

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: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet S Parts I-III Date/Time Prepared: 5/30/2012 7:15 pm
--	----------------------	---	--

PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input checked="" 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: 5/30/2012 Time: 7:15 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 IU HEALTH BLACKFORD HOSPITAL for the cost reporting period beginning 01/01/2011 and ending 12/31/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	166,159	406,011	433,079	996,305	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	160,505	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	326,664	406,011	433,079	996,305	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet S Parts I-III Date/Time Prepared: 5/30/2012 7:15 pm
--	----------------------	---------------------------------------	---

PART I - COST REPORT STATUS

Provider use only
 1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only
 5. Cost Report Status
 (1) As Submitted
 (2) Settled without Audit
 (3) Settled with Audit
 (4) Reopened
 (5) Amended
 6. Date Received:
 7. Contractor No.
 8. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN
 10. NPR Date:
 11. Contractor's Vendor Code: 04
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 5/30/2012 Time: 7:15 pm

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

Encryption Information
 ECR: Date: 5/30/2012 Time: 7:15 pm
 2iO81N.dyGi8RxGLz11Ta7wGI2:120
 OAh:p0ZfZXtjQBI BegdeJLVD6HpmQk
 oHMP0Yfftk0x7FxH
 PI: Date: 5/30/2012 Time: 7:15 pm
 3vG6LHHp.i6poL0dxlNkswHAc.57m0
 WI D140hi xgi kGvSLI owkpnNgs7I r1e
 Beri Lvzj Su0ayt7n

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

 Title

 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	166,159	406,011	433,079	996,305	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	160,505	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	326,664	406,011	433,079	996,305	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 151302		Period: From 01/01/2011 To 12/31/2011		Worksheet S-2 Part I Date/Time Prepared: 5/30/2012 5:23 pm			
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 410 PILGRIM STREET			PO Box:							1.00
2.00	City: HARTFORD CITY			State: IN		Zip Code: 47348		County: BLACKFORD			2.00
		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	
								V	XVIII	XIX	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		IU HEALTH BLACKFORD HOSPITAL	151302	99915	1	02/10/2000	N	0	0	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		BLACKFORD COMMUNITY SWING BED	15Z302	99915		02/01/2000	N	0	0	7.00
8.00	Swing Beds - NF							N		N	8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC							N	N	N	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)						2		21.00		
Inpatient PPS Information											
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N		N		22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.						2		N		23.00
		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.		0	0	0	0	0		24.00		
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.		0	0	0	0	0		25.00		
							Urban/Rural S	Date of Geogr			
							1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.						2		26.00		
27.00	For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification (in column 2).						2		27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0		35.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/30/2012 5:23 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00	61.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00	
		Program Name 1.00	Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151302

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

Worksheet S-2
Part I
Date/Time Prepared:
5/30/2012 5:23 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: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/30/2012 5:23 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.		N		75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.			N	80.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(i)? Enter "Y" for yes and "N" for no.			N	86.00
			V	XIX	
			1.00	2.00	
Title V or XIX Inpatient Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	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	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		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.		N	N	109.00
			1.00		2.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.		N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			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.		Y		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 151302		Period: From 01/01/2011 To 12/31/2011		Worksheet S-2 Part I Date/Time Prepared: 5/30/2012 5:23 pm	
				1.00			2.00		
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.							134.00	
All Providers									
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)			Y		15H059		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: IU HEALTH, INC			Contractor's Name: NGS		Contractor's Number: 00130			141.00
142.00	Street: 340 W. 10TH STREET			PO Box:					142.00
143.00	City: INDIANAPOLIS			State: 18		Zip Code: 46202			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	
								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.			Y					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)			495,160					168.00
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: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part II Date/Time Prepared: 5/30/2012 5:23 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	R	03/31/2012	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A			
		Description	Y/N	Date	
		0	1.00	2.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y		04/18/2012	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N			20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part II Date/Time Prepared: 5/30/2012 5:23 pm
---	--	----------------------	---	--

		Part A				
		Description	Y/N	Date		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	1.00 N	2.00		21.00
					1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)						
Capital Related Cost						
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		N			22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N			23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N			24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N			25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N			26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N			27.00
Interest Expense						
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		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.					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?		Y			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.		Y			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.		N			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		Y			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N			40.00

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/18/2012	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151302

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2012 5:23 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	15	5,475	46,248.00		1.00
2.00 HMO						2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		15	5,475	46,248.00		7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00					13.00
14.00 Total (see instructions)		15	5,475	46,248.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0			17.00
18.00 SUBPROVIDER	42.00	0	0			18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00					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)		15				27.00
28.00 Observation Bed Days						28.00
28.02 SUBPROVIDER - IRF	41.00					28.02
28.03 SUBPROVIDER	42.00					28.03
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151302

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2012 5:23 pm

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	1,217	117	1,927		1.00
2.00 HMO		83	36			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	1,224	0	1,224		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,441	117	3,151		7.00
8.00 INTENSIVE CARE UNIT	0	0	0	0		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	0		0	0		13.00
14.00 Total (see instructions)	0	2,441	117	3,151		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0		17.00
18.00 SUBPROVIDER	0	0	0	0		18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	0	0	0		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		3	19		28.00
28.02 SUBPROVIDER - IRF				0		28.02
28.03 SUBPROVIDER				0		28.03
29.00 Ambulance Trips		1,638				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: 151302

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2012 5:23 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	301	1.00
2.00 HMO					22	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	123.00	0.00	0	301	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0.00	0.00	0	0	17.00
18.00 SUBPROVIDER	0.00	0.00	0.00	0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00	0.00	0.00			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	123.00	0.00			27.00
28.00 Observation Bed Days						28.00
28.02 SUBPROVIDER - IRF						28.02
28.03 SUBPROVIDER						28.03
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151302

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2012 5:23 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)	44	478		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)	44	478		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF	0	0		17.00
18.00 SUBPROVIDER	0	0		18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
25.10 CMHC - CORF				25.10
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
28.02 SUBPROVIDER - IRF				28.02
28.03 SUBPROVIDER				28.03
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet S-10 Date/Time Prepared: 5/30/2012 5:23 pm
---	----------------------	---	--

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)		0.411531	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		525,966	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		5,518,349	6.00
7.00	Medicaid cost (line 1 times line 6)		2,270,972	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		1,745,006	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone SCHIP		0	9.00
10.00	Stand-alone SCHIP charges		0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		2,676,291	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		1,101,377	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		1,101,377	16.00
Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		2,846,383	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	0	0	0
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	0	0	0
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	0	0	0
			1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		2,841,548	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		222,792	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		2,618,756	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		1,077,699	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		1,077,699	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,924,082	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151302

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

Worksheet A
Date/Time Prepared:
5/30/2012 5:23 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 NEW CAP REL COSTS-BLDG & FIXT		1,271,855	1,271,855	0	1,271,855	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
3.00 OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00 EMPLOYEE BENEFITS	0	113,740	113,740	0	113,740	4.00
5.01 ADMITTING	109,464	285,523	394,987	0	394,987	5.01
5.02 OTHER ADMINISTRATIVE AND GENERAL	379,363	2,454,526	2,833,889	-2,897	2,830,992	5.02
7.00 OPERATION OF PLANT	116,790	443,773	560,563	-41	560,522	7.00
9.00 HOUSEKEEPING	151,239	136,408	287,647	-19,415	268,232	9.00
10.00 DIETARY	143,669	141,864	285,533	-207,967	77,566	10.00
11.00 CAFETERIA	0	0	0	207,353	207,353	11.00
13.00 NURSING ADMINISTRATION	238,560	36,891	275,451	-2	275,449	13.00
14.00 CENTRAL SERVICES & SUPPLY	59,023	5,702	64,725	425,101	489,826	14.00
15.00 PHARMACY	441	554,250	554,691	78,070	632,761	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	5,289	5,289	0	5,289	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1,549,914	226,717	1,776,631	-42,937	1,733,694	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	274,605	192,975	467,580	-123,876	343,704	50.00
53.00 ANESTHESIOLOGY	0	111,977	111,977	-7,863	104,114	53.00
54.00 RADIOLOGY-DIAGNOSTIC	444,371	512,784	957,155	-34,887	922,268	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	1,211,780	1,211,780	-197,219	1,014,561	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00 RESPIRATORY THERAPY	117,458	469,756	587,214	-33,312	553,902	65.00
65.01 SLEEP LAB	0	55,365	55,365	-1,316	54,049	65.01
66.00 PHYSICAL THERAPY	0	380,000	380,000	-2,013	377,987	66.00
67.00 OCCUPATIONAL THERAPY	112	70,502	70,614	-12	70,602	67.00
68.00 SPEECH PATHOLOGY	0	6,402	6,402	0	6,402	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	24,497	24,497	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	10,217	10,217	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	55,500	55,500	-35,898	19,602	73.00
76.00 CARDIOLOGY	0	0	0	0	0	76.00
76.97 CARDIAC REHABILITATION	0	0	0	15,747	15,747	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	74,801	9,000	83,801	-1,128	82,673	90.00
91.00 EMERGENCY	1,066,221	895,154	1,961,375	-20,442	1,940,933	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	855,975	237,942	1,093,917	-29,760	1,064,157	95.00
99.10 CORF	0	0	0	0	0	99.10
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	5,582,006	9,885,675	15,467,681	0	15,467,681	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
194.02 PHARMACY	0	0	0	0	0	194.02
200.00 TOTAL (SUM OF LINES 118-199)	5,582,006	9,885,675	15,467,681	0	15,467,681	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151302

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

Worksheet A
Date/Time Prepared:
5/30/2012 5:23 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	523,384	1,795,239	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	EMPLOYEE BENEFITS	165,960	279,700	4.00
5.01	ADMITTING	236,144	631,131	5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL	975,814	3,806,806	5.02
7.00	OPERATION OF PLANT	-23,423	537,099	7.00
9.00	HOUSEKEEPING	13,720	281,952	9.00
10.00	DIETARY	-73,398	4,168	10.00
11.00	CAFETERIA	2,488	209,841	11.00
13.00	NURSING ADMINISTRATION	0	275,449	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	489,826	14.00
15.00	PHARMACY	-272	632,489	15.00
16.00	MEDICAL RECORDS & LIBRARY	-45	5,244	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	1,733,694	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	343,704	50.00
53.00	ANESTHESIOLOGY	-96,674	7,440	53.00
54.00	RADIOLOGY-DIAGNOSTIC	-18,942	903,326	54.00
57.00	CT SCAN	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	-37,992	976,569	60.00
60.01	BLOOD LABORATORY	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	RESPIRATORY THERAPY	-2,856	551,046	65.00
65.01	SLEEP LAB	0	54,049	65.01
66.00	PHYSICAL THERAPY	-1,010	376,977	66.00
67.00	OCCUPATIONAL THERAPY	0	70,602	67.00
68.00	SPEECH PATHOLOGY	0	6,402	68.00
69.00	ELECTROCARDIOLOGY	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	24,497	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	10,217	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	19,602	73.00
76.00	CARDIOLOGY	0	0	76.00
76.97	CARDIAC REHABILITATION	0	15,747	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	CLINIC	0	82,673	90.00
91.00	EMERGENCY	-702,560	1,238,373	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	-5,650	1,058,507	95.00
99.10	CORF	0	0	99.10
101.00	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS				
109.00	PANCREAS ACQUISITION	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	110.00
111.00	ISLET ACQUISITION	0	0	111.00
113.00	INTEREST EXPENSE	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	954,688	16,422,369	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.01
194.02	PHARMACY	0	0	194.02
200.00	TOTAL (SUM OF LINES 118-199)	954,688	16,422,369	200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
A - BILLABLE MEDICAL SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	24,497	1.00	
	TOTALS		0	24,497		
B - BILLABLE IMPLANT SUPPLIES						
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	10,217	1.00	
	TOTALS		0	10,217		
C - NON-BILLABLE MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	425,101	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
	TOTALS		0	425,101		
D - BILLABLE DRUGS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	18,827	1.00	
	TOTALS		0	18,827		
E - NON-BILLABLE DRUGS						
1.00	PHARMACY	15.00	0	78,954	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	
	TOTALS		0	78,954		
F - CAFETERIA						
1.00	CAFETERIA	11.00	104,332	103,021	1.00	
	TOTALS		104,332	103,021		
G - CARDIAC REHAB						
1.00	CARDIAC REHABILITATION	76.97	13,648	2,099	1.00	
	TOTALS		13,648	2,099		
500.00	Grand Total: Increases		117,980	662,716	500.00	

RECLASSIFICATIONS

Provider CCN: 151302

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

Worksheet A-6
Date/Time Prepared:
5/30/2012 5:23 pm

		Decreases				Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - BILLABLE MEDICAL SUPPLIES							
1.00	OPERATING ROOM	50.00	0	24,497	0		1.00
	TOTALS		0	24,497			
B - BILLABLE IMPLANT SUPPLIES							
1.00	OPERATING ROOM	50.00	0	10,217	0		1.00
	TOTALS		0	10,217			
C - NON-BILLABLE MEDICAL SUPPLIES							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	2,124	0		1.00
2.00	OPERATION OF PLANT	7.00	0	41	0		2.00
3.00	HOUSEKEEPING	9.00	0	19,415	0		3.00
4.00	DIETARY	10.00	0	614	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	2	0		5.00
6.00	PHARMACY	15.00	0	884	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	42,893	0		7.00
8.00	OPERATING ROOM	50.00	0	85,263	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	7,863	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	16,060	0		10.00
11.00	LABORATORY	60.00	0	186,068	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	17,219	0		12.00
13.00	SLEEP LAB	65.01	0	1,316	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	2,013	0		14.00
15.00	OCCUPATIONAL THERAPY	67.00	0	12	0		15.00
16.00	DRUGS CHARGED TO PATIENTS	73.00	0	7,772	0		16.00
17.00	CLINIC	90.00	0	1,128	0		17.00
18.00	EMERGENCY	91.00	0	19,985	0		18.00
19.00	AMBULANCE SERVICES	95.00	0	14,429	0		19.00
	TOTALS		0	425,101			
D - BILLABLE DRUGS							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	18,827	0		1.00
	TOTALS		0	18,827			
E - NON-BILLABLE DRUGS							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	773	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	44	0		2.00
3.00	OPERATING ROOM	50.00	0	3,899	0		3.00
4.00	LABORATORY	60.00	0	11,151	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	346	0		5.00
6.00	DRUGS CHARGED TO PATIENTS	73.00	0	46,953	0		6.00
7.00	EMERGENCY	91.00	0	457	0		7.00
8.00	AMBULANCE SERVICES	95.00	0	15,331	0		8.00
	TOTALS		0	78,954			
F - CAFETERIA							
1.00	DIETARY	10.00	104,332	103,021	0		1.00
	TOTALS		104,332	103,021			
G - CARDIAC REHAB							
1.00	RESPIRATORY THERAPY	65.00	13,648	2,099	0		1.00
	TOTALS		13,648	2,099			
500.00	Grand Total: Decreases		117,980	662,716			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151302

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/30/2012 5:23 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	190,324	0	0	0	1.00
2.00	Land Improvements	275,335	0	0	0	2.00
3.00	Buildings and Fixtures	14,849,229	60,199	0	60,199	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	5,366,986	155,838	0	155,838	6.00
7.00	HIT designated Assets	0	495,160	0	495,160	7.00
8.00	Subtotal (sum of lines 1-7)	20,681,874	711,197	0	711,197	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	20,681,874	711,197	0	711,197	10.00
SUMMARY OF CAPITAL						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,271,855	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,271,855	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151302

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/30/2012 5:23 pm

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	190,324	0		1.00	
2.00	Land Improvements	275,335	0		2.00	
3.00	Buildings and Fixtures	14,859,870	0		3.00	
4.00	Building Improvements	0	0		4.00	
5.00	Fixed Equipment	0	0		5.00	
6.00	Movable Equipment	5,388,593	0		6.00	
7.00	HIT designated Assets	495,160	0		7.00	
8.00	Subtotal (sum of lines 1-7)	21,209,282	0		8.00	
9.00	Reconciling Items	0	0		9.00	
10.00	Total (line 8 minus line 9)	21,209,282	0		10.00	
SUMMARY OF CAPITAL						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,271,855		1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00	
3.00	Total (sum of lines 1-2)	0	1,271,855		3.00	
ALLOCATION OF OTHER CAPITAL						
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,795,239	0
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0
3.00	Total (sum of lines 1-2)	0	0	0	1,795,239	0

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151302

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/30/2012 5:23 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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,795,239	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,795,239	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151302

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

Worksheet A-8
Date/Time Prepared:
5/30/2012 5:23 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center		Line #
			1.00	2.00	3.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	NEW CAP REL COSTS-MVBLE EQUIP	2.00 2.00
3.00 Investment income - other (chapter 2)		0			0.00 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	-855,672			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	1,744,576			12.00
13.00 Laundry and linen service		0			0.00 13.00
14.00 Cafeteria-employees and guests		0			0.00 14.00
15.00 Rental of quarters to employee and others		0			0.00 15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00 16.00
17.00 Sale of drugs to other than patients		0			0.00 17.00
18.00 Sale of medical records and abstracts		0			0.00 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00 19.00
20.00 Vending machines		0			0.00 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00 23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00 24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00 25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0	NEW CAP REL COSTS-MVBLE EQUIP	2.00 27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00 28.00
29.00 Physicians' assistant			0		0.00 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00 30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00 31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	320,640		NEW CAP REL COSTS-BLDG & FIXT	1.00 32.00
33.00 IHAA AND AHA LOBBY COSTS	A	-2,095		OTHER ADMINISTRATIVE AND GENERAL	5.02 33.00
34.00 MARKETING ADVERTISING COSTS	A	-15,772		OTHER ADMINISTRATIVE AND GENERAL	5.02 34.00
35.00 ANESTHESIA PURCHASED SERVICE	A	-3,457		ANESTHESIOLOGY	53.00 35.00
36.00 NON ALLOW INTEREST EXP	A	-66,479		OTHER ADMINISTRATIVE AND GENERAL	5.02 36.00
37.00 PATIENT PHONE COSTS	A	-3,025		OTHER ADMINISTRATIVE AND GENERAL	5.02 37.00
38.00 MISCELL INCOME	B	-53,866		NEW CAP REL COSTS-BLDG & FIXT	1.00 38.00
39.00 MISCELL INCOME	B	-9,059		OTHER ADMINISTRATIVE AND GENERAL	5.02 39.00
40.00 MISCELL INCOME	B	-22,694		OPERATION OF PLANT	7.00 40.00
41.00 MISCELL INCOME	B	-73,398		DIETARY	10.00 41.00
42.00 MISCELL INCOME	B	-283		PHARMACY	15.00 42.00
43.00 MISCELL INCOME	B	-45		MEDICAL RECORDS & LIBRARY	16.00 43.00
44.00 MISCELL INCOME	B	-822		RADIOLOGY-DIAGNOSTIC	54.00 44.00
45.00 MISCELL INCOME	B	-120		LABORATORY	60.00 45.00
45.01 MISCELL INCOME	B	-2,856		RESPIRATORY THERAPY	65.00 45.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 151302

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

Worksheet A-8

Date/Time Prepared:
5/30/2012 5:23 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	
45.02 MISCELL INCOME	B	-1,010	PHYSICAL THERAPY	66.00	45.02
45.03 MISCELL INCOME	A	125	AMBULANCE SERVICES	95.00	45.03
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		954,688			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151302

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

Worksheet A-8

Date/Time Prepared:
5/30/2012 5:23 pm

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	9	32.00
33.00	IHAA AND AHA LOBBY COSTS	0	33.00
34.00	MARKETING ADVERTISING COSTS	0	34.00
35.00	ANESTHESIA PURCHASED SERVICE	0	35.00
36.00	NON ALLOW INTEREST EXP	0	36.00
37.00	PATIENT PHONE COSTS	0	37.00
38.00	MI SCELL INCOME	9	38.00
39.00	MI SCELL INCOME	0	39.00
40.00	MI SCELL INCOME	0	40.00
41.00	MI SCELL INCOME	0	41.00
42.00	MI SCELL INCOME	0	42.00
43.00	MI SCELL INCOME	0	43.00
44.00	MI SCELL INCOME	0	44.00
45.00	MI SCELL INCOME	0	45.00
45.01	MI SCELL INCOME	0	45.01
45.02	MI SCELL INCOME	0	45.02
45.03	MI SCELL INCOME	0	45.03
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: 151302

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

Worksheet A-8-1

Date/Time Prepared: 5/30/2012 5:23 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	1.00	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	4.00	EMPLOYEE BENEFITS		2.00
3.00	5.01	ADMINISTRATIVE AND GENERAL		3.00
4.00	5.02	OPERATION OF PLANT		4.00
4.01	7.00	HOUSEKEEPING		4.01
4.02	9.00	CAFETERIA		4.02
4.03	11.00	PHARMACY		4.03
4.04	15.00	LABORATORY		4.04
4.05	60.00	LABORATORY		4.05
4.06	5.01	ADMINISTRATIVE AND GENERAL		4.06
4.07	7.00	OPERATION OF PLANT		4.07
4.08	10.00	DIETARY		4.08
4.09	13.00	NURSING ADMINISTRATION		4.09
4.10	15.00	PHARMACY		4.10
4.11	30.00	ADULTS & PEDIATRICS		4.11
4.12	50.00	OPERATING ROOM		4.12
4.13	54.00	RADIOLOGY-DIAGNOSTIC		4.13
4.14	60.00	LABORATORY		4.14
4.15	65.00	RESPIRATORY THERAPY		4.15
4.16	65.01	SLEEP LAB		4.16
4.17	66.00	PHYSICAL THERAPY		4.17
4.18	67.00	OCCUPATIONAL THERAPY		4.18
4.19	68.00	SPEECH PATHOLOGY		4.19
4.20	90.00	CLINIC		4.20
4.21	91.00	EMERGENCY		4.21
4.22	95.00	AMBULANCE SERVICES		4.22
4.23	0.00			4.23
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		B	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.

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

Provider CCN: 151302

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

Worksheet A-8-1

Date/Time Prepared: 5/30/2012 5:23 pm

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	256,610	0	256,610	9		1.00
2.00	173,888	7,928	165,960	0		2.00
3.00	236,144	0	236,144	0		3.00
4.00	2,522,475	1,450,231	1,072,244	0		4.00
4.01	55,916	56,645	-729	0		4.01
4.02	13,720	0	13,720	0		4.02
4.03	2,488	0	2,488	0		4.03
4.04	11	0	11	0		4.04
4.05	228,752	230,624	-1,872	0		4.05
4.06	277,776	277,776	0	0		4.06
4.07	3,638	3,638	0	0		4.07
4.08	6,584	6,584	0	0		4.08
4.09	39	39	0	0		4.09
4.10	223,591	223,591	0	0		4.10
4.11	43,233	43,233	0	0		4.11
4.12	12,310	12,310	0	0		4.12
4.13	235,733	235,733	0	0		4.13
4.14	613,385	613,385	0	0		4.14
4.15	427,959	427,959	0	0		4.15
4.16	53,088	53,088	0	0		4.16
4.17	314,949	314,949	0	0		4.17
4.18	71,084	71,084	0	0		4.18
4.19	6,402	6,402	0	0		4.19
4.20	220	220	0	0		4.20
4.21	4,791	4,791	0	0		4.21
4.22	5,356	5,356	0	0		4.22
4.23	0	0	0	0		4.23
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	5,790,142	4,045,566	1,744,576		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	HOSPITAL	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: 151302

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

Worksheet A-8-2

Date/Time Prepared:
5/30/2012 5:23 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	53.00	ANESTHESIOLOGY	93,217	93,217	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	18,120	18,120	2.00
3.00	60.00	LABORATORY	36,000	36,000	3.00
4.00	91.00	EMERGENCY	702,560	702,560	4.00
5.00	95.00	AMBULANCE SERVICES	5,775	5,775	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			855,672	855,672	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151302

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

Worksheet A-8-2

Date/Time Prepared:
5/30/2012 5:23 pm

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151302

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

Worksheet A-8-2

Date/Time Prepared:
5/30/2012 5:23 pm

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151302

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

Worksheet A-8-2

Date/Time Prepared:
5/30/2012 5:23 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	93,217	1.00
2.00	0	18,120	2.00
3.00	0	36,000	3.00
4.00	0	702,560	4.00
5.00	0	5,775	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	855,672	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151302

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2012 5:23 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	ADMITTING	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT	1,795,239	1,795,239				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0		0			2.00
4.00 EMPLOYEE BENEFITS	279,700	0	0	279,700		4.00
5.01 ADMITTING	631,131	0	0	5,485	636,616	5.01
5.02 OTHER ADMINISTRATIVE AND GENERAL	3,806,806	137,659	0	19,009	0	5.02
7.00 OPERATION OF PLANT	537,099	565,752	0	5,852	0	7.00
9.00 HOUSEKEEPING	281,952	25,169	0	7,578	0	9.00
10.00 DIETARY	4,168	24,846	0	1,971	0	10.00
11.00 CAFETERIA	209,841	65,849	0	5,228	0	11.00
13.00 NURSING ADMINISTRATION	275,449	5,493	0	11,954	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	489,826	28,903	0	2,957	0	14.00
15.00 PHARMACY	632,489	19,640	0	22	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	5,244	27,575	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1,733,694	272,805	0	77,663	46,318	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	343,704	187,172	0	13,760	50,744	50.00
53.00 ANESTHESIOLOGY	7,440	0	0	0	2,185	53.00
54.00 RADIOLOGY-DIAGNOSTIC	903,326	145,558	0	22,266	144,496	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	976,569	39,711	0	0	139,788	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00 RESPIRATORY THERAPY	551,046	29,801	0	5,202	21,721	65.00
65.01 SLEEP LAB	54,049	0	0	0	7,881	65.01
66.00 PHYSICAL THERAPY	376,977	0	0	0	16,283	66.00
67.00 OCCUPATIONAL THERAPY	70,602	0	0	6	532	67.00
68.00 SPEECH PATHOLOGY	6,402	0	0	0	68	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	24,497	0	0	0	1,069	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	10,217	0	0	0	709	72.00
73.00 DRUGS CHARGED TO PATIENTS	19,602	0	0	0	45,930	73.00
76.00 RADIOLOGY	0	0	0	0	0	76.00
76.97 CARDIAC REHABILITATION	15,747	5,027	0	684	1,627	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	82,673	68,147	0	3,748	3,054	90.00
91.00 EMERGENCY	1,238,373	136,725	0	53,425	84,257	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	1,058,507	0	0	42,890	69,954	95.00
99.10 CORF	0	0	0	0	0	99.10
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	16,422,369	1,785,832	0	279,700	636,616	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,407	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
194.02 PHARMACY	0	0	0	0	0	194.02
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 TOTAL (sum lines 118-201)	16,422,369	1,795,239	0	279,700	636,616	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151302

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2012 5:23 pm

Cost Center Description	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	
	5A.01	5.02	7.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.01 ADMITTING						5.01
5.02 OTHER ADMINISTRATIVE AND GENERAL	3,963,474	3,963,474				5.02
7.00 OPERATION OF PLANT	1,108,703	352,705	1,461,408			7.00
9.00 HOUSEKEEPING	314,699	100,113	33,689	448,501		9.00
10.00 DIETARY	30,985	9,857	33,256	10,447	84,545	10.00
11.00 CAFETERIA	280,918	89,367	88,139	27,688		11.00
13.00 NURSING ADMINISTRATION	292,896	93,177	7,353	2,310		13.00
14.00 CENTRAL SERVICES & SUPPLY	521,686	165,961	38,687	12,153		14.00
15.00 PHARMACY	652,151	207,465	26,288	8,258		15.00
16.00 MEDICAL RECORDS & LIBRARY	32,819	10,441	36,909	11,594		16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,130,480	677,758	365,149	114,708	84,545	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	595,380	189,405	250,528	78,701	0	50.00
53.00 ANESTHESIOLOGY	9,625	3,062	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	1,215,646	386,726	194,829	61,203	0	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	1,156,068	367,773	53,153	16,697	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00 RESPIRATORY THERAPY	607,770	193,346	39,888	12,530	0	65.00
65.01 SLEEP LAB	61,930	19,701	0	0	0	65.01
66.00 PHYSICAL THERAPY	393,260	125,105	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	71,140	22,631	0	0	0	67.00
68.00 SPEECH PATHOLOGY	6,470	2,058	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	25,566	8,133	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	10,926	3,476	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	65,532	20,847	0	0	0	73.00
76.00 RADIOLOGY	0	0	0	0	0	76.00
76.97 CARDIAC REHABILITATION	23,085	7,344	6,728	2,114	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	157,622	50,143	91,215	28,654	0	90.00
91.00 EMERGENCY	1,512,780	481,252	183,006	57,489	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	1,171,351	372,635	0	0	0	95.00
99.10 CORF	0	0	0	0	0	99.10
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	16,412,962	3,960,481	1,448,817	444,546	84,545	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,407	2,993	12,591	3,955	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
194.02 PHARMACY	0	0	0	0	0	194.02
200.00 Cross Foot Adjustments	0	0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	16,422,369	3,963,474	1,461,408	448,501	84,545	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151302

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2012 5:23 pm

Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.01 ADMITTING						5.01
5.02 OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00 OPERATION OF PLANT						7.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA	486,112					11.00
13.00 NURSING ADMINISTRATION	17,328	413,064				13.00
14.00 CENTRAL SERVICES & SUPPLY	10,244	0	748,731			14.00
15.00 PHARMACY	0	0	1,549	895,711		15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	0	0	91,763	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	172,162	264,417	75,140	406	6,677	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	21,559	33,111	192,281	36,001	7,315	50.00
53.00 ANESTHESIOLOGY	0	0	13,774	0	315	53.00
54.00 RADIOLOGY-DIAGNOSTIC	46,175	0	28,134	173,837	20,822	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	325,957	102,961	20,151	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00 RESPIRATORY THERAPY	7,441	0	29,949	3,195	3,131	65.00
65.01 SLEEP LAB	0	0	2,305	0	1,136	65.01
66.00 PHYSICAL THERAPY	0	0	3,526	0	2,347	66.00
67.00 OCCUPATIONAL THERAPY	0	0	21	0	77	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	10	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	154	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	102	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	13,615	433,534	6,621	73.00
76.00 RADIOLOGY	0	0	0	0	0	76.00
76.97 CARDIAC REHABILITATION	1,223	0	217	0	235	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	10,703	16,438	1,976	0	440	90.00
91.00 EMERGENCY	64,523	99,098	35,010	4,220	12,146	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	134,754	0	25,277	141,557	10,084	95.00
99.10 CORF	0	0	0	0	0	99.10
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	486,112	413,064	748,731	895,711	91,763	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
194.02 PHARMACY	0	0	0	0	0	194.02
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)	486,112	413,064	748,731	895,711	91,763	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151302

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2012 5:23 pm

Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00 EMPLOYEE BENEFITS				4.00
5.01 ADMITTING				5.01
5.02 OTHER ADMINISTRATIVE AND GENERAL				5.02
7.00 OPERATION OF PLANT				7.00
9.00 HOUSEKEEPING				9.00
10.00 DIETARY				10.00
11.00 CAFETERIA				11.00
13.00 NURSING ADMINISTRATION				13.00
14.00 CENTRAL SERVICES & SUPPLY				14.00
15.00 PHARMACY				15.00
16.00 MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS	3,891,442	0	3,891,442	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	31.00
41.00 SUBPROVIDER - IRF	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	42.00
43.00 NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	1,404,281	0	1,404,281	50.00
53.00 ANESTHESIOLOGY	26,776	0	26,776	53.00
54.00 RADIOLOGY-DIAGNOSTIC	2,127,372	0	2,127,372	54.00
57.00 CT SCAN	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 LABORATORY	2,042,760	0	2,042,760	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
65.00 RESPIRATORY THERAPY	897,250	0	897,250	65.00
65.01 SLEEP LAB	85,072	0	85,072	65.01
66.00 PHYSICAL THERAPY	524,238	0	524,238	66.00
67.00 OCCUPATIONAL THERAPY	93,869	0	93,869	67.00
68.00 SPEECH PATHOLOGY	8,538	0	8,538	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	33,853	0	33,853	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	14,504	0	14,504	72.00
73.00 DRUGS CHARGED TO PATIENTS	540,149	0	540,149	73.00
76.00 CARDIOLOGY	0	0	0	76.00
76.97 CARDIAC REHABILITATION	40,946	0	40,946	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00 CLINIC	357,191	0	357,191	90.00
91.00 EMERGENCY	2,449,524	0	2,449,524	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 AMBULANCE SERVICES	1,855,658	0	1,855,658	95.00
99.10 CORF	0	0	0	99.10
101.00 HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS				
109.00 PANCREAS ACQUISITION	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	111.00
113.00 INTEREST EXPENSE				113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	16,393,423	0	16,393,423	118.00
NONREIMBURSABLE COST CENTERS				
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	28,946	0	28,946	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.00
194.01 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.01
194.02 PHARMACY	0	0	0	194.02
200.00 Cross Foot Adjustments	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	16,422,369	0	16,422,369	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151302

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

Worksheet B
Part II
Date/Time Prepared:
5/30/2012 5:23 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	0	0	0	0	4.00
5.01	ADMINISTRATIVE	0	0	0	0	5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL	0	137,659	0	137,659	5.02
7.00	OPERATION OF PLANT	0	565,752	0	565,752	7.00
9.00	HOUSEKEEPING	0	25,169	0	25,169	9.00
10.00	DIETARY	0	24,846	0	24,846	10.00
11.00	CAFETERIA	0	65,849	0	65,849	11.00
13.00	NURSING ADMINISTRATION	0	5,493	0	5,493	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	28,903	0	28,903	14.00
15.00	PHARMACY	0	19,640	0	19,640	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	27,575	0	27,575	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	272,805	0	272,805	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	42.00
43.00	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	187,172	0	187,172	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	145,558	0	145,558	54.00
57.00	CT SCAN	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	LABORATORY	0	39,711	0	39,711	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	29,801	0	29,801	65.00
65.01	SLEEP LAB	0	0	0	0	65.01
66.00	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	CARDIOLOGY	0	0	0	0	76.00
76.97	CARDIAC REHABILITATION	0	5,027	0	5,027	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	CLINIC	0	68,147	0	68,147	90.00
91.00	EMERGENCY	0	136,725	0	136,725	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	0	0	0	95.00
99.10	CORF	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	111.00
113.00	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,785,832	0	1,785,832	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,407	0	9,407	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.01
194.02	PHARMACY	0	0	0	0	194.02
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0		0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,795,239	0	1,795,239	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151302		Period: From 01/01/2011 To 12/31/2011		Worksheet B Part II Date/Time Prepared: 5/30/2012 5:23 pm	
Cost Center Description		ADMINITTING	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	
		5.01	5.02	7.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	ADMINITTING	0					5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL	0	137,659				5.02
7.00	OPERATION OF PLANT	0	12,250	578,002			7.00
9.00	HOUSEKEEPING	0	3,477	13,324	41,970		9.00
10.00	DIETARY	0	342	13,153	978	39,319	10.00
11.00	CAFETERIA	0	3,104	34,860	2,591		11.00
13.00	NURSING ADMINISTRATION	0	3,236	2,908	216		13.00
14.00	CENTRAL SERVICES & SUPPLY	0	5,764	15,301	1,137		14.00
15.00	PHARMACY	0	7,206	10,397	773		15.00
16.00	MEDICAL RECORDS & LIBRARY	0	363	14,598	1,085		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	23,542	144,421	10,733	39,319	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	6,578	99,087	7,365	0	50.00
53.00	ANESTHESIOLOGY	0	106	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	13,432	77,057	5,727	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	12,773	21,022	1,563	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	6,715	15,776	1,173	0	65.00
65.01	SLEEP LAB	0	684	0	0	0	65.01
66.00	PHYSICAL THERAPY	0	4,345	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	786	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	71	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	282	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	121	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	724	0	0	0	73.00
76.00	CARDIOLOGY	0	0	0	0	0	76.00
76.97	CARDIAC REHABILITATION	0	255	2,661	198	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	1,742	36,076	2,681	0	90.00
91.00	EMERGENCY	0	16,715	72,381	5,380	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	0	12,942	0	0	0	95.00
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	137,555	573,022	41,600	39,319	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	104	4,980	370	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
194.02	PHARMACY	0	0	0	0	0	194.02
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)	0	137,659	578,002	41,970	39,319	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151302		Period: From 01/01/2011 To 12/31/2011		Worksheet B Part II Date/Time Prepared: 5/30/2012 5:23 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	ADMINITTING						5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	OPERATION OF PLANT						7.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	106,404					11.00
13.00	NURSING ADMINISTRATION	3,793	15,646				13.00
14.00	CENTRAL SERVICES & SUPPLY	2,242	0	53,347			14.00
15.00	PHARMACY	0	0	110	38,126		15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	43,621	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	37,684	10,015	5,354	17	3,175	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	4,719	1,254	13,700	1,532	3,479	50.00
53.00	ANESTHESIOLOGY	0	0	981	0	150	53.00
54.00	RADIOLOGY-DIAGNOSTIC	10,107	0	2,005	7,399	9,885	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	23,226	4,383	9,583	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	1,629	0	2,134	136	1,489	65.00
65.01	SLEEP LAB	0	0	164	0	540	65.01
66.00	PHYSICAL THERAPY	0	0	251	0	1,116	66.00
67.00	OCCUPATIONAL THERAPY	0	0	1	0	36	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	5	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	73	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	49	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	970	18,454	3,149	73.00
76.00	CARDIOLOGY	0	0	0	0	0	76.00
76.97	CARDIAC REHABILITATION	268	0	15	0	112	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	2,343	623	141	0	209	90.00
91.00	EMERGENCY	14,123	3,754	2,494	180	5,776	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	29,496	0	1,801	6,025	4,795	95.00
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	106,404	15,646	53,347	38,126	43,621	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
194.02	PHARMACY	0	0	0	0	0	194.02
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)	106,404	15,646	53,347	38,126	43,621	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet B Part II Date/Time Prepared: 5/30/2012 5:23 pm
-------------------------------------	--	----------------------	---	--

Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00 EMPLOYEE BENEFITS				4.00
5.01 ADMITTING				5.01
5.02 OTHER ADMINISTRATIVE AND GENERAL				5.02
7.00 OPERATION OF PLANT				7.00
9.00 HOUSEKEEPING				9.00
10.00 DIETARY				10.00
11.00 CAFETERIA				11.00
13.00 NURSING ADMINISTRATION				13.00
14.00 CENTRAL SERVICES & SUPPLY				14.00
15.00 PHARMACY				15.00
16.00 MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS	547,065	0	547,065	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	31.00
41.00 SUBPROVIDER - IRF	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	42.00
43.00 NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	324,886	0	324,886	50.00
53.00 ANESTHESIOLOGY	1,237	0	1,237	53.00
54.00 RADIOLOGY-DIAGNOSTIC	271,170	0	271,170	54.00
57.00 CT SCAN	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 LABORATORY	112,261	0	112,261	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
65.00 RESPIRATORY THERAPY	58,853	0	58,853	65.00
65.01 SLEEP LAB	1,388	0	1,388	65.01
66.00 PHYSICAL THERAPY	5,712	0	5,712	66.00
67.00 OCCUPATIONAL THERAPY	823	0	823	67.00
68.00 SPEECH PATHOLOGY	76	0	76	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	355	0	355	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	170	0	170	72.00
73.00 DRUGS CHARGED TO PATIENTS	23,297	0	23,297	73.00
76.00 CARDIOLOGY	0	0	0	76.00
76.97 CARDIAC REHABILITATION	8,536	0	8,536	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00 CLINIC	111,962	0	111,962	90.00
91.00 EMERGENCY	257,528	0	257,528	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 AMBULANCE SERVICES	55,059	0	55,059	95.00
99.10 CORF	0	0	0	99.10
101.00 HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS				
109.00 PANCREAS ACQUISITION	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	111.00
113.00 INTEREST EXPENSE				113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1,780,378	0	1,780,378	118.00
NONREIMBURSABLE COST CENTERS				
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,861	0	14,861	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.00
194.01 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.01
194.02 PHARMACY	0	0	0	194.02
200.00 Cross Foot Adjustments	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	1,795,239	0	1,795,239	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151302

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

Worksheet B-1
Date/Time Prepared:
5/30/2012 5:23 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	Reconciliation	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT	50,000					1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		50,000				2.00
4.00 EMPLOYEE BENEFITS	0	0	5,582,006			4.00
5.01 ADMITTING	0	0	109,464	39,386,501		5.01
5.02 OTHER ADMINISTRATIVE AND GENERAL	3,834	3,834	379,363	0	-3,963,474	5.02
7.00 OPERATION OF PLANT	15,757	15,757	116,790	0	0	7.00
9.00 HOUSEKEEPING	701	701	151,239	0	0	9.00
10.00 DIETARY	692	692	39,337	0	0	10.00
11.00 CAFETERIA	1,834	1,834	104,332	0	0	11.00
13.00 NURSING ADMINISTRATION	153	153	238,560	0	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	805	805	59,023	0	0	14.00
15.00 PHARMACY	547	547	441	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	768	768	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	7,598	7,598	1,549,914	2,865,682	0	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	5,213	5,213	274,605	3,139,503	0	50.00
53.00 ANESTHESIOLOGY	0	0	0	135,183	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	4,054	4,054	444,371	8,939,178	0	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	1,106	1,106	0	8,648,616	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00 RESPIRATORY THERAPY	830	830	103,810	1,343,883	0	65.00
65.01 SLEEP LAB	0	0	0	487,616	0	65.01
66.00 PHYSICAL THERAPY	0	0	0	1,007,402	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	112	32,931	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	4,222	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	66,159	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	43,870	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	2,841,658	0	73.00
76.00 CARDIOLOGY	0	0	0	0	0	76.00
76.97 CARDIAC REHABILITATION	140	140	13,648	100,682	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	1,898	1,898	74,801	188,941	0	90.00
91.00 EMERGENCY	3,808	3,808	1,066,221	5,212,959	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	0	0	855,975	4,328,016	0	95.00
99.10 CORF	0	0	0	0	0	99.10
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	49,738	49,738	5,582,006	39,386,501	-3,963,474	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	262	262	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
194.02 PHARMACY	0	0	0	0	0	194.02
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	1,795,239	0	279,700	636,616		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	35.904780	0.000000	0.050107	0.016163		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			0	0		204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000000	0.000000		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151302

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

Worksheet B-1

Date/Time Prepared:
5/30/2012 5:23 pm

Cost Center Description	OTHER	OPERATION OF	HOUSEKEEPING	DIETARY	CAFETERIA	
	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	PLANT (SQUARE FEET)	(SQUARE FEET)	(MEALS SERVED)	(FTE'S)	
	5.02	7.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.01 ADMIN TTING						5.01
5.02 OTHER ADMINISTRATIVE AND GENERAL	12,458,895					5.02
7.00 OPERATION OF PLANT	1,108,703	30,409				7.00
9.00 HOUSEKEEPING	314,699	701	29,708			9.00
10.00 DIETARY	30,985	692	692	100		10.00
11.00 CAFETERIA	280,918	1,834	1,834	0	9,538	11.00
13.00 NURSING ADMINISTRATION	292,896	153	153	0	340	13.00
14.00 CENTRAL SERVICES & SUPPLY	521,686	805	805	0	201	14.00
15.00 PHARMACY	652,151	547	547	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	32,819	768	768	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,130,480	7,598	7,598	100	3,378	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	595,380	5,213	5,213	0	423	50.00
53.00 ANESTHESIOLOGY	9,625	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	1,215,646	4,054	4,054	0	906	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	1,156,068	1,106	1,106	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00 RESPIRATORY THERAPY	607,770	830	830	0	146	65.00
65.01 SLEEP LAB	61,930	0	0	0	0	65.01
66.00 PHYSICAL THERAPY	393,260	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	71,140	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	6,470	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	25,566	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	10,926	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	65,532	0	0	0	0	73.00
76.00 RADIOLOGY	0	0	0	0	0	76.00
76.97 CARDIAC REHABILITATION	23,085	140	140	0	24	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	157,622	1,898	1,898	0	210	90.00
91.00 EMERGENCY	1,512,780	3,808	3,808	0	1,266	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	1,171,351	0	0	0	2,644	95.00
99.10 CORF	0	0	0	0	0	99.10
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	12,449,488	30,147	29,446	100	9,538	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,407	262	262	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.01
194.02 PHARMACY	0	0	0	0	0	194.02
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)	3,963,474	1,461,408	448,501	84,545	486,112	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.318124	48.058404	15.096977	845.450000	50.965821	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	137,659	578,002	41,970	39,319	106,404	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.011049	19.007596	1.412751	393.190000	11.155798	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151302

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

Worksheet B-1

Date/Time Prepared:
5/30/2012 5:23 pm

Cost Center Description		NURSING ADMINISTRATION (FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.01	ADMITTING					5.01
5.02	OTHER ADMINISTRATIVE AND GENERAL					5.02
7.00	OPERATION OF PLANT					7.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION	5,277				13.00
14.00	CENTRAL SERVICES & SUPPLY	0	427,404			14.00
15.00	PHARMACY	0	884	97,008		15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	39,386,501	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,378	42,893	44	2,865,682	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	42.00
43.00	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	423	109,761	3,899	3,139,503	50.00
53.00	ANESTHESIOLOGY	0	7,863	0	135,183	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	16,060	18,827	8,939,178	54.00
57.00	CT SCAN	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	LABORATORY	0	186,068	11,151	8,648,616	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	17,096	346	1,343,883	65.00
65.01	SLEEP LAB	0	1,316	0	487,616	65.01
66.00	PHYSICAL THERAPY	0	2,013	0	1,007,402	66.00
67.00	OCCUPATIONAL THERAPY	0	12	0	32,931	67.00
68.00	SPEECH PATHOLOGY	0	0	0	4,222	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	66,159	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	43,870	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	7,772	46,953	2,841,658	73.00
76.00	CARDIOLOGY	0	0	0	0	76.00
76.97	CARDIAC REHABILITATION	0	124	0	100,682	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	CLINIC	210	1,128	0	188,941	90.00
91.00	EMERGENCY	1,266	19,985	457	5,212,959	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	14,429	15,331	4,328,016	95.00
99.10	CORF	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	111.00
113.00	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	5,277	427,404	97,008	39,386,501	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.01
194.02	PHARMACY	0	0	0	0	194.02
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)	413,064	748,731	895,711	91,763	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	78.276293	1.751811	9.233373	0.002330	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	15,646	53,347	38,126	43,621	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2.964942	0.124816	0.393019	0.001108	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151302

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

Worksheet C
Part I
Date/Time Prepared:
5/30/2012 5:23 pm

		Title XVIII		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS		3,891,442	0	0	30.00
31.00	INTENSIVE CARE UNIT		0	0	0	31.00
41.00	SUBPROVIDER - IRF		0	0	0	41.00
42.00	SUBPROVIDER		0	0	0	42.00
43.00	NURSERY		0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM		1,404,281	0	0	50.00
53.00	ANESTHESIOLOGY		26,776	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC		2,127,372	0	0	54.00
57.00	CT SCAN		0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00
59.00	CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	LABORATORY		2,042,760	0	0	60.00
60.01	BLOOD LABORATORY		0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	897,250	0	0	65.00
65.01	SLEEP LAB	0	85,072	0	0	65.01
66.00	PHYSICAL THERAPY	0	524,238	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	93,869	0	0	67.00
68.00	SPEECH PATHOLOGY	0	8,538	0	0	68.00
69.00	ELECTROCARDIOLOGY		0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		33,853	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT		14,504	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS		540,149	0	0	73.00
76.00	CARDIOLOGY		0	0	0	76.00
76.97	CARDIAC REHABILITATION		40,946	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC		0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
90.00	CLINIC		357,191	0	0	90.00
91.00	EMERGENCY		2,449,524	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		23,324	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES		1,855,658	0	0	95.00
99.10	CORF		0	0	0	99.10
101.00	HOME HEALTH AGENCY		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION		0	0	0	109.00
110.00	INTESTINAL ACQUISITION		0	0	0	110.00
111.00	ISLET ACQUISITION		0	0	0	111.00
113.00	INTEREST EXPENSE		0	0	0	113.00
200.00	Subtotal (see instructions)	0	16,416,747	0	0	200.00
201.00	Less Observation Beds		23,324	0	0	201.00
202.00	Total (see instructions)	0	16,393,423	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151302

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

Worksheet C
Part I
Date/Time Prepared:
5/30/2012 5:23 pm

		Title XVIII			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,865,682		2,865,682			30.00
31.00	INTENSIVE CARE UNIT	0		0			31.00
41.00	SUBPROVIDER - IRF	0		0			41.00
42.00	SUBPROVIDER	0		0			42.00
43.00	NURSERY	0		0			43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	868,746	2,270,757	3,139,503	0.447294	0.000000	50.00
53.00	ANESTHESIOLOGY	51,286	83,897	135,183	0.198072	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	523,731	8,415,448	8,939,179	0.237983	0.000000	54.00
57.00	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	LABORATORY	1,202,109	7,446,507	8,648,616	0.236195	0.000000	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000	62.00
65.00	RESPIRATORY THERAPY	534,846	809,037	1,343,883	0.667655	0.000000	65.00
65.01	SLEEP LAB	0	487,616	487,616	0.174465	0.000000	65.01
66.00	PHYSICAL THERAPY	164,614	842,788	1,007,402	0.520386	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	32,931	0	32,931	2.850475	0.000000	67.00
68.00	SPEECH PATHOLOGY	4,222	0	4,222	2.022264	0.000000	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	31,272	34,887	66,159	0.511692	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	4,720	39,150	43,870	0.330613	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,662,228	1,179,430	2,841,658	0.190082	0.000000	73.00
76.00	CARDIOLOGY	0	0	0	0.000000	0.000000	76.00
76.97	CARDIAC REHABILITATION	0	100,682	100,682	0.406686	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	CLINIC	0	188,941	188,941	1.890490	0.000000	90.00
91.00	EMERGENCY	183,579	5,029,380	5,212,959	0.469891	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	26,542	478,818	505,360	0.046153	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	8,829	4,319,188	4,328,017	0.428755	0.000000	95.00
99.10	CORF	0	0	0			99.10
101.00	HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS							
109.00	PANCREAS ACQUISITION	0	0	0			109.00
110.00	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	ISLET ACQUISITION	0	0	0			111.00
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	8,165,337	31,726,526	39,891,863			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	8,165,337	31,726,526	39,891,863			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/30/2012 5:23 pm
		Title XVIII	Hospital	Cost
Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS			30.00
31.00	INTENSIVE CARE UNIT			31.00
41.00	SUBPROVIDER - IRF			41.00
42.00	SUBPROVIDER			42.00
43.00	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.000000		50.00
53.00	ANESTHESIOLOGY	0.000000		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	CT SCAN	0.000000		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	LABORATORY	0.000000		60.00
60.01	BLOOD LABORATORY	0.000000		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	RESPIRATORY THERAPY	0.000000		65.00
65.01	SLEEP LAB	0.000000		65.01
66.00	PHYSICAL THERAPY	0.000000		66.00
67.00	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	SPEECH PATHOLOGY	0.000000		68.00
69.00	ELECTROCARDIOLOGY	0.000000		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	CARDIOLOGY	0.000000		76.00
76.97	CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	CLINIC	0.000000		90.00
91.00	EMERGENCY	0.000000		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	0.000000		95.00
99.10	CORF			99.10
101.00	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
109.00	PANCREAS ACQUISITION			109.00
110.00	INTESTINAL ACQUISITION			110.00
111.00	ISLET ACQUISITION			111.00
113.00	INTEREST EXPENSE			113.00
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: 151302

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

Worksheet C
Part I
Date/Time Prepared:
5/30/2012 5:23 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	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS		3,891,442	0	0	30.00	
31.00	INTENSIVE CARE UNIT		0	0	0	31.00	
41.00	SUBPROVIDER - IRF		0	0	0	41.00	
42.00	SUBPROVIDER		0	0	0	42.00	
43.00	NURSERY		0	0	0	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM		1,404,281	0	0	50.00	
53.00	ANESTHESIOLOGY		26,776	0	0	53.00	
54.00	RADIOLOGY-DIAGNOSTIC		2,127,372	0	0	54.00	
57.00	CT SCAN		0	0	0	57.00	
58.00	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00	
59.00	CARDIAC CATHETERIZATION		0	0	0	59.00	
60.00	LABORATORY		2,042,760	0	0	60.00	
60.01	BLOOD LABORATORY		0	0	0	60.01	
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	62.00	
65.00	RESPIRATORY THERAPY	0	897,250	0	0	65.00	
65.01	SLEEP LAB	0	85,072	0	0	65.01	
66.00	PHYSICAL THERAPY	0	524,238	0	0	66.00	
67.00	OCCUPATIONAL THERAPY	0	93,869	0	0	67.00	
68.00	SPEECH PATHOLOGY	0	8,538	0	0	68.00	
69.00	ELECTROCARDIOLOGY		0	0	0	69.00	
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		33,853	0	0	71.00	
72.00	IMPL. DEV. CHARGED TO PATIENT		14,504	0	0	72.00	
73.00	DRUGS CHARGED TO PATIENTS		540,149	0	0	73.00	
76.00	CARDIOLOGY		0	0	0	76.00	
76.97	CARDIAC REHABILITATION		40,946	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC		0	0	0	88.00	
89.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00	
90.00	CLINIC		357,191	0	0	90.00	
91.00	EMERGENCY		2,449,524	0	0	91.00	
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		23,324	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES		1,855,658	0	0	95.00	
99.10	CORF		0	0	0	99.10	
101.00	HOME HEALTH AGENCY		0	0	0	101.00	
SPECIAL PURPOSE COST CENTERS							
109.00	PANCREAS ACQUISITION		0	0	0	109.00	
110.00	INTESTINAL ACQUISITION		0	0	0	110.00	
111.00	ISLET ACQUISITION		0	0	0	111.00	
113.00	INTEREST EXPENSE		0	0	0	113.00	
200.00	Subtotal (see instructions)		16,416,747	0	0	200.00	
201.00	Less Observation Beds		23,324	0	0	201.00	
202.00	Total (see instructions)		16,393,423	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151302

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

Worksheet C
Part I
Date/Time Prepared:
5/30/2012 5:23 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				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,865,682		2,865,682			30.00
31.00	INTENSIVE CARE UNIT	0		0			31.00
41.00	SUBPROVIDER - IRF	0		0			41.00
42.00	SUBPROVIDER	0		0			42.00
43.00	NURSERY	0		0			43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	868,746	2,270,757	3,139,503	0.447294	0.000000	50.00
53.00	ANESTHESIOLOGY	51,286	83,897	135,183	0.198072	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	523,731	8,415,448	8,939,179	0.237983	0.000000	54.00
57.00	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	LABORATORY	1,202,109	7,446,507	8,648,616	0.236195	0.000000	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000	62.00
65.00	RESPIRATORY THERAPY	534,846	809,037	1,343,883	0.667655	0.000000	65.00
65.01	SLEEP LAB	0	487,616	487,616	0.174465	0.000000	65.01
66.00	PHYSICAL THERAPY	164,614	842,788	1,007,402	0.520386	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	32,931	0	32,931	2.850475	0.000000	67.00
68.00	SPEECH PATHOLOGY	4,222	0	4,222	2.022264	0.000000	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	31,272	34,887	66,159	0.511692	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	4,720	39,150	43,870	0.330613	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,662,228	1,179,430	2,841,658	0.190082	0.000000	73.00
76.00	CARDIOLOGY	0	0	0	0.000000	0.000000	76.00
76.97	CARDIAC REHABILITATION	0	100,682	100,682	0.406686	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	CLINIC	0	188,941	188,941	1.890490	0.000000	90.00
91.00	EMERGENCY	183,579	5,029,380	5,212,959	0.469891	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	26,542	478,818	505,360	0.046153	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	8,829	4,319,188	4,328,017	0.428755	0.000000	95.00
99.10	CORF	0	0	0			99.10
101.00	HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS							
109.00	PANCREAS ACQUISITION	0	0	0			109.00
110.00	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	ISLET ACQUISITION	0	0	0			111.00
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	8,165,337	31,726,526	39,891,863			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	8,165,337	31,726,526	39,891,863			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/30/2012 5:23 pm
		Title XIX	Hospital	Cost
Cost Center Description	PPS Inpatient Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS			30.00
31.00	INTENSIVE CARE UNIT			31.00
41.00	SUBPROVIDER - IRF			41.00
42.00	SUBPROVIDER			42.00
43.00	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.000000		50.00
53.00	ANESTHESIOLOGY	0.000000		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	CT SCAN	0.000000		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	LABORATORY	0.000000		60.00
60.01	BLOOD LABORATORY	0.000000		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	RESPIRATORY THERAPY	0.000000		65.00
65.01	SLEEP LAB	0.000000		65.01
66.00	PHYSICAL THERAPY	0.000000		66.00
67.00	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	SPEECH PATHOLOGY	0.000000		68.00
69.00	ELECTROCARDIOLOGY	0.000000		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	CARDIOLOGY	0.000000		76.00
76.97	CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	CLINIC	0.000000		90.00
91.00	EMERGENCY	0.000000		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	0.000000		95.00
99.10	CORF			99.10
101.00	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
109.00	PANCREAS ACQUISITION			109.00
110.00	INTESTINAL ACQUISITION			110.00
111.00	ISLET ACQUISITION			111.00
113.00	INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part II Date/Time Prepared: 5/30/2012 5:23 pm
--	--	----------------------	---	--

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							
50.00	OPERATING ROOM	324,886	3,139,503	0.103483	261,738	27,085	50.00
53.00	ANESTHESIOLOGY	1,237	135,183	0.009151	14,144	129	53.00
54.00	RADIOLOGY-DIAGNOSTIC	271,170	8,939,179	0.030335	174,774	5,302	54.00
57.00	CT SCAN	0	0	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	LABORATORY	112,261	8,648,616	0.012980	551,332	7,156	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
65.00	RESPIRATORY THERAPY	58,853	1,343,883	0.043793	220,122	9,640	65.00
65.01	SLEEP LAB	1,388	487,616	0.002847	0	0	65.01
66.00	PHYSICAL THERAPY	5,712	1,007,402	0.005670	22,523	128	66.00
67.00	OCCUPATIONAL THERAPY	823	32,931	0.024992	3,514	88	67.00
68.00	SPEECH PATHOLOGY	76	4,222	0.018001	1,814	33	68.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	355	66,159	0.005366	11,625	62	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	170	43,870	0.003875	189	1	72.00
73.00	DRUGS CHARGED TO PATIENTS	23,297	2,841,658	0.008198	670,361	5,496	73.00
76.00	CARDIOLOGY	0	0	0.000000	0	0	76.00
76.97	CARDIAC REHABILITATION	8,536	100,682	0.084782	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	CLINIC	111,962	188,941	0.592577	0	0	90.00
91.00	EMERGENCY	257,528	5,212,959	0.049402	68,793	3,399	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	505,360	0.000000	7,686	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	1,178,254	32,698,164		2,008,615	58,519	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151302

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

Worksheet D
Part IV
Date/Time Prepared:
5/30/2012 5:23 pm

Cost Center Description		Title XVIII				Hospital		Total Cost (sum of col 1 through col. 4)
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	OPERATING ROOM	0	0	0	0	0	50.00	
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
57.00	CT SCAN	0	0	0	0	0	57.00	
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00	LABORATORY	0	0	0	0	0	60.00	
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01	
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00	
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00	
65.01	SLEEP LAB	0	0	0	0	0	65.01	
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00	
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00	
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
76.00	CARDIOLOGY	0	0	0	0	0	76.00	
76.97	CARDIAC REHABILITATION	0	0	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS								
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00	
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00	
90.00	CLINIC	0	0	0	0	0	90.00	
91.00	EMERGENCY	0	0	0	0	0	91.00	
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS								
95.00	AMBULANCE SERVICES						95.00	
200.00	Total (Lines 50-199)	0	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/30/2012 5:23 pm
--	----------------------	---------------------------------------	---

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	3,139,503	0.000000	0.000000	261,738	50.00
53.00	ANESTHESIOLOGY	0	135,183	0.000000	0.000000	14,144	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	8,939,179	0.000000	0.000000	174,774	54.00
57.00	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	LABORATORY	0	8,648,616	0.000000	0.000000	551,332	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000	0	62.00
65.00	RESPIRATORY THERAPY	0	1,343,883	0.000000	0.000000	220,122	65.00
65.01	SLEEP LAB	0	487,616	0.000000	0.000000	0	65.01
66.00	PHYSICAL THERAPY	0	1,007,402	0.000000	0.000000	22,523	66.00
67.00	OCCUPATIONAL THERAPY	0	32,931	0.000000	0.000000	3,514	67.00
68.00	SPEECH PATHOLOGY	0	4,222	0.000000	0.000000	1,814	68.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	66,159	0.000000	0.000000	11,625	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	43,870	0.000000	0.000000	189	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	2,841,658	0.000000	0.000000	670,361	73.00
76.00	CARDIOLOGY	0	0	0.000000	0.000000	0	76.00
76.97	CARDIAC REHABILITATION	0	100,682	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	CLINIC	0	188,941	0.000000	0.000000	0	90.00
91.00	EMERGENCY	0	5,212,959	0.000000	0.000000	68,793	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	505,360	0.000000	0.000000	7,686	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	0	32,698,164			2,008,615	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151302

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

Worksheet D
Part IV
Date/Time Prepared:
5/30/2012 5:23 pm

Cost Center Description		Title XVIII			Hospital	Cost	
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	SLEEP LAB	0	0	0	0	0	65.01
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	CARDIOLOGY	0	0	0	0	0	76.00
76.97	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/30/2012 5:23 pm
--	----------------------	---	--

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Cost
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	0	50.00
53.00	ANESTHESIOLOGY	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	CT SCAN	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	0	0	60.00
60.01	BLOOD LABORATORY	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	RESPIRATORY THERAPY	0	0	65.00
65.01	SLEEP LAB	0	0	65.01
66.00	PHYSICAL THERAPY	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	CARDIOLOGY	0	0	76.00
76.97	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	CLINIC	0	0	90.00
91.00	EMERGENCY	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES			95.00
200.00	Total (Lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/30/2012 5:23 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see instructions)	Charges			
			Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
	1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.447294	0	700,254	0	50.00
53.00	ANESTHESIOLOGY	0.198072	0	22,371	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.237983	0	2,340,529	0	54.00
57.00	CT SCAN	0.000000	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	LABORATORY	0.236195	0	2,502,741	0	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0.667655	0	395,465	0	65.00
65.01	SLEEP LAB	0.174465	0	181,724	0	65.01
66.00	PHYSICAL THERAPY	0.520386	0	315,164	0	66.00
67.00	OCCUPATIONAL THERAPY	2.850475	0	0	0	67.00
68.00	SPEECH PATHOLOGY	2.022264	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.511692	0	4,414	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.330613	0	10,692	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.190082	0	316,682	4,074	73.00
76.00	CARDIOLOGY	0.000000	0	0	0	76.00
76.97	CARDIAC REHABILITATION	0.406686	0	35,834	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000				88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00	CLINIC	1.890490	0	150,543	0	90.00
91.00	EMERGENCY	0.469891	0	1,244,745	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.046153	0	224,114	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0.428755		0		95.00
200.00	Subtotal (see instructions)		0	8,445,272	4,074	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	8,445,272	4,074	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/30/2012 5:23 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	313,219	0		50.00
53.00 ANESTHESIOLOGY	0	4,431	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	557,006	0		54.00
57.00 CT SCAN	0	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00 LABORATORY	0	591,135	0		60.00
60.01 BLOOD LABORATORY	0	0	0		60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
65.00 RESPIRATORY THERAPY	0	264,034	0		65.00
65.01 SLEEP LAB	0	31,704	0		65.01
66.00 PHYSICAL THERAPY	0	164,007	0		66.00
67.00 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	0	0	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,259	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	3,535	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	60,196	774		73.00
76.00 RADIOLOGY	0	0	0		76.00
76.97 CARDIAC REHABILITATION	0	14,573	0		76.97
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00 CLINIC	0	284,600	0		90.00
91.00 EMERGENCY	0	584,894	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	10,344	0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES		0			95.00
200.00 Subtotal (see instructions)	0	2,885,937	774		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	2,885,937	774		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151302 Component CCN: 15Z302	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/30/2012 5:23 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	
	1.00	2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.447294	0	0	0	50.00
53.00 ANESTHESIOLOGY	0.198072	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.237983	0	0	0	54.00
57.00 CT SCAN	0.000000	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00 LABORATORY	0.236195	0	0	0	60.00
60.01 BLOOD LABORATORY	0.000000	0	0	0	60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	62.00
65.00 RESPIRATORY THERAPY	0.667655	0	0	0	65.00
65.01 SLEEP LAB	0.174465	0	0	0	65.01
66.00 PHYSICAL THERAPY	0.520386	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	2.850475	0	0	0	67.00
68.00 SPEECH PATHOLOGY	2.022264	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.511692	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.330613	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.190082	0	0	0	73.00
76.00 RADIOLOGY	0.000000	0	0	0	76.00
76.97 CARDIAC REHABILITATION	0.406686	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0.000000				88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00 CLINIC	1.890490	0	0	0	90.00
91.00 EMERGENCY	0.469891	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.046153	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES	0.428755		0		95.00
200.00 Subtotal (see instructions)		0	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151302 Component CCN: 15Z302	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/30/2012 5:23 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	0	0		50.00
53.00 ANESTHESIOLOGY	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00 CT SCAN	0	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00 LABORATORY	0	0	0		60.00
60.01 BLOOD LABORATORY	0	0	0		60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
65.00 RESPIRATORY THERAPY	0	0	0		65.00
65.01 SLEEP LAB	0	0	0		65.01
66.00 PHYSICAL THERAPY	0	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	0	0	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00 CARDIOLOGY	0	0	0		76.00
76.97 CARDIAC REHABILITATION	0	0	0		76.97
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00 CLINIC	0	0	0		90.00
91.00 EMERGENCY	0	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES		0			95.00
200.00 Subtotal (see instructions)	0	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part I Date/Time Prepared: 5/30/2012 5:23 pm
--	----------------------	---	---

Cost Center Description	Title XIX			Hospital	Cost	
	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	547,065	0	547,065	1,946	281.12	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0.00	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00 SUBPROVIDER	0	0	0	0	0.00	42.00
43.00 NURSERY	0	0	0	0	0.00	43.00
200.00 Total (lines 30-199)	547,065		547,065	1,946		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151302		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part I Date/Time Prepared: 5/30/2012 5:23 pm	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Title XIX Hospital		Cost	
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	117	32,891			30.00	
31.00	INTENSIVE CARE UNIT	0	0			31.00	
41.00	SUBPROVIDER - IRF	0	0			41.00	
42.00	SUBPROVIDER	0	0			42.00	
43.00	NURSERY	0	0			43.00	
200.00	Total (lines 30-199)	117	32,891			200.00	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part II Date/Time Prepared: 5/30/2012 5:23 pm
--	--	----------------------	---	--

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							
50.00	OPERATING ROOM	324,886	3,139,503	0.103483	67,089	6,943	50.00
53.00	ANESTHESIOLOGY	1,237	135,183	0.009151	4,081	37	53.00
54.00	RADIOLOGY-DIAGNOSTIC	271,170	8,939,179	0.030335	32,496	986	54.00
57.00	CT SCAN	0	0	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	LABORATORY	112,261	8,648,616	0.012980	77,071	1,000	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
65.00	RESPIRATORY THERAPY	58,853	1,343,883	0.043793	24,622	1,078	65.00
65.01	SLEEP LAB	1,388	487,616	0.002847	0	0	65.01
66.00	PHYSICAL THERAPY	5,712	1,007,402	0.005670	324	2	66.00
67.00	OCCUPATIONAL THERAPY	823	32,931	0.024992	0	0	67.00
68.00	SPEECH PATHOLOGY	76	4,222	0.018001	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	355	66,159	0.005366	588	3	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	170	43,870	0.003875	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	23,297	2,841,658	0.008198	100,215	822	73.00
76.00	CARDIOLOGY	0	0	0.000000	0	0	76.00
76.97	CARDIAC REHABILITATION	8,536	100,682	0.084782	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	CLINIC	111,962	188,941	0.592577	0	0	90.00
91.00	EMERGENCY	257,528	5,212,959	0.049402	25,181	1,244	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	505,360	0.000000	3,601	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	1,178,254	32,698,164		335,268	12,115	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151302		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part III Date/Time Prepared: 5/30/2012 5:23 pm	
Cost Center Description		Title XIX		Hospital		Cost	
		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
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	0	0	0	0	0	43.00
200.00	Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part III Date/Time Prepared: 5/30/2012 5:23 pm
---	----------------------	---	---

Cost Center Description	Title XIX					Hospital		Cost	
	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School				
	6.00	7.00	8.00	9.00	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	ADULTS & PEDIATRICS	1,946	0.00	117	0	0	0	30.00	
31.00	INTENSIVE CARE UNIT	0	0.00	0	0	0	0	31.00	
41.00	SUBPROVIDER - IRF	0	0.00	0	0	0	0	41.00	
42.00	SUBPROVIDER	0	0.00	0	0	0	0	42.00	
43.00	NURSERY	0	0.00	0	0	0	0	43.00	
200.00	Total (lines 30-199)	1,946		117	0	0	0	200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151302		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part III Date/Time Prepared: 5/30/2012 5:23 pm	
Cost Center Description		PSA Adj . Allied Health Cost	PSA Adj . All Other Medical Education Cost	Title XIX		Hospital Cost	
		12.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0			30.00	
31.00	INTENSIVE CARE UNIT	0	0			31.00	
41.00	SUBPROVIDER - IRF	0	0			41.00	
42.00	SUBPROVIDER	0	0			42.00	
43.00	NURSERY	0	0			43.00	
200.00	Total (lines 30-199)	0	0			200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151302

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

Worksheet D
Part IV
Date/Time Prepared:
5/30/2012 5:23 pm

Cost Center Description		Title XIX				Hospital		Total Cost (sum of col 1 through col. 4)
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	OPERATING ROOM	0	0	0	0	0	50.00	
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
57.00	CT SCAN	0	0	0	0	0	57.00	
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00	LABORATORY	0	0	0	0	0	60.00	
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01	
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00	
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00	
65.01	SLEEP LAB	0	0	0	0	0	65.01	
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00	
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00	
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
76.00	CARDIOLOGY	0	0	0	0	0	76.00	
76.97	CARDIAC REHABILITATION	0	0	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS								
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00	
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00	
90.00	CLINIC	0	0	0	0	0	90.00	
91.00	EMERGENCY	0	0	0	0	0	91.00	
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS								
95.00	AMBULANCE SERVICES						95.00	
200.00	Total (Lines 50-199)	0	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151302

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

Worksheet D
Part IV
Date/Time Prepared:
5/30/2012 5:23 pm

Cost Center Description		Title XIX			Hospital		Cost
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	3,139,503	0.000000	0.000000	67,089	50.00
53.00	ANESTHESIOLOGY	0	135,183	0.000000	0.000000	4,081	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	8,939,179	0.000000	0.000000	32,496	54.00
57.00	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	LABORATORY	0	8,648,616	0.000000	0.000000	77,071	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000	0	62.00
65.00	RESPIRATORY THERAPY	0	1,343,883	0.000000	0.000000	24,622	65.00
65.01	SLEEP LAB	0	487,616	0.000000	0.000000	0	65.01
66.00	PHYSICAL THERAPY	0	1,007,402	0.000000	0.000000	324	66.00
67.00	OCCUPATIONAL THERAPY	0	32,931	0.000000	0.000000	0	67.00
68.00	SPEECH PATHOLOGY	0	4,222	0.000000	0.000000	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	66,159	0.000000	0.000000	588	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	43,870	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	2,841,658	0.000000	0.000000	100,215	73.00
76.00	CARDIOLOGY	0	0	0.000000	0.000000	0	76.00
76.97	CARDIAC REHABILITATION	0	100,682	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	CLINIC	0	188,941	0.000000	0.000000	0	90.00
91.00	EMERGENCY	0	5,212,959	0.000000	0.000000	25,181	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	505,360	0.000000	0.000000	3,601	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	0	32,698,164			335,268	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151302

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

Worksheet D
Part IV
Date/Time Prepared:
5/30/2012 5:23 pm

Cost Center Description		Title XIX			Hospital	Cost	
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	SLEEP LAB	0	0	0	0	0	65.01
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	CARDIOLOGY	0	0	0	0	0	76.00
76.97	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151302

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

Worksheet D
Part IV
Date/Time Prepared:
5/30/2012 5:23 pm

Cost Center Description		PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	Title XIX	Hospital	Cost
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0			50.00
53.00	ANESTHESIOLOGY	0	0			53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0			54.00
57.00	CT SCAN	0	0			57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
59.00	CARDIAC CATHETERIZATION	0	0			59.00
60.00	LABORATORY	0	0			60.00
60.01	BLOOD LABORATORY	0	0			60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0			62.00
65.00	RESPIRATORY THERAPY	0	0			65.00
65.01	SLEEP LAB	0	0			65.01
66.00	PHYSICAL THERAPY	0	0			66.00
67.00	OCCUPATIONAL THERAPY	0	0			67.00
68.00	SPEECH PATHOLOGY	0	0			68.00
69.00	ELECTROCARDIOLOGY	0	0			69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0			72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0			73.00
76.00	CARDIOLOGY	0	0			76.00
76.97	CARDIAC REHABILITATION	0	0			76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0			89.00
90.00	CLINIC	0	0			90.00
91.00	EMERGENCY	0	0			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES					95.00
200.00	Total (Lines 50-199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/30/2012 5:23 pm
		Title XIX	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost	
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
	1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.447294	0	132,332	0	50.00
53.00	ANESTHESIOLOGY	0.198072	0	4,414	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.237983	0	458,540	0	54.00
57.00	CT SCAN	0.000000	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	LABORATORY	0.236195	0	410,996	0	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0.667655	0	41,264	0	65.00
65.01	SLEEP LAB	0.174465	0	22,310	0	65.01
66.00	PHYSICAL THERAPY	0.520386	0	38,036	0	66.00
67.00	OCCUPATIONAL THERAPY	2.850475	0	0	0	67.00
68.00	SPEECH PATHOLOGY	2.022264	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.511692	0	4,910	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.330613	0	7,037	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.190082	0	78,592	0	73.00
76.00	CARDIOLOGY	0.000000	0	0	0	76.00
76.97	CARDIAC REHABILITATION	0.406686	0	8,085	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000				88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00	CLINIC	1.890490	0	4,289	0	90.00
91.00	EMERGENCY	0.469891	0	338,742	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.046153	0	17,371	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0.428755	0	347,474		95.00
200.00	Subtotal (see instructions)		0	1,914,392	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	1,914,392	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/30/2012 5:23 pm
	Title XIX	Hospital	Cost

Cost Center Description	Costs			
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)	
	5.00	6.00	7.00	
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	59,191	0	50.00
53.00 ANESTHESIOLOGY	0	874	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	109,125	0	54.00
57.00 CT SCAN	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 LABORATORY	0	97,075	0	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
65.00 RESPIRATORY THERAPY	0	27,550	0	65.00
65.01 SLEEP LAB	0	3,892	0	65.01
66.00 PHYSICAL THERAPY	0	19,793	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,512	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	2,327	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	14,939	0	73.00
76.00 CARDIOLOGY	0	0	0	76.00
76.97 CARDIAC REHABILITATION	0	3,288	0	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00 CLINIC	0	8,108	0	90.00
91.00 EMERGENCY	0	159,172	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	802	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 AMBULANCE SERVICES		148,981		95.00
200.00 Subtotal (see instructions)	0	657,629	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	657,629	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/30/2012 5:23 pm
Cost Center Description		Cost		
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,170	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,946	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,946	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		1,224	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,217	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)		1,224	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,891,442	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)		1,502,558	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,388,884	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,157,181	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,157,181	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.107410	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,108.52	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,388,884	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,227.58	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,493,965	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,493,965	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/30/2012 5:23 pm	
Cost Center Description			Title XVIII		Hospital	Cost
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				630,177	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				2,124,142	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges				0	54.00
55.00	Target amount per discharge				0.00	55.00
56.00	Target amount (line 54 x line 55)				0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0	57.00
58.00	Bonus payment (see instructions)				0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0	61.00
62.00	Relief payment (see instructions)				0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				1,502,558	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)				1,502,558	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)				19	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,227.59	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				23,324	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151302

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

Worksheet D-1
Date/Time Prepared:
5/30/2012 5:23 pm

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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/30/2012 5:23 pm
Cost Center Description				Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,170	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,946	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,946	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)		117	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,891,442	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)		3,891,442	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,157,181	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,157,181	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.803948	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,108.52	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,891,442	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,999.71	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		233,966	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)		233,966	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/30/2012 5:23 pm	
Cost Center Description			Title XIX	Hospital	Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				104,710	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				338,676	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges				0	54.00
55.00	Target amount per discharge				0.00	55.00
56.00	Target amount (line 54 x line 55)				0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0	57.00
58.00	Bonus payment (see instructions)				0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0	61.00
62.00	Relief payment (see instructions)				0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)				19	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,999.71	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				37,994	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151302

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

Worksheet D-1
Date/Time Prepared:
5/30/2012 5:23 pm

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/30/2012 5:23 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		1,436,003		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.447294	261,738	117,074	50.00
53.00	ANESTHESIOLOGY	0.198072	14,144	2,802	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.237983	174,774	41,593	54.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.236195	551,332	130,222	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
65.00	RESPIRATORY THERAPY	0.667655	220,122	146,966	65.00
65.01	SLEEP LAB	0.174465	0	0	65.01
66.00	PHYSICAL THERAPY	0.520386	22,523	11,721	66.00
67.00	OCCUPATIONAL THERAPY	2.850475	3,514	10,017	67.00
68.00	SPEECH PATHOLOGY	2.022264	1,814	3,668	68.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.511692	11,625	5,948	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.330613	189	62	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.190082	670,361	127,424	73.00
76.00	CARDIOLOGY	0.000000	0	0	76.00
76.97	CARDIAC REHABILITATION	0.406686	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	1.890490	0	0	90.00
91.00	EMERGENCY	0.469891	68,793	32,325	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.046153	7,686	355	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		2,008,615	630,177	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		2,008,615		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3	
		Component CCN: 15Z302		Date/Time Prepared: 5/30/2012 5:23 pm	
		Title XVIII	Swing Beds - SNF	Cost	
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		640,193		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.447294	8,806	3,939	50.00
53.00	ANESTHESIOLOGY	0.198072	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.237983	94,516	22,493	54.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.236195	240,704	56,853	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
65.00	RESPIRATORY THERAPY	0.667655	184,377	123,100	65.00
65.01	SLEEP LAB	0.174465	0	0	65.01
66.00	PHYSICAL THERAPY	0.520386	123,626	64,333	66.00
67.00	OCCUPATIONAL THERAPY	2.850475	22,696	64,694	67.00
68.00	SPEECH PATHOLOGY	2.022264	2,351	4,754	68.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.511692	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.330613	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.190082	490,778	93,288	73.00
76.00	CARDIOLOGY	0.000000	0	0	76.00
76.97	CARDIAC REHABILITATION	0.406686	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	1.890490	0	0	90.00
91.00	EMERGENCY	0.469891	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.046153	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		1,167,854	433,454	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		1,167,854		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/30/2012 5:23 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		138,280		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.447294	67,089	30,009	50.00
53.00	ANESTHESIOLOGY	0.198072	4,081	808	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.237983	32,496	7,733	54.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.236195	77,071	18,204	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
65.00	RESPIRATORY THERAPY	0.667655	24,622	16,439	65.00
65.01	SLEEP LAB	0.174465	0	0	65.01
66.00	PHYSICAL THERAPY	0.520386	324	169	66.00
67.00	OCCUPATIONAL THERAPY	2.850475	0	0	67.00
68.00	SPEECH PATHOLOGY	2.022264	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.511692	588	301	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.330613	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.190082	100,215	19,049	73.00
76.00	CARDIOLOGY	0.000000	0	0	76.00
76.97	CARDIAC REHABILITATION	0.406686	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	CLINIC	1.890490	0	0	90.00
91.00	EMERGENCY	0.469891	25,181	11,832	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.046153	3,601	166	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		335,268	104,710	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		335,268		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3	
		Component CCN: 15Z302		Date/Time Prepared: 5/30/2012 5:23 pm	
		Title XIX	Swing Beds - SNF	Cost	
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		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.447294	0	0	50.00
53.00	ANESTHESIOLOGY	0.198072	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.237983	0	0	54.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.236195	0	0	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
65.00	RESPIRATORY THERAPY	0.667655	0	0	65.00
65.01	SLEEP LAB	0.174465	0	0	65.01
66.00	PHYSICAL THERAPY	0.520386	0	0	66.00
67.00	OCCUPATIONAL THERAPY	2.850475	0	0	67.00
68.00	SPEECH PATHOLOGY	2.022264	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.511692	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.330613	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.190082	0	0	73.00
76.00	CARDIOLOGY	0.000000	0	0	76.00
76.97	CARDIAC REHABILITATION	0.406686	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	CLINIC	1.890490	0	0	90.00
91.00	EMERGENCY	0.469891	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.046153	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		0	0	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)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/30/2012 5:23 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			2,886,711 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			2,886,711 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)			2,915,578 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			37,710 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,172,764 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			1,705,104 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			1,705,104 30.00
31.00	Primary payer payments			35 31.00
32.00	Subtotal (line 30 minus line 31)			1,705,069 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)			192,810 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			192,810 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			188,802 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			1,897,879 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			1,897,879 40.00
41.00	Interim payments			1,491,868 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)			406,011 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/30/2012 5:23 pm
	Title XVIII	Hospital	Cost
			Overrides
			1.00
WORKSHEET OVERRIDE VALUES			
112.00	Override of Ancillary service charges (line 12)		0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151302

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

Worksheet E-1
Part I
Date/Time Prepared:
5/30/2012 5:23 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,663,987		1,127,129	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	09/18/2011	77,918		317,771	3.01	
3.02		11/22/2011	10,457		46,968	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		88,375		364,739	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,752,362		1,491,868	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		166,159		406,011	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,918,521		1,897,879	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151302

Period: From 01/01/2011

Worksheet E-1

Component CCN: 15Z302

To 12/31/2011

Part I
Date/Time Prepared:
5/30/2012 5:23 pm

Title XVIII

Swing Beds - SNF

Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,691,314		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	09/19/2011	39,967		0	3.01
3.02		11/22/2011	17,763		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		57,730		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)		1,749,044		0	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		160,505		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,909,549		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 151302

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

Worksheet E-1
Part II
Date/Time Prepared:
5/30/2012 5:23 pm

		Title XVIII	Hospital	Cost	
				1.00	
DATA COLLECTION NEEDED FOR THE HIT CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			478	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			1,217	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2			83	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			1,927	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			39,891,863	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			0	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			495,160	7.00
8.00	Calculation of the HIT incentive payment (see instructions)			433,079	8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH					
30.00	Initial /interim HIT payment(s)			0	30.00
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 minus line 30, plus or minus line 31)			433,079	32.00
				Overrides	
				1.00	
CONTRACTOR OVERRIDES					
108.00	Override of HIT payment				108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151302

Period:

Worksheet E-2

Component CCN: 15Z302

From 01/01/2011
To 12/31/2011

Date/Time Prepared:
5/30/2012 5:23 pm

		Title XVIII		Swing Beds - SNF		Cost	
		Part A		Part B			
		1.00		2.00			
COMPUTATION OF NET COST OF COVERED SERVICES							
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,517,584		0			1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)						2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	437,789		0			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00			4.00
5.00	Program days	1,224		0			5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0			6.00
7.00	Utilization review - physician compensation - SNF optional method only	0					7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,955,373		0			8.00
9.00	Primary payer payments (see instructions)	0		0			9.00
10.00	Subtotal (line 8 minus line 9)	1,955,373		0			10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		0			11.00
12.00	Subtotal (line 10 minus line 11)	1,955,373		0			12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	49,949		0			13.00
14.00	80% of Part B costs (line 12 x 80%)			0			14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,905,424		0			15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		0			16.00
17.00	Reimbursable bad debts (see instructions)	4,125		0			17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	4,125		0			18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	1,909,549		0			19.00
20.00	Interim payments	1,749,044		0			20.00
21.00	Tentative settlement (for contractor use only)	0		0			21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	160,505		0			22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0		0			23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet E-2
		Component CCN: 15Z302	Date/Time Prepared: 5/30/2012 5:23 pm	
		Title XIX	Swing Beds - SNF	Cost
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	0		3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
17.00	Reimbursable bad debts (see instructions)	0		17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	0		19.00
20.00	Interim payments	0		20.00
21.00	Tentative settlement (for contractor use only)	0		21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	0		22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0		23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part V Date/Time Prepared: 5/30/2012 5:23 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services			2,124,142 1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 thru 3)			2,124,142 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5) . For CAH (see instructions)			2,145,383 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2,145,383 19.00
20.00	Deductibles (exclude professional component)			250,172 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			1,895,211 22.00
23.00	Coinsurance			2,547 23.00
24.00	Subtotal (line 22 minus line 23)			1,892,664 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			25,857 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			25,857 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			22,203 27.00
28.00	Subtotal (sum of lines 24 and 25 or 26)			1,918,521 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (line 28, plus or minus lines 29)			1,918,521 30.00
31.00	Interim payments			1,752,362 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)			166,159 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151302	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2012 5:23 pm
		Title XIX	Hospital	Cost
				1.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		338,676	1.00
2.00	Medical and other services		657,629	2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		996,305	4.00
5.00	Inpatient primary payer payments		0	5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		996,305	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		0	8.00
9.00	Ancillary service charges		2,249,660	9.00
10.00	Organ acquisition charges, net of revenue		0	10.00
11.00	Incentive from target amount computation		0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		2,249,660	12.00
CUSTOMARY CHRGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		2,249,660	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		1,253,355	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		996,305	21.00
PROSPECTIVE PAYMENT AMOUNT				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		0	23.00
24.00	Program capital payments		0	24.00
25.00	Capital exception payments (see instructions)		0	25.00
26.00	Routine and Ancillary service other pass through costs		0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX enter the sum of lines 27 and 21.		996,305	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		996,305	31.00
32.00	Deductibles		0	32.00
33.00	Coinsurance		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Utilization review		0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		996,305	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		996,305	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		996,305	40.00
41.00	Interim payments		0	41.00
42.00	Balance due provider/program (line 40 minus 41)		996,305	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	43.00

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

Provider CCN: 151302

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

Worksheet G
Date/Time Prepared:
5/30/2012 5:23 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-38,347	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	1,632,344	0	0	0	4.00
5.00	Other receivable	-223,185	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	181,023	0	0	0	7.00
8.00	Prepaid expenses	54,877	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	1,606,712	0	0	0	11.00
FIXED ASSETS						
12.00	Land	190,324	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	14,860,605	0	0	0	15.00
16.00	Accumulated depreciation	-4,868,656	0	0	0	16.00
17.00	Leasehold improvements	275,335	0	0	0	17.00
18.00	Accumulated depreciation	-152,037	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	5,388,593	0	0	0	23.00
24.00	Accumulated depreciation	-3,863,185	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	11,830,979	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	58,652	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	58,652	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	13,496,343	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	976,482	0	0	0	37.00
38.00	Salaries, wages, and fees payable	549,067	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	12,563	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,538,112	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	800,351	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	101,011	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	901,362	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,439,474	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	11,056,869				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	11,056,869	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	13,496,343	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151302

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

Worksheet G-1

Date/Time Prepared:
5/30/2012 5:23 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		8,604,696	
2.00	Net income (loss) (From Wkst. G-3, line 29)		2,452,173			2.00
3.00	Total (sum of line 1 and line 2)		11,056,869		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		11,056,869		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		11,056,869		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151302

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

Worksheet G-1

Date/Time Prepared:
5/30/2012 5:23 pm

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151302

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

Worksheet G-2 Parts

Date/Time Prepared:
5/30/2012 5:23 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,157,181		2,157,181	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	708,501		708,501	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,865,682		2,865,682	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,865,682		2,865,682	17.00
18.00	Ancillary services	5,290,825	27,218,396	32,509,221	18.00
19.00	Outpatient services	0	188,941	188,941	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	8,829	4,319,188	4,328,017	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,165,336	31,726,525	39,891,861	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		15,467,681		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		15,467,681		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151302

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

Worksheet G-3

Date/Time Prepared:
5/30/2012 5:23 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	39,891,861	1.00
2.00	Less contractual allowances and discounts on patients' accounts	24,106,079	2.00
3.00	Net patient revenues (line 1 minus line 2)	15,785,782	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	15,467,681	4.00
5.00	Net income from service to patients (line 3 minus line 4)	318,101	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	389,052	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	ER PHYSICIAN REVENUE	1,745,020	24.00
25.00	Total other income (sum of lines 6-24)	2,134,072	25.00
26.00	Total (line 5 plus line 25)	2,452,173	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,452,173	29.00