.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	3,093			16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2	1,533	928	131,047	0	30.00
ANCILLARY SERVICE COST CENTERS						
54.00 RADIOLOGY-DIAGNOSTIC	0	128	0	641	0	54.00
54.02 IMAGING CENTER	0	0	0	0	0	54.02
57.00 CT SCAN	0	0	0	2	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	128	0	153	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	0	256	155	1,706	0	65.00
66.00 PHYSICAL THERAPY	1	383	1,701	99,010	0	66.00
69.00 ELECTROCARDIOLOGY	0	0	0	1	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	8,418	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	6,537	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 EMERGENCY	0	0	0	0	0	91.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.02 NEUROPSYCH OFFICE	0	128	309	3,999	0	93.02
93.03 SLEEP LAB	0	0	0	4,996	0	93.03
93.04 PHYSICIANS OFFICE	0	0	0	9,637	0	93.04
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	3	2,556	3,093	266,147	0	118.00
NONREIMBURSABLE COST CENTERS						
200.00 Cross Foot Adjustments				0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	3	2,556	3,093	266,147	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 153039

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT		1.00
1.01	CAP REL COSTS-BLDG & FIXT		1.01
4.00	EMPLOYEE BENEFITS		4.00
5.00	ADMINISTRATIVE & GENERAL		5.00
7.00	OPERATION OF PLANT		7.00
8.00	LAUNDRY & LINEN SERVICE		8.00
9.00	HOUSEKEEPING		9.00
10.00	DIETARY		10.00
11.00	CAFETERIA		11.00
13.00	NURSING ADMINISTRATION		13.00
16.00	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	131,047	30.00
ANCILLARY SERVICE COST CENTERS			
54.00	RADIOLOGY-DIAGNOSTIC	641	54.00
54.02	IMAGING CENTER	0	54.02
57.00	CT SCAN	2	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	CARDIAC CATHETERIZATION	0	59.00
60.00	LABORATORY	153	60.00
60.01	BLOOD LABORATORY	0	60.01
65.00	RESPIRATORY THERAPY	1,706	65.00
66.00	PHYSICAL THERAPY	99,010	66.00
69.00	ELECTROCARDIOLOGY	1	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,418	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	6,537	73.00
OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
91.00	EMERGENCY	0	91.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	93.00
93.02	NEUROPSYCH OFFICE	3,999	93.02
93.03	SLEEP LAB	4,996	93.03
93.04	PHYSICIANS OFFICE	9,637	93.04
OTHER REIMBURSABLE COST CENTERS			
99.10	CORF	0	99.10
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	266,147	118.00
NONREIMBURSABLE COST CENTERS			
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	266,147	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 153039

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

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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	BLDG & FIXT (DIRECT ALLOCATION)				
	1.00	1.01				
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	57,082				1.00
1.01	CAP REL COSTS-BLDG & FIXT	0	100			1.01
4.00	EMPLOYEE BENEFITS	197	0	7,231,941		4.00
5.00	ADMINISTRATIVE & GENERAL	4,713	0	1,117,735	-2,679,502	10,548,956
7.00	OPERATION OF PLANT	22,044	0	358,655	0	1,836,796
8.00	LAUNDRY & LINEN SERVICE	719	0	0	0	44,753
9.00	HOUSEKEEPING	453	0	77,172	0	127,805
10.00	DIETARY	5,829	0	186,516	0	369,937
11.00	CAFETERIA	0	0	849	0	1,577
13.00	NURSING ADMINISTRATION	329	0	69,741	0	80,017
16.00	MEDICAL RECORDS & LIBRARY	350	0	222,616	0	280,893
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	10,574	0	1,095,786	0	1,546,506
ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	68	0	4,568	0	8,946
54.02	IMAGING CENTER	0	0	0	0	0
57.00	CT SCAN	0	0	0	0	871
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	81
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	LABORATORY	0	0	0	0	13,481
60.01	BLOOD LABORATORY	0	0	0	0	0
65.00	RESPIRATORY THERAPY	96	0	245,054	0	309,386
66.00	PHYSICAL THERAPY	7,593	100	3,046,571	0	4,279,064
69.00	ELECTROCARDIOLOGY	0	0	0	0	301
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,088	0	39,712	0	259,568
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	DRUGS CHARGED TO PATIENTS	700	0	296,487	0	761,624
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
91.00	EMERGENCY	0	0	0	0	0
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
93.02	NEUROPSYCH OFFICE	463	0	76,515	0	96,005
93.03	SLEEP LAB	554	0	370,705	0	497,906
93.04	PHYSICIANS OFFICE	1,312	0	23,259	0	33,439
OTHER REIMBURSABLE COST CENTERS						
99.10	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	57,082	100	7,231,941	-2,679,502	10,548,956
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	232,809	33,338	926,476		2,679,502
203.00	Unit cost multiplier (Wkst. B, Part I)	4.078501	333.380000	0.128109		0.254006
204.00	Cost to be allocated (per Wkst. B, Part II)			803		19,346
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000111		0.001834

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 153039

Period:
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Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
	7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
1.01						1.01
4.00						4.00
5.00						5.00
7.00	30,128					7.00
8.00	719	70,992				8.00
9.00	453	0	28,956			9.00
10.00	5,829	0	5,829	19,914		10.00
11.00	0	0	0	0	10,594	11.00
13.00	329	0	329	0	171	13.00
16.00	350	0	350	0	736	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	10,574	70,992	10,574	19,914	2,856	30.00
ANCILLARY SERVICE COST CENTERS						
54.00	68	0	68	0	7	54.00
54.02	0	0	0	0	0	54.02
57.00	0	0	0	0	0	57.00
58.00	0	0	0	0	0	58.00
59.00	0	0	0	0	0	59.00
60.00	0	0	0	0	0	60.00
60.01	0	0	0	0	0	60.01
65.00	96	0	96	0	461	65.00
66.00	7,593	0	7,593	0	4,913	66.00
69.00	0	0	0	0	0	69.00
71.00	1,088	0	1,088	0	98	71.00
72.00	0	0	0	0	0	72.00
73.00	700	0	700	0	384	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	0	0	0	0	0	88.00
89.00	0	0	0	0	0	89.00
91.00	0	0	0	0	0	91.00
93.00	0	0	0	0	0	93.00
93.02	463	0	463	0	123	93.02
93.03	554	0	554	0	789	93.03
93.04	1,312	0	1,312	0	56	93.04
OTHER REIMBURSABLE COST CENTERS						
99.10	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
118.00	30,128	70,992	28,956	19,914	10,594	118.00
NONREIMBURSABLE COST CENTERS						
200.00						200.00
201.00						201.00
202.00	2,303,353	111,090	194,901	948,778	1,978	202.00
203.00	76.452237	1.564824	6.730937	47.643768	0.186709	203.00
204.00	93,317	5,241	3,494	43,230	3	204.00
205.00	3.097351	0.073825	0.120666	2.170835	0.000283	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 153039

Period:
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Cost Center Description		NURSING ADMINISTRATION (DIRECT NRSING HRS) 13.00	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT			1.00
1.01	CAP REL COSTS-BLDG & FIXT			1.01
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	100		13.00
16.00	MEDICAL RECORDS & LIBRARY	0	100	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	60	30	30.00
ANCILLARY SERVICE COST CENTERS				
54.00	RADIOLOGY-DIAGNOSTIC	5	0	54.00
54.02	IMAGING CENTER	0	0	54.02
57.00	CT SCAN	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	5	0	60.00
60.01	BLOOD LABORATORY	0	0	60.01
65.00	RESPIRATORY THERAPY	10	5	65.00
66.00	PHYSICAL THERAPY	15	55	66.00
69.00	ELECTROCARDIOLOGY	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	EMERGENCY	0	0	91.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
93.02	NEUROPSYCH OFFICE	5	10	93.02
93.03	SLEEP LAB	0	0	93.03
93.04	PHYSICIANS OFFICE	0	0	93.04
OTHER REIMBURSABLE COST CENTERS				
99.10	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	100	100	118.00
NONREIMBURSABLE COST CENTERS				
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)	127,741	381,493	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1,277.410000	3,814.930000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	2,556	3,093	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	25.560000	30.930000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153039

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

Worksheet C
Part I
Date/Time Prepared:
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		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	4,070,401		4,070,401	0	4,070,401	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	RADIOLOGY-DIAGNOSTIC	23,263		23,263	0	23,263	54.00
54.02	IMAGING CENTER	0		0	0	0	54.02
57.00	CT SCAN	1,092		1,092	0	1,092	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	102		102	0	102	58.00
59.00	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	LABORATORY	23,292		23,292	0	23,292	60.00
60.01	BLOOD LABORATORY	0		0	0	0	60.01
65.00	RESPIRATORY THERAPY	427,892	0	427,892	0	427,892	65.00
66.00	PHYSICAL THERAPY	6,227,486	0	6,227,486	0	6,227,486	66.00
69.00	ELECTROCARDIOLOGY	377		377	0	377	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	416,021		416,021	0	416,021	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,013,382		1,013,382	0	1,013,382	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	EMERGENCY	0		0	0	0	91.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
93.02	NEUROPSYCH OFFICE	203,463		203,463	0	203,463	93.02
93.03	SLEEP LAB	670,608		670,608	27,882	698,490	93.03
93.04	PHYSICIANS OFFICE	151,079		151,079	0	151,079	93.04
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0		0		0	99.10
200.00	Subtotal (see instructions)	13,228,458	0	13,228,458	27,882	13,256,340	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	13,228,458	0	13,228,458	27,882	13,256,340	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153039

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
Title XVIII Hospital PPS						
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	5,632,100		5,632,100			30.00
ANCILLARY SERVICE COST CENTERS						
54.00 RADIOLOGY-DIAGNOSTIC	16,063	0	16,063	1.448235	0.000000	54.00
54.02 IMAGING CENTER	0	0	0	0.000000	0.000000	54.02
57.00 CT SCAN	15,703	0	15,703	0.069541	0.000000	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	3,923	0	3,923	0.026001	0.000000	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00 LABORATORY	1,378,765	11,019	1,389,784	0.016759	0.000000	60.00
60.01 BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00 RESPIRATORY THERAPY	722,872	27,058	749,930	0.570576	0.000000	65.00
66.00 PHYSICAL THERAPY	3,660,408	9,360,719	13,021,127	0.478260	0.000000	66.00
69.00 ELECTROCARDIOLOGY	130,613	0	130,613	0.002886	0.000000	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	362,510	0	362,510	1.147612	0.000000	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	1,043,498	40	1,043,538	0.971102	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0			88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
91.00 EMERGENCY	0	0	0	0.000000	0.000000	91.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
93.02 NEUROPSYCH OFFICE	165,688	54,300	219,988	0.924882	0.000000	93.02
93.03 SLEEP LAB	0	3,323,004	3,323,004	0.201808	0.000000	93.03
93.04 PHYSICIANS OFFICE	0	0	0	0.000000	0.000000	93.04
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0			99.10
200.00 Subtotal (see instructions)	13,132,143	12,776,140	25,908,283			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	13,132,143	12,776,140	25,908,283			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153039

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

Worksheet C
Part I
Date/Time Prepared:
5/23/2012 3:47 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
54.00	RADIOLOGY-DIAGNOSTIC	1.448235			54.00
54.02	IMAGING CENTER	0.000000			54.02
57.00	CT SCAN	0.069541			57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.026001			58.00
59.00	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	LABORATORY	0.016759			60.00
60.01	BLOOD LABORATORY	0.000000			60.01
65.00	RESPIRATORY THERAPY	0.570576			65.00
66.00	PHYSICAL THERAPY	0.478260			66.00
69.00	ELECTROCARDIOLOGY	0.002886			69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.147612			71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.971102			73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC				88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER				89.00
91.00	EMERGENCY	0.000000			91.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000			93.00
93.02	NEUROPSYCH OFFICE	0.924882			93.02
93.03	SLEEP LAB	0.210198			93.03
93.04	PHYSICIANS OFFICE	0.000000			93.04
OTHER REIMBURSABLE COST CENTERS					
99.10	CORF				99.10
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: 153039

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

Worksheet C
Part I
Date/Time Prepared:
5/23/2012 3:47 pm

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00		4.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	4,070,401		4,070,401	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	RADIOLOGY-DIAGNOSTIC	23,263		23,263	0	0	54.00
54.02	IMAGING CENTER	0		0	0	0	54.02
57.00	CT SCAN	1,092		1,092	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	102		102	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	LABORATORY	23,292		23,292	0	0	60.00
60.01	BLOOD LABORATORY	0		0	0	0	60.01
65.00	RESPIRATORY THERAPY	427,892	0	427,892	0	0	65.00
66.00	PHYSICAL THERAPY	6,227,486	0	6,227,486	0	0	66.00
69.00	ELECTROCARDIOLOGY	377		377	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	416,021		416,021	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,013,382		1,013,382	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	EMERGENCY	0		0	0	0	91.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
93.02	NEUROPSYCH OFFICE	203,463		203,463	0	0	93.02
93.03	SLEEP LAB	670,608		670,608	0	0	93.03
93.04	PHYSICIANS OFFICE	151,079		151,079	0	0	93.04
OTHER REIMBURSABLE COST CENTERS							
99.10	CORF	0		0	0	0	99.10
200.00	Subtotal (see instructions)	13,228,458	0	13,228,458	0	0	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	13,228,458	0	13,228,458	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 153039	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/23/2012 3:47 pm
		Title XIX	Hospital	Cost

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	5,632,100		5,632,100			30.00
ANCILLARY SERVICE COST CENTERS						
54.00 RADIOLOGY-DIAGNOSTIC	16,063	0	16,063	1.448235	0.000000	54.00
54.02 IMAGING CENTER	0	0	0	0.000000	0.000000	54.02
57.00 CT SCAN	15,703	0	15,703	0.069541	0.000000	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	3,923	0	3,923	0.026001	0.000000	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00 LABORATORY	1,378,765	11,019	1,389,784	0.016759	0.000000	60.00
60.01 BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00 RESPIRATORY THERAPY	722,872	27,058	749,930	0.570576	0.000000	65.00
66.00 PHYSICAL THERAPY	3,660,408	9,360,719	13,021,127	0.478260	0.000000	66.00
69.00 ELECTROCARDIOLOGY	130,613	0	130,613	0.002886	0.000000	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	362,510	0	362,510	1.147612	0.000000	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	1,043,498	40	1,043,538	0.971102	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
91.00 EMERGENCY	0	0	0	0.000000	0.000000	91.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
93.02 NEUROPSYCH OFFICE	165,688	54,300	219,988	0.924882	0.000000	93.02
93.03 SLEEP LAB	0	3,323,004	3,323,004	0.201808	0.000000	93.03
93.04 PHYSICIANS OFFICE	0	0	0	0.000000	0.000000	93.04
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF	0	0	0			99.10
200.00 Subtotal (see instructions)	13,132,143	12,776,140	25,908,283			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	13,132,143	12,776,140	25,908,283			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153039

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

Worksheet C
Part I
Date/Time Prepared:
5/23/2012 3:47 pm

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					
54.00	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.02	IMAGING CENTER	0.000000			54.02
57.00	CT SCAN	0.000000			57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	LABORATORY	0.000000			60.00
60.01	BLOOD LABORATORY	0.000000			60.01
65.00	RESPIRATORY THERAPY	0.000000			65.00
66.00	PHYSICAL THERAPY	0.000000			66.00
69.00	ELECTROCARDIOLOGY	0.000000			69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
91.00	EMERGENCY	0.000000			91.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000			93.00
93.02	NEUROPSYCH OFFICE	0.000000			93.02
93.03	SLEEP LAB	0.000000			93.03
93.04	PHYSICIANS OFFICE	0.000000			93.04
OTHER REIMBURSABLE COST CENTERS					
99.10	CORF				99.10
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 153039		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part I Date/Time Prepared: 5/23/2012 3:47 pm	
Cost Center Description		Title XVIII		Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	131,047	0	131,047	6,638	19.74	30.00
200.00	Total (Lines 30-199)	131,047		131,047	6,638		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 153039		Period: From 01/01/2011 To 12/31/2011	Worksheet D Part I Date/Time Prepared: 5/23/2012 3:47 pm
		Title XVIII		Hospital	PPS
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	5,684	112,202		
200.00	Total (Lines 30-199)	5,684	112,202		30.00 200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 153039	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part II Date/Time Prepared: 5/23/2012 3:47 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
54.00	RADIOLOGY-DIAGNOSTIC	641	16,063	0.039905	10,659	425	54.00
54.02	IMAGING CENTER	0	0	0.000000	0	0	54.02
57.00	CT SCAN	2	15,703	0.000127	11,361	1	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	3,923	0.000000	1,752	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	LABORATORY	153	1,389,784	0.000110	1,209,783	133	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	1,706	749,930	0.002275	642,478	1,462	65.00
66.00	PHYSICAL THERAPY	99,010	13,021,127	0.007604	3,051,028	23,200	66.00
69.00	ELECTROCARDIOLOGY	1	130,613	0.000008	116,104	1	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,418	362,510	0.023221	303,170	7,040	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	6,537	1,043,538	0.006264	884,092	5,538	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	EMERGENCY	0	0	0.000000	0	0	91.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
93.02	NEUROPSYCH OFFICE	3,999	219,988	0.018178	0	0	93.02
93.03	SLEEP LAB	4,996	3,323,004	0.001503	0	0	93.03
93.04	PHYSICIANS OFFICE	9,637	0	0.000000	0	0	93.04
200.00	Total (lines 50-199)	135,100	20,276,183		6,230,427	37,800	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 153039		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part III Date/Time Prepared: 5/23/2012 3:47 pm	
Cost Center Description		Title XVIII		Hospital		PPS	
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00	Total (Lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 153039		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part III Date/Time Prepared: 5/23/2012 3:47 pm	
Cost Center Description		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PPS	
		6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	6,638	0.00	5,684	0		30.00
200.00	Total (Lines 30-199)	6,638		5,684	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153039

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

Worksheet D
Part IV
Date/Time Prepared:
5/23/2012 3:47 pm

Cost Center Description		Title XVIII				Hospital	PPS	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									
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00	
54.02	IMAGING CENTER	0	0	0	0	0	0	54.02	
57.00	CT SCAN	0	0	0	0	0	0	57.00	
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00	
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00	
60.00	LABORATORY	0	0	0	0	0	0	60.00	
60.01	BLOOD LABORATORY	0	0	0	0	0	0	60.01	
65.00	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00	
66.00	PHYSICAL THERAPY	0	0	0	0	0	0	66.00	
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00	
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00	
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00	
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00	
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00	
91.00	EMERGENCY	0	0	0	0	0	0	91.00	
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	0	93.00	
93.02	NEUROPSYCH OFFICE	0	0	0	0	0	0	93.02	
93.03	SLEEP LAB	0	0	0	0	0	0	93.03	
93.04	PHYSICIANS OFFICE	0	0	0	0	0	0	93.04	
200.00	Total (lines 50-199)	0	0	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153039

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

Worksheet D
Part IV
Date/Time Prepared:
5/23/2012 3:47 pm

Cost Center Description		Title XVIII			Hospital		PPS
		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							
54.00	RADIOLOGY-DIAGNOSTIC	0	16,063	0.000000	0.000000	10,659	54.00
54.02	IMAGING CENTER	0	0	0.000000	0.000000	0	54.02
57.00	CT SCAN	0	15,703	0.000000	0.000000	11,361	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	3,923	0.000000	0.000000	1,752	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	LABORATORY	0	1,389,784	0.000000	0.000000	1,209,783	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	RESPIRATORY THERAPY	0	749,930	0.000000	0.000000	642,478	65.00
66.00	PHYSICAL THERAPY	0	13,021,127	0.000000	0.000000	3,051,028	66.00
69.00	ELECTROCARDIOLOGY	0	130,613	0.000000	0.000000	116,104	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	362,510	0.000000	0.000000	303,170	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,043,538	0.000000	0.000000	884,092	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	EMERGENCY	0	0	0.000000	0.000000	0	91.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
93.02	NEUROPSYCH OFFICE	0	219,988	0.000000	0.000000	0	93.02
93.03	SLEEP LAB	0	3,323,004	0.000000	0.000000	0	93.03
93.04	PHYSICIANS OFFICE	0	0	0.000000	0.000000	0	93.04
200.00	Total (Lines 50-199)	0	20,276,183			6,230,427	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153039

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

Worksheet D
Part IV
Date/Time Prepared:
5/23/2012 3:47 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
Title XVIII Hospital PPS						
ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.02	IMAGING CENTER	0	0	0		54.02
57.00	CT SCAN	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	LABORATORY	0	0	0		60.00
60.01	BLOOD LABORATORY	0	0	0		60.01
65.00	RESPIRATORY THERAPY	0	3,914	0		65.00
66.00	PHYSICAL THERAPY	0	12,411	0		66.00
69.00	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	EMERGENCY	0	0	0		91.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
93.02	NEUROPSYCH OFFICE	0	0	0		93.02
93.03	SLEEP LAB	0	1,203,040	0		93.03
93.04	PHYSICIANS OFFICE	0	0	0		93.04
200.00	Total (Lines 50-199)	0	1,219,365	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 153039	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/23/2012 3:47 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	
		1.00	2.00	3.00				
ANCILLARY SERVICE COST CENTERS								
54.00	RADIOLOGY-DIAGNOSTIC	1.448235	0	0	0	0	0	54.00
54.02	IMAGING CENTER	0.000000	0	0	0	0	0	54.02
57.00	CT SCAN	0.069541	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.026001	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	0	59.00
60.00	LABORATORY	0.016759	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0.570576	3,914	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0.478260	12,411	0	0	0	0	66.00
69.00	ELECTROCARDIOLOGY	0.002886	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.147612	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.971102	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	RURAL HEALTH CLINIC	0.000000						88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000						89.00
91.00	EMERGENCY	0.000000	0	0	0	0	0	91.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	0	93.00
93.02	NEUROPSYCH OFFICE	0.924882	0	0	0	0	0	93.02
93.03	SLEEP LAB	0.201808	1,203,040	0	0	0	0	93.03
93.04	PHYSICIANS OFFICE	0.000000	0	0	0	0	0	93.04
200.00	Subtotal (see instructions)		1,219,365	0	0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		1,219,365	0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 153039	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/23/2012 3:47 pm
Title XVIII		Hospital	PPS

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.02 IMAGING CENTER	0	0	0		54.02
57.00 CT SCAN	0	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00 LABORATORY	0	0	0		60.00
60.01 BLOOD LABORATORY	0	0	0		60.01
65.00 RESPIRATORY THERAPY	2,233	0	0		65.00
66.00 PHYSICAL THERAPY	5,936	0	0		66.00
69.00 ELECTROCARDIOLOGY	0	0	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00 EMERGENCY	0	0	0		91.00
93.00 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
93.02 NEUROPSYCH OFFICE	0	0	0		93.02
93.03 SLEEP LAB	242,783	0	0		93.03
93.04 PHYSICIANS OFFICE	0	0	0		93.04
200.00 Subtotal (see instructions)	250,952	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)	250,952	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 153039	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/23/2012 3:47 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,638	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,638	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)		6,638	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		5,684	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,070,401	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,070,401	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		5,632,100	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		5,632,100	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.722715	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)		848.46	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,070,401	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)		613.20	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,485,429	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,485,429	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 153039		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 5/23/2012 3:47 pm	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						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)					3,069,117	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,554,546	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)					112,202	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					37,800	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					150,002	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					6,404,544	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 153039		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 5/23/2012 3:47 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	131,047	4,070,401	0.032195	0	0	90.00
91.00	Nursing School cost	0	4,070,401	0.000000	0	0	91.00
92.00	Allied health cost	0	4,070,401	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,070,401	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 153039	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/23/2012 3:47 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		4,826,412		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	RADIOLOGY-DIAGNOSTIC	1.448235	10,659	15,437	54.00
54.02	IMAGING CENTER	0.000000	0	0	54.02
57.00	CT SCAN	0.069541	11,361	790	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.026001	1,752	46	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.016759	1,209,783	20,275	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0.570576	642,478	366,583	65.00
66.00	PHYSICAL THERAPY	0.478260	3,051,028	1,459,185	66.00
69.00	ELECTROCARDIOLOGY	0.002886	116,104	335	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.147612	303,170	347,922	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.971102	884,092	858,544	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	EMERGENCY	0.000000	0	0	91.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
93.02	NEUROPSYCH OFFICE	0.924882	0	0	93.02
93.03	SLEEP LAB	0.210198	0	0	93.03
93.04	PHYSICIANS OFFICE	0.000000	0	0	93.04
200.00	Total (sum of lines 50-94 and 96-98)		6,230,427	3,069,117	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)		6,230,427		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 153039	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/23/2012 3:47 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		121,523		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	RADIOLOGY-DIAGNOSTIC	1.448235	0	0	54.00
54.02	IMAGING CENTER	0.000000	0	0	54.02
57.00	CT SCAN	0.069541	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.026001	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.016759	21,447	359	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0.570576	18,606	10,616	65.00
66.00	PHYSICAL THERAPY	0.478260	98,558	47,136	66.00
69.00	ELECTROCARDIOLOGY	0.002886	1,250	4	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.147612	5,843	6,705	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.971102	20,782	20,181	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
91.00	EMERGENCY	0.000000	0	0	91.00
93.00	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
93.02	NEUROPSYCH OFFICE	0.924882	2,090	1,933	93.02
93.03	SLEEP LAB	0.201808	0	0	93.03
93.04	PHYSICIANS OFFICE	0.000000	0	0	93.04
200.00	Total (sum of lines 50-94 and 96-98)		168,576	86,934	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)		168,576		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 153039	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/23/2012 3:47 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		250,952	2.00
3.00	PPS payments		269,346	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)		0	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)		0	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)		269,346	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		91,568	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)		177,778	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)		177,778	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		177,778	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)		44,437	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		31,106	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		38,697	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		208,884	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)		208,884	40.00
41.00	Interim payments		177,779	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)		31,105	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 153039

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

Worksheet E-1
Part I
Date/Time Prepared:
5/23/2012 3:47 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		6,985,148		177,779	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	08/09/2011	17,352		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-17,352		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		6,967,796		177,779	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		50,917		31,105	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		7,018,713		208,884	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 153039	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part III Date/Time Prepared: 5/23/2012 3:47 pm
		Title XVII	Hospital	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			7,045,174 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0186 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			160,158 3.00
4.00	Outlier Payments			0 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			18,186,301 10.00
11.00	Medical Education Adjustment Factor $\{(1 + (\text{line 9}/\text{line 10})) \text{ raised to the power of } .6876 - 1\}$.			0.000000 11.00
12.00	Medical Education Adjustment (line 1 multiplied by line 11).			0 12.00
13.00	Total PPS Payment (sum of lines 1, 3, 4 and 12)			7,205,332 13.00
14.00	Nursing and Allied Health Managed Care payment (see instruction)			0 14.00
15.00	Organ acquisition			0 15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 16.00
17.00	Subtotal (see instructions)			7,205,332 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			7,205,332 19.00
20.00	Deductibles			180,774 20.00
21.00	Subtotal (line 19 minus line 20)			7,024,558 21.00
22.00	Coinurance			26,594 22.00
23.00	Subtotal (line 21 minus line 22)			6,997,964 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			29,642 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			20,749 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			10,333 26.00
27.00	Subtotal (sum of lines 23 and 25)			7,018,713 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			7,018,713 32.00
33.00	Interim payments			6,967,796 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus the sum lines 33 and 34)			50,917 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			10,000 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00