

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: 151313	Period: From 01/01/2011 To 12/31/2011	Worksheet S Parts I-III Date/Time Prepared: 5/10/2012 10:30 am
--	----------------------	---	---

<b>PART I - COST REPORT STATUS</b>			
Provider use only	1. <input type="checkbox"/> Electronically filed cost report	Date: 5/10/2012 Time: 10:30 am	
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
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: 4 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 WOODLAWN HOSPITAL for the cost reporting period beginning 01/01/2011 and ending 12/31/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) \_\_\_\_\_  
 Officer or Administrator of Provider(s)

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	50,716	-189,775	0	304,298	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	20,548	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	-1	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	71,264	-189,776	0	304,298	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: 151313		Period: From 01/01/2011 To 12/31/2011		Worksheet S-2 Part I Date/Time Prepared: 5/10/2012 10:26 am		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00 Street: 1400 EAST 9TH STREET		PO Box:		Zip Code: 46975-		County: FULTON				
2.00 City: ROCHESTER		State: IN								
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		
Hospital and Hospital-Based Component Identification:										
3.00 Hospital		WOODLAWN HOSPITAL	151313	99915	1	01/01/1966	N	O	O	3.00
4.00 Subprovider - IPF										4.00
5.00 Subprovider - IRF										5.00
6.00 Subprovider - (Other)										6.00
7.00 Swing Beds - SNF		WOODLAWN HOSPITAL SWINGBED	152313	99915		10/23/2001	N	O	N	7.00
8.00 Swing Beds - NF							N		N	8.00
9.00 Hospital-Based SNF										9.00
10.00 Hospital-Based NF										10.00
11.00 Hospital-Based OLTC										11.00
12.00 Hospital-Based HHA		WOODLAWN HOSPITAL HOME HEALTH	157104	99915		02/07/1984	N	P	N	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)								8		21.00
Inpatient PPS Information										
22.00 Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						N				22.00
23.00 Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.						3		N		23.00
		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00 If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.		0	0	0	0	0	0		24.00	
25.00 If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.		0	0	0	0	0	0		25.00	
						Urban/Rural S	Date of Geogr			
						1.00	2.00			
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.						1				26.00
27.00 For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification (in column 2).						1				27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0				35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151313	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/10/2012 10:26 am		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V 1.00	XVIII 2.00	XIX 3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
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	
<b>Teaching Hospitals</b>						
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	
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
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	
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
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: 151313		Period: From 01/01/2011 To 12/31/2011		Worksheet S-2 Part I Date/Time Prepared: 5/10/2012 10:26 am		
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
65.00	If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. Use subscripted lines 65.01 through 65.50 for each additional primary care program. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4.			0.00	0.00	0.000000		65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
				1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000		66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000		67.00
						1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N				70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0		71.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151313	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/10/2012 10:26 am		
			1.00	2.00	3.00	
<b>Inpatient Rehabilitation Facility PPS</b>						
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			
<b>Long Term Care Hospital PPS</b>						
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.			N	80.00	
<b>TEFRA Providers</b>						
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		
<b>Title V or XIX Inpatient Services</b>						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00	
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	97.00	
<b>Rural Providers</b>						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N		106.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00	
			Physical	Occupational	Speech	Respiratory
			1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		Y	N	N	N
			1.00		2.00	
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.		N		115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1	118.00	
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.		1,000,000	4,000,000	119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00	
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		121.00	
<b>Transplant Center Information</b>						
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: 151313		Period: From 01/01/2011 To 12/31/2011		Worksheet S-2 Part I Date/Time Prepared: 5/10/2012 10:26 am	
			1.00	2.00				
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.							134.00
All Providers								
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y					140.00
		1.00	2.00	3.00				
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.								
141.00	Name:	Contractor's Name:		Contractor's Number:				141.00
142.00	Street:	PO Box:						142.00
143.00	City:	State:		Zip Code:				143.00
							1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y					144.00
145.00	If costs for renal services are claimed on Worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N					145.00
							1.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N					146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N					147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N					148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N					149.00
				Part A	Part B			
				1.00	2.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital		N		N			155.00
156.00	Subprovider - IPF		N		N			156.00
157.00	Subprovider - IRF		N		N			157.00
158.00	SUBPROVIDER		N		N			158.00
159.00	SNF		N		N			159.00
160.00	HOME HEALTH AGENCY		N		N			160.00
161.00	CMHC				N			161.00
161.10	CORF				N			161.10
							1.00	
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N			165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							0168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151313	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part II Date/Time Prepared: 5/10/2012 10:26 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A			
		Description	Y/N	Date	
		0	1.00	2.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	02/17/2012		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N			20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151313	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part II Date/Time Prepared: 5/10/2012 10:26 am
---	--	----------------------	---	---

		Part A			
		Description	Y/N	Date	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	N	2.00	21.00
					1.00
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
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
<b>Interest Expense</b>					
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
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
<b>Provider-Based Physicians</b>					
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
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 151313

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
5/10/2012 10:26 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151313

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/10/2012 10:26 am

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours		
	Line Number					
	1.00	2.00	3.00	4.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	21	7,665	32,664.00		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)		21	7,665	32,664.00		7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	3,408.00		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00					13.00
14.00 Total (see instructions)		25	9,125	36,072.00		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)		25				27.00
28.00 Observation Bed Days						28.00
28.02 SUBPROVIDER - IRF	41.00					28.02
28.03 SUBPROVIDER	42.00					28.03
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151313

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/10/2012 10:26 am

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	1,503	265	3,490		1.00
2.00 HMO		0	562			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	132	0	132		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	92		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,635	265	3,714		7.00
8.00 INTENSIVE CARE UNIT	0	142	0	330		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	1,777	265	4,044		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	2,186	0	4,209		22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0		25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0		26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	679		28.00
28.02 SUBPROVIDER - IRF				0		28.02
28.03 SUBPROVIDER				0		28.03
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				0		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			0	0		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151313

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/10/2012 10:26 am

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	372	1.00
2.00 HMO					0	2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	342.73	0.00	0	372	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	342.73	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: 151313

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/10/2012 10:26 am

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	74	989		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)	74	989		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

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 151313 Component CCN: 157104		Period: From 01/01/2011 To 12/31/2011		Worksheet S-4 Date/Time Prepared: 5/10/2012 10:26 am	
				Home Health Agency I		PPS	
				1.00			
0.00	County					0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	
2.00	Unduplicated Census Count (see instructions)	0.00	75.00	0.00	0.00	0.00	
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	0.00		0.00	0.00	0.00	
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	
5.00	Other Administrative Personnel			0.00	0.00	0.00	
6.00	Direct Nursing Service			0.00	0.00	0.00	
7.00	Nursing Supervisor			0.00	0.00	0.00	
8.00	Physical Therapy Service			0.00	0.00	0.00	
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	
10.00	Occupational Therapy Service			0.00	0.00	0.00	
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	
12.00	Speech Pathology Service			0.00	0.00	0.00	
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	
14.00	Medical Social Service			0.00	0.00	0.00	
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	
16.00	Home Health Aide			0.00	0.00	0.00	
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	
18.00	Other (specify)			0.00	0.00	0.00	
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).						
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	762	27	28	15	832	
22.00	Skilled Nursing Visit Charges	137,160	4,860	5,040	2,700	149,760	
23.00	Physical Therapy Visits	347	0	8	7	362	
24.00	Physical Therapy Visit Charges	52,189	0	1,203	1,053	54,445	
25.00	Occupational Therapy Visits	65	0	3	4	72	
26.00	Occupational Therapy Visit Charges	9,776	0	451	602	10,829	
27.00	Speech Pathology Visits	31	0	0	0	31	
28.00	Speech Pathology Visit Charges	4,662	0	0	0	4,662	
29.00	Medical Social Service Visits	0	0	0	0	0	
30.00	Medical Social Service Visit Charges	0	0	0	0	0	
31.00	Home Health Aide Visits	855	25	3	6	889	
32.00	Home Health Aide Visit Charges	61,133	1,788	215	429	63,565	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,060	52	42	32	2,186	
34.00	Other Charges	0	0	0	0	0	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	264,920	6,648	6,909	4,784	283,261	
36.00	Total Number of Episodes (standard/non outlier)	98		16	3	117	
37.00	Total Number of Outlier Episodes		1		0	1	
38.00	Total Non-Routine Medical Supply Charges	4,019	390	42	153	4,604	



RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151313

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

Worksheet A  
Date/Time Prepared:  
5/10/2012 10:26 am

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 NEW CAP REL COSTS-BLDG & FIXT		1,908,855	1,908,855	84,847	1,993,702	1.00
4.00 EMPLOYEE BENEFITS	173,427	2,014,443	2,187,870	0	2,187,870	4.00
5.00 ADMINISTRATIVE & GENERAL	1,799,883	1,623,197	3,423,080	660,294	4,083,374	5.00
7.00 OPERATION OF PLANT	257,707	1,083,089	1,340,796	42,765	1,383,561	7.00
8.00 LAUNDRY & LINEN SERVICE	14,349	100,380	114,729	0	114,729	8.00
9.00 HOUSEKEEPING	273,959	141,053	415,012	0	415,012	9.00
10.00 DIETARY	325,785	285,787	611,572	-402,325	209,247	10.00
11.00 CAFETERIA	0	0	0	402,325	402,325	11.00
13.00 NURSING ADMINISTRATION	178,243	47,912	226,155	0	226,155	13.00
14.00 CENTRAL SERVICES & SUPPLY	31,334	42,042	73,376	0	73,376	14.00
15.00 PHARMACY	258,537	2,323,872	2,582,409	0	2,582,409	15.00
16.00 MEDICAL RECORDS & LIBRARY	426,419	179,652	606,071	0	606,071	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	2,224,906	844,392	3,069,298	0	3,069,298	30.00
31.00 INTENSIVE CARE UNIT	357,779	119,089	476,868	0	476,868	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
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	709,767	2,036,549	2,746,316	0	2,746,316	50.00
51.00 RECOVERY ROOM	274,193	88,507	362,700	0	362,700	51.00
53.00 ANESTHESIOLOGY	0	655,674	655,674	0	655,674	53.00
54.00 RADIOLOGY-DIAGNOSTIC	1,172,121	1,494,918	2,667,039	0	2,667,039	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	621,963	1,101,256	1,723,219	0	1,723,219	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	908,340	320,502	1,228,842	0	1,228,842	65.00
66.00 PHYSICAL THERAPY	872,489	218,656	1,091,145	0	1,091,145	66.00
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
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 EMERGENCY	831,772	1,723,515	2,555,287	0	2,555,287	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
99.10 CORF	0	0	0	0	0	99.10
101.00 HOME HEALTH AGENCY	389,211	193,735	582,946	0	582,946	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 INTEREST EXPENSE		0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	12,102,184	18,547,075	30,649,259	787,906	31,437,165	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	5,604,138	1,652,663	7,256,801	-658,896	6,597,905	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 ADVERTISING	84,993	430,784	515,777	-129,010	386,767	194.00
200.00 TOTAL (SUM OF LINES 118-199)	17,791,315	20,630,522	38,421,837	0	38,421,837	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151313

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

Worksheet A  
Date/Time Prepared:  
5/10/2012 10:26 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	NEW CAP REL COSTS-BLDG & FIXT	23,210	2,016,912	1.00
4.00	EMPLOYEE BENEFITS	0	2,187,870	4.00
5.00	ADMINISTRATIVE & GENERAL	-233,884	3,849,490	5.00
7.00	OPERATION OF PLANT	0	1,383,561	7.00
8.00	LAUNDRY & LINEN SERVICE	0	114,729	8.00
9.00	HOUSEKEEPING	0	415,012	9.00
10.00	DIETARY	-28,897	180,350	10.00
11.00	CAFETERIA	-115,627	286,698	11.00
13.00	NURSING ADMINISTRATION	0	226,155	13.00
14.00	CENTRAL SERVICES & SUPPLY	-19,883	53,493	14.00
15.00	PHARMACY	-530,533	2,051,876	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	606,071	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	0	3,069,298	30.00
31.00	INTENSIVE CARE UNIT	0	476,868	31.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	0	2,746,316	50.00
51.00	RECOVERY ROOM	0	362,700	51.00
53.00	ANESTHESIOLOGY	-598,454	57,220	53.00
54.00	RADIOLOGY-DIAGNOSTIC	-110,268	2,556,771	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	1,723,219	60.00
60.01	BLOOD LABORATORY	0	0	60.01
65.00	RESPIRATORY THERAPY	-56,307	1,172,535	65.00
66.00	PHYSICAL THERAPY	-50,065	1,041,080	66.00
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
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	RURAL HEALTH CLINIC	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	EMERGENCY	-943,557	1,611,730	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
99.10	CORF	0	0	99.10
101.00	HOME HEALTH AGENCY	0	582,946	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	INTEREST EXPENSE	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-2,664,265	28,772,900	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	RESEARCH	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	6,597,905	192.00
193.00	NONPAID WORKERS	0	0	193.00
194.00	ADVERTISING	0	386,767	194.00
200.00	TOTAL (SUM OF LINES 118-199)	-2,664,265	35,757,572	200.00

RECLASSIFICATIONS

Provider CCN: 151313

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

Worksheet A-6

Date/Time Prepared:  
5/10/2012 10:26 am

		Increases			
Cost Center		Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	214,319	188,006	1.00
	TOTALS		214,319	188,006	
C - PHYSICIANS CLINIC					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	84,847	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	57,408	2.00
3.00	OPERATION OF PLANT	7.00	0	42,765	3.00
	TOTALS		0	185,020	
D - ADVERTISING					
1.00	ADMINISTRATIVE & GENERAL	5.00	21,259	107,751	1.00
	TOTALS		21,259	107,751	
E - PHYSICIAN OFFICE ADMIN					
1.00	ADMINISTRATIVE & GENERAL	5.00	351,794	122,082	1.00
	TOTALS		351,794	122,082	
500.00	Grand Total: Increases		587,372	602,859	500.00

RECLASSIFICATIONS

Provider CCN: 151313

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

Worksheet A-6

Date/Time Prepared:  
5/10/2012 10:26 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - CAFETERIA</b>							
1.00	DIETARY	10.00	214,319	188,006	0		1.00
	TOTALS		214,319	188,006			
<b>C - PHYSICIANS CLINIC</b>							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	185,020	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	185,020			
<b>D - ADVERTISING</b>							
1.00	ADVERTISING	194.00	21,259	107,751	0		1.00
	TOTALS		21,259	107,751			
<b>E - PHYSICIAN OFFICE ADMIN</b>							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	351,794	122,082	0		1.00
	TOTALS		351,794	122,082			
500.00	Grand Total: Decreases		587,372	602,859			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151313

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
5/10/2012 10:26 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	3.00	4.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	345,223	0	0	0	1.00
2.00	Land Improvements	392,849	32,197	0	47,893	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	23,527,547	177,469	0	619,223	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	9,317,125	1,147,449	0	2,875,424	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	33,582,744	1,357,115	0	3,542,540	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	33,582,744	1,357,115	0	3,542,540	10.00
<b>SUMMARY OF CAPITAL</b>						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
	<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,033,834	0	530,793	344,228	1.00
3.00	Total (sum of lines 1-2)	1,033,834	0	530,793	344,228	3.00
<b>COMPUTATION OF RATIOS</b>						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
	<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151313

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
5/10/2012 10:26 am

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	345,223	0			1.00
2.00	Land Improvements	377,153	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	23,085,793	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	7,589,150	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	31,397,319	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	31,397,319	0			10.00
<b>SUMMARY OF CAPITAL</b>						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,908,855			1.00
3.00	Total (sum of lines 1-2)	0	1,908,855			3.00
<b>ALLOCATION OF OTHER CAPITAL</b>						
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
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,118,681	0 1.00
3.00	Total (sum of lines 1-2)	0	0	0	1,118,681	0 3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151313

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
5/10/2012 10:26 am

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	554,003	344,228	0	0	2,016,912	1.00
3.00	Total (sum of lines 1-2)	554,003	344,228	0	0	2,016,912	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151313

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

Worksheet A-8

Date/Time Prepared:  
5/10/2012 10:26 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #		
			1.00	2.00	3.00	4.00
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 - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	*** Cost Center Deleted ***	2.00	2.00
3.00 Investment income - other (chapter 2)			0		0.00	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	7.00
8.00 Television and radio service (chapter 21)			0		0.00	8.00
9.00 Parking lot (chapter 21)			0		0.00	9.00
10.00 Provider-based physician adjustment	A-8-2	-1,084,625	0			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	43,881				12.00
13.00 Laundry and linen service			0		0.00	13.00
14.00 Cafeteria-employees and guests			0		0.00	14.00
15.00 Rental of quarters to employee and others			0		0.00	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	16.00
17.00 Sale of drugs to other than patients			0		0.00	17.00
18.00 Sale of medical records and abstracts			0		0.00	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	19.00
20.00 Vending machines			0		0.00	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00	25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	*** Cost Center Deleted ***	2.00	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00	28.00
29.00 Physicians' assistant			0		0.00	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00	30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	32.00
33.00 DELINQUENT A/R -INT INCME	B	-99	0	NEW CAP REL COSTS-BLDG & FIXT	1.00	33.00
34.00 PATIENT ACCOUNTS - INT INCOME	B	-11,632	0	NEW CAP REL COSTS-BLDG & FIXT	1.00	34.00
35.00 OTHER INCOME -INT INCME	B	-7,210	0	NEW CAP REL COSTS-BLDG & FIXT	1.00	35.00
36.00 SAVINGS -INT INCME	B	-1,730	0	NEW CAP REL COSTS-BLDG & FIXT	1.00	36.00
37.00 EDUCATION OTHER REVENUE	B	-2,718	0	ADMINISTRATIVE & GENERAL	5.00	37.00
38.00 CLERICAL FEES -HIM	B	-21,225	0	ADMINISTRATIVE & GENERAL	5.00	38.00
39.00 MISC REV -OTH REV	B	-69,073	0	ADMINISTRATIVE & GENERAL	5.00	39.00
40.00 CHAPLAIN - OTHER REVENUE	B	-2,100	0	ADMINISTRATIVE & GENERAL	5.00	40.00
41.00 CHECKING -INT INCME	B	-5,081	0	ADMINISTRATIVE & GENERAL	5.00	41.00
42.00 PATIENT SUPPLY/SUPPLEMENT CHAR	B	-3,559	0	DIETARY	10.00	42.00
43.00 HOME MEAL PROGRAM	B	-17,191	0	DIETARY	10.00	43.00
44.00 DIETARY SPEC EVENTS	B	-8,147	0	DIETARY	10.00	44.00
45.00 HOUSEKEEPING VENDING-OTH REV	B	-68	0	CAFETERIA	11.00	45.00
45.01 CAFETERIA SALES	B	-115,559	0	CAFETERIA	11.00	45.01
45.02 SUPPLY SALES	B	-19,883	0	CENTRAL SERVICES & SUPPLY	14.00	45.02
45.03 DRUG SALES	B	-530,533	0	PHARMACY	15.00	45.03
45.04 RESPIRATORY OTHER REV	B	-25,507	0	RESPIRATORY THERAPY	65.00	45.04

ADJUSTMENTS TO EXPENSES

Provider CCN: 151313

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

Worksheet A-8

Date/Time Prepared:  
5/10/2012 10:26 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center			Line #
			1.00	2.00		3.00
45.05 PT - OTHER REVENUE	B	-9,631	PHYSICAL THERAPY	66.00	45.05	
45.06 OCC THE R OTH REV	B	-25,434	PHYSICAL THERAPY	66.00	45.06	
45.07 ATHLETIC TRAINING -OTH REV	B	-15,000	PHYSICAL THERAPY	66.00	45.07	
45.08 PHYSICIAN RECRUITMENT	A	-46,626	ADMINISTRATIVE & GENERAL	5.00	45.08	
45.09 PHYSICIAN RECRUITMENT	A	-82,289	ADMINISTRATIVE & GENERAL	5.00	45.09	
45.10 IHA AND AHA LOBBYING	A	-4,772	ADMINISTRATIVE & GENERAL	5.00	45.10	
45.11 ANESTHESIA OFFSET	A	-598,454	ANESTHESIOLOGY	53.00	45.11	
45.12		0		0.00	45.12	
45.13		0		0.00	45.13	
45.14		0		0.00	45.14	
45.15		0		0.00	45.15	
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,664,265			50.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 151313

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

Worksheet A-8

Date/Time Prepared:  
5/10/2012 10:26 am

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	DELINQUENT A/R -INT INCOME	11	33.00
34.00	PATIENT ACCOUNTS - INT INCOME	11	34.00
35.00	OTHER INCOME -INT INCOME	11	35.00
36.00	SAVINGS -INT INCOME	11	36.00
37.00	EDUCATION OTHER REVENUE	0	37.00
38.00	CLERICAL FEES -HIM	0	38.00
39.00	MISC REV -OTH REV	0	39.00
40.00	CHAPLAIN - OTHER REVENUE	0	40.00
41.00	CHECKING -INT INCOME	0	41.00
42.00	PATIENT SUPPLY/SUPPLEMENT CHAR	0	42.00
43.00	HOME MEAL PROGRAM	0	43.00
44.00	DIETARY SPEC EVENTS	0	44.00
45.00	HOUSEKEEPING VENDING-OTH REV	0	45.00
45.01	CAFETERIA SALES	0	45.01
45.02	SUPPLY SALES	0	45.02
45.03	DRUG SALES	0	45.03
45.04	RESPIRATORY OTHER REV	0	45.04
45.05	PT - OTHER REVENUE	0	45.05
45.06	OCC THER OTH REV	0	45.06
45.07	ATHLETIC TRAINING -OTH REV	0	45.07
45.08	PHYSICIAN RECRUITMENT	0	45.08
45.09	PHYSICIAN RECRUITMENT	0	45.09
45.10	IHA AND AHA LOBBYING	0	45.10
45.11	ANESTHESIA OFFSET	0	45.11
45.12		0	45.12
45.13		0	45.13
45.14		0	45.14
45.15		0	45.15

ADJUSTMENTS TO EXPENSES		Provider CCN: 151313	Period: From 01/01/2011 To 12/31/2011	Worksheet A-8 Date/Time Prepared: 5/10/2012 10:26 am
Cost Center Description		Wkst. A-7 Ref.		
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	5.00		50.00

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

Provider CCN: 151313

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

Worksheet A-8-1

Date/Time Prepared:  
5/10/2012 10:26 am

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

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

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

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

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

6.00	B	WOODLAWN HOSPIT	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: 151313

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

Worksheet A-8-1

Date/Time Prepared:  
5/10/2012 10:26 am

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	43,881	0	43,881	11	1.00
2.00	0	0	0	0	2.00
3.00	0	0	0	0	3.00
4.00	0	0	0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				
	43,881	0	43,881		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	6.00	
<b>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>			

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151313

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

Worksheet A-8-2

Date/Time Prepared:  
5/10/2012 10:26 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	54.00	RADIOLOGY-DIAGNOSTIC	69,353	69,353	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	28,961	28,961	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	11,954	11,954	3.00
4.00	60.00	LABORATORY	22,913	0	4.00
5.00	65.00	RESPIRATORY THERAPY	30,800	30,800	5.00
6.00	65.00	RESPIRATORY THERAPY	2,450	0	6.00
7.00	91.00	EMERGENCY	1,429,804	943,557	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00			1,596,235	1,084,625	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151313

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

Worksheet A-8-2

Date/Time Prepared:  
5/10/2012 10:26 am

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	22,913	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	2,450	0	0	0	0	6.00
7.00	486,247	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	511,610					200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151313

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

Worksheet A-8-2

Date/Time Prepared:  
5/10/2012 10:26 am

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151313

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

Worksheet A-8-2

Date/Time Prepared:  
5/10/2012 10:26 am

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	69,353	1.00
2.00	0	28,961	2.00
3.00	0	11,954	3.00
4.00	0	0	4.00
5.00	0	30,800	5.00
6.00	0	0	6.00
7.00	0	943,557	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	1,084,625	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151313		Period: From 01/01/2011 To 12/31/2011		Worksheet A-8-3 Par	
				Occupational Therapy		Date/Time Prepared: 5/10/2012 10:26 am	
						Cost	
						1.00	
<b>PART I - GENERAL INFORMATION</b>							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					780	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	6.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	67.24	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	33.62	33.62	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					403	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					403	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					403	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					67.17	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					52,393	22.00
23.00	Total salary equivalency (see instructions)					52,393	23.00
<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>							
<b>Standard Travel Allowance</b>							
24.00	Therapists (line 3 times column 2, line 11)					26,224	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					26,224	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					26,224	28.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
<b>Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>							
<b>Standard Travel Expense</b>							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151313		Period: From 01/01/2011 To 12/31/2011		Worksheet A-8-3 Part Date/Time Prepared: 5/10/2012 10:26 am	
				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
<b>PART V - OVERTIME COMPUTATION</b>							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
<b>CALCULATION OF LIMIT</b>							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52.00	Adjusted hourly salary equivalency amount (see instructions)	67.24	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
<b>Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT</b>							
57.00	Salary equivalency amount (from line 23)					52,393	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					52,393	63.00
64.00	Total cost of outside supplier services (from your records)					417	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
<b>LINE 33 CALCULATION</b>							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					26,224	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					26,224	100.02
<b>LINE 34 CALCULATION</b>							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					0	101.02
<b>LINE 35 CALCULATION</b>							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151313

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/10/2012 10:26 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 NEW CAP REL COSTS-BLDG & FIXT	2,016,912	2,016,912					1.00
4.00 EMPLOYEE BENEFITS	2,187,870	6,777	2,194,647				4.00
5.00 ADMINISTRATIVE & GENERAL	3,849,490	443,884	270,680	4,564,054	4,564,054	4,564,054	5.00
7.00 OPERATION OF PLANT	1,383,561	199,252	32,102	1,614,915	236,285	236,285	7.00
8.00 LAUNDRY & LINEN SERVICE	114,729	5,790	1,787	122,306	17,895	17,895	8.00
9.00 HOUSEKEEPING	415,012	6,727	34,127	455,866	66,700	66,700	9.00
10.00 DIETARY	180,350	24,146	13,885	218,381	31,952	31,952	10.00
11.00 CAFETERIA	286,698	48,999	26,698	362,395	53,023	53,023	11.00
13.00 NURSING ADMINISTRATION	226,155	1,250	22,204	249,609	36,521	36,521	13.00
14.00 CENTRAL SERVICES & SUPPLY	53,493	27,551	3,903	84,947	12,429	12,429	14.00
15.00 PHARMACY	2,051,876	12,204	32,206	2,096,286	306,716	306,716	15.00
16.00 MEDICAL RECORDS & LIBRARY	606,071	24,031	53,119	683,221	99,965	99,965	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 ADULTS & PEDIATRICS	3,069,298	213,940	277,154	3,560,392	520,935	520,935	30.00
31.00 INTENSIVE CARE UNIT	476,868	30,330	44,568	551,766	80,731	80,731	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	0	42.00
43.00 NURSERY	0	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 OPERATING ROOM	2,746,316	232,197	88,415	3,066,928	448,735	448,735	50.00
51.00 RECOVERY ROOM	362,700	6,875	34,156	403,731	59,071	59,071	51.00
53.00 ANESTHESIOLOGY	57,220	0	0	57,220	8,372	8,372	53.00
54.00 RADIOLOGY-DIAGNOSTIC	2,556,771	112,801	146,010	2,815,582	411,959	411,959	54.00
57.00 CT SCAN	0	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00 LABORATORY	1,723,219	38,094	77,477	1,838,790	269,041	269,041	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	1,172,535	60,348	113,151	1,346,034	196,944	196,944	65.00
66.00 PHYSICAL THERAPY	1,041,080	37,666	108,685	1,187,431	173,738	173,738	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
91.00 EMERGENCY	1,611,730	99,938	103,613	1,815,281	265,601	265,601	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	0	96.00
99.10 CORF	0	0	0	0	0	0	99.10
101.00 HOME HEALTH AGENCY	582,946	0	48,484	631,430	92,387	92,387	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00 INTEREST EXPENSE	0	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	28,772,900	1,632,800	1,532,424	27,726,565	3,389,000	3,389,000	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	6,597,905	370,246	654,284	7,622,435	1,115,274	1,115,274	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	0	193.00
194.00 ADVERTISING	386,767	13,866	7,939	408,572	59,780	59,780	194.00
200.00 Cross Foot Adjustments	0	0	0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	35,757,572	2,016,912	2,194,647	35,757,572	4,564,054	4,564,054	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151313

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/10/2012 10:26 am

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT	1,851,200					7.00
8.00	LAUNDRY & LINEN SERVICE	7,840	148,041				8.00
9.00	HOUSEKEEPING	9,110	18,860	550,536			9.00
10.00	DIETARY	32,698	1,447	1,361	285,839		10.00
11.00	CAFETERIA	66,355	0	10,038	0	491,811	11.00
13.00	NURSING ADMINISTRATION	1,693	0	1,292	0	6,882	13.00
14.00	CENTRAL SERVICES & SUPPLY	37,309	0	0	0	2,530	14.00
15.00	PHARMACY	16,527	0	4,984	0	15,612	15.00
16.00	MEDICAL RECORDS & LIBRARY	32,542	0	7,730	0	34,969	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	289,719	47,901	127,262	262,514	128,336	30.00
31.00	INTENSIVE CARE UNIT	41,073	4,340	24,760	23,325	16,776	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
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	314,443	31,933	114,201	0	62,549	50.00
51.00	RECOVERY ROOM	9,311	0	0	0	15,485	51.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	152,756	11,626	34,567	0	57,943	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	51,587	0	44,097	0	37,398	60.00
60.01	BLOOD LABORATORY	0	0	0	0	36,107	60.01
65.00	RESPIRATORY THERAPY	81,724	8,733	31,937	0	0	65.00
66.00	PHYSICAL THERAPY	51,008	2,894	18,945	0	37,625	66.00
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
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	135,337	20,307	62,212	0	35,829	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,331,032	148,041	483,386	285,839	488,041	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	501,391	0	65,881	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	ADVERTISING	18,777	0	1,269	0	3,770	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,851,200	148,041	550,536	285,839	491,811	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151313

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/10/2012 10:26 am

Cost Center Description	NURSING	CENTRAL	PHARMACY	MEDICAL	Subtotal	
	ADMINISTRATIVE	SERVICES & SUPPLY		RECORDS & LIBRARY		
	13.00	14.00	15.00	16.00	24.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA						11.00
13.00 NURSING ADMINISTRATION	295,997					13.00
14.00 CENTRAL SERVICES & SUPPLY	0	137,215				14.00
15.00 PHARMACY	0	0	2,440,125			15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	0	858,427		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	124,830	5,659	0	53,965	5,121,513	30.00
31.00 INTENSIVE CARE UNIT	18,102	944	0	8,575	770,392	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
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	40,538	99,989	0	129,617	4,308,933	50.00
51.00 RECOVERY ROOM	16,977	2,074	0	15,048	521,697	51.00
53.00 ANESTHESIOLOGY	0	1,179	0	14,070	80,841	53.00
54.00 RADIOLOGY-DIAGNOSTIC	15,281	6,258	0	193,489	3,699,461	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	384	0	129,398	2,370,695	60.00
60.01 BLOOD LABORATORY	0	0	0	0	36,107	60.01
65.00 RESPIRATORY THERAPY	2,391	1,208	0	64,361	1,733,332	65.00
66.00 PHYSICAL THERAPY	0	962	0	28,612	1,501,215	66.00
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	2,440,125	134,858	2,574,983	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 EMERGENCY	52,393	4,498	0	86,434	2,477,892	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
99.10 CORF	0	0	0	0	0	99.10
101.00 HOME HEALTH AGENCY	25,485	463	0	0	749,765	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	295,997	123,618	2,440,125	858,427	25,946,826	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	13,597	0	0	9,318,578	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 ADVERTISING	0	0	0	0	492,168	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	295,997	137,215	2,440,125	858,427	35,757,572	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151313

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/10/2012 10:26 am

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	NEW CAP REL COSTS-BLDG & FIXT			1.00
4.00	EMPLOYEE BENEFITS			4.00
5.00	ADMINISTRATIVE & GENERAL			5.00
7.00	OPERATION OF PLANT			7.00
8.00	LAUNDRY & LINEN SERVICE			8.00
9.00	HOUSEKEEPING			9.00
10.00	DIETARY			10.00
11.00	CAFETERIA			11.00
13.00	NURSING ADMINISTRATION			13.00
14.00	CENTRAL SERVICES & SUPPLY			14.00
15.00	PHARMACY			15.00
16.00	MEDICAL RECORDS & LIBRARY			16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	0	5,121,513	30.00
31.00	INTENSIVE CARE UNIT	0	770,392	31.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	0	4,308,933	50.00
51.00	RECOVERY ROOM	0	521,697	51.00
53.00	ANESTHESIOLOGY	0	80,841	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	3,699,461	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	2,370,695	60.00
60.01	BLOOD LABORATORY	0	36,107	60.01
65.00	RESPIRATORY THERAPY	0	1,733,332	65.00
66.00	PHYSICAL THERAPY	0	1,501,215	66.00
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	2,574,983	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	RURAL HEALTH CLINIC	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	EMERGENCY	0	2,477,892	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
99.10	CORF	0	0	99.10
101.00	HOME HEALTH AGENCY	0	749,765	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	INTEREST EXPENSE			113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	25,946,826	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	RESEARCH	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	9,318,578	192.00
193.00	NONPAID WORKERS	0	0	193.00
194.00	ADVERTISING	0	492,168	194.00
200.00	Cross Foot Adjustments	0	0	200.00
201.00	Negative Cost Centers	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	35,757,572	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151313

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/10/2012 10:26 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	EMPLOYEE BENEFITS	0	6,777	6,777	6,777		4.00
5.00	ADMINISTRATIVE & GENERAL	0	443,884	443,884	837	444,721	5.00
7.00	OPERATION OF PLANT	0	199,252	199,252	99	23,024	7.00
8.00	LAUNDRY & LINEN SERVICE	0	5,790	5,790	6	1,744	8.00
9.00	HOUSEKEEPING	0	6,727	6,727	105	6,499	9.00
10.00	DIETARY	0	24,146	24,146	43	3,113	10.00
11.00	CAFETERIA	0	48,999	48,999	83	5,167	11.00
13.00	NURSING ADMINISTRATION	0	1,250	1,250	69	3,559	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	27,551	27,551	12	1,211	14.00
15.00	PHARMACY	0	12,204	12,204	100	29,887	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	24,031	24,031	164	9,741	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	0	213,940	213,940	857	50,761	30.00
31.00	INTENSIVE CARE UNIT	0	30,330	30,330	138	7,867	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
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0	232,197	232,197	273	43,725	50.00
51.00	RECOVERY ROOM	0	6,875	6,875	106	5,756	51.00
53.00	ANESTHESIOLOGY	0	0	0	0	816	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	112,801	112,801	451	40,142	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	38,094	38,094	239	26,216	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	60,348	60,348	350	19,190	65.00
66.00	PHYSICAL THERAPY	0	37,666	37,666	336	16,929	66.00
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
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	0	99,938	99,938	320	25,880	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	0	0	150	9,002	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,632,800	1,632,800	4,738	330,229	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	370,246	370,246	2,014	108,667	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	ADVERTISING	0	13,866	13,866	25	5,825	194.00
200.00	Cross Foot Adjustments			0			200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	2,016,912	2,016,912	6,777	444,721	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151313			Period: From 01/01/2011 To 12/31/2011		Worksheet B Part II Date/Time Prepared: 5/10/2012 10:26 am	
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
		7.00	8.00	9.00	10.00	11.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	NEW CAP REL COSTS-BLDG & FIXT							1.00
4.00	EMPLOYEE BENEFITS							4.00
5.00	ADMINISTRATIVE & GENERAL							5.00
7.00	OPERATION OF PLANT	222,375						7.00
8.00	LAUNDRY & LINEN SERVICE	942	8,482					8.00
9.00	HOUSEKEEPING	1,094	1,081	15,506				9.00
10.00	DIETARY	3,928	83		38	31,351		10.00
11.00	CAFETERIA	7,971	0	283	0		62,503	11.00
13.00	NURSING ADMINISTRATION	203	0	36	0		875	13.00
14.00	CENTRAL SERVICES & SUPPLY	4,482	0	0	0		322	14.00
15.00	PHARMACY	1,985	0	140	0		1,984	15.00
16.00	MEDICAL RECORDS & LIBRARY	3,909	0	218	0		4,444	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	ADULTS & PEDIATRICS	34,802	2,744	3,583	28,793		16,309	30.00
31.00	INTENSIVE CARE UNIT	4,934	249	697	2,558		2,132	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
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	OPERATING ROOM	37,772	1,830	3,217	0		7,949	50.00
51.00	RECOVERY ROOM	1,118	0	0	0		1,968	51.00
53.00	ANESTHESIOLOGY	0	0	0	0		0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	18,350	666	974	0		7,364	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	6,197	0	1,242	0		4,753	60.00
60.01	BLOOD LABORATORY	0	0	0	0		4,589	60.01
65.00	RESPIRATORY THERAPY	9,817	500	900	0		0	65.00
66.00	PHYSICAL THERAPY	6,127	166	534	0		4,782	66.00
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
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	RURAL HEALTH CLINIC	0	0	0	0		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		0	89.00
91.00	EMERGENCY	16,257	1,163	1,752	0		4,553	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)							92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0		0	96.00
99.10	CORF	0	0	0	0		0	99.10
101.00	HOME HEALTH AGENCY	0	0	0	0		0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	INTEREST EXPENSE							113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	159,888	8,482	13,614	31,351		62,024	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		0	190.00
191.00	RESEARCH	0	0	0	0		0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	60,231	0	1,856	0		0	192.00
193.00	NONPAID WORKERS	0	0	0	0		0	193.00
194.00	ADVERTISING	2,256	0	36	0		479	194.00
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers	0	0	0	0		0	201.00
202.00	TOTAL (sum lines 118-201)	222,375	8,482	15,506	31,351		62,503	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151313		Period: From 01/01/2011 To 12/31/2011		Worksheet B Part II Date/Time Prepared: 5/10/2012 10:26 am	
Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION	5,992					13.00
14.00	CENTRAL SERVICES & SUPPLY	0	33,578				14.00
15.00	PHARMACY	0	0	46,300			15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	42,507		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	2,527	1,385	0	2,674	358,375	30.00
31.00	INTENSIVE CARE UNIT	366	231	0	425	49,927	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
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	821	24,468	0	6,423	358,675	50.00
51.00	RECOVERY ROOM	344	508	0	746	17,421	51.00
53.00	ANESTHESIOLOGY	0	289	0	697	1,802	53.00
54.00	RADIOLOGY-DIAGNOSTIC	309	1,531	0	9,557	192,145	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	94	0	6,412	83,247	60.00
60.01	BLOOD LABORATORY	0	0	0	0	4,589	60.01
65.00	RESPIRATORY THERAPY	48	296	0	3,189	94,638	65.00
66.00	PHYSICAL THERAPY	0	235	0	1,418	68,193	66.00
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	46,300	6,683	52,983	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	1,061	1,101	0	4,283	156,308	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	516	113	0	0	9,781	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	5,992	30,251	46,300	42,507	1,448,084	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	3,327	0	0	546,341	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	ADVERTISING	0	0	0	0	22,487	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	5,992	33,578	46,300	42,507	2,016,912	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151313

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/10/2012 10:26 am

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	NEW CAP REL COSTS-BLDG & FIXT			1.00
4.00	EMPLOYEE BENEFITS			4.00
5.00	ADMINISTRATIVE & GENERAL			5.00
7.00	OPERATION OF PLANT			7.00
8.00	LAUNDRY & LINEN SERVICE			8.00
9.00	HOUSEKEEPING			9.00
10.00	DIETARY			10.00
11.00	CAFETERIA			11.00
13.00	NURSING ADMINISTRATION			13.00
14.00	CENTRAL SERVICES & SUPPLY			14.00
15.00	PHARMACY			15.00
16.00	MEDICAL RECORDS & LIBRARY			16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	0	358,375	30.00
31.00	INTENSIVE CARE UNIT	0	49,927	31.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	0	358,675	50.00
51.00	RECOVERY ROOM	0	17,421	51.00
53.00	ANESTHESIOLOGY	0	1,802	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	192,145	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	83,247	60.00
60.01	BLOOD LABORATORY	0	4,589	60.01
65.00	RESPIRATORY THERAPY	0	94,638	65.00
66.00	PHYSICAL THERAPY	0	68,193	66.00
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	52,983	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	RURAL HEALTH CLINIC	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	EMERGENCY	0	156,308	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
99.10	CORF	0	0	99.10
101.00	HOME HEALTH AGENCY	0	9,781	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	INTEREST EXPENSE			113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,448,084	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	RESEARCH	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	546,341	192.00
193.00	NONPAID WORKERS	0	0	193.00
194.00	ADVERTISING	0	22,487	194.00
200.00	Cross Foot Adjustments	0	0	200.00
201.00	Negative Cost Centers	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	2,016,912	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151313

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

Worksheet B-1

Date/Time Prepared:  
5/10/2012 10:26 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)						
	1.00	4.00					
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	122,623					1.00
4.00	EMPLOYEE BENEFITS	412	17,617,888				4.00
5.00	ADMINISTRATIVE & GENERAL	26,987	2,172,936	-4,564,054	31,193,518		5.00
7.00	OPERATION OF PLANT	12,114	257,707	0	1,614,915	83,110	7.00
8.00	LAUNDRY & LINEN SERVICE	352	14,349	0	122,306	352	8.00
9.00	HOUSEKEEPING	409	273,959	0	455,866	409	9.00
10.00	DIETARY	1,468	111,466	0	218,381	1,468	10.00
11.00	CAFETERIA	2,979	214,319	0	362,395	2,979	11.00
13.00	NURSING ADMINISTRATION	76	178,243	0	249,609	76	13.00
14.00	CENTRAL SERVICES & SUPPLY	1,675	31,334	0	84,947	1,675	14.00
15.00	PHARMACY	742	258,537	0	2,096,286	742	15.00
16.00	MEDICAL RECORDS & LIBRARY	1,461	426,419	0	683,221	1,461	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	13,007	2,224,906	0	3,560,392	13,007	30.00
31.00	INTENSIVE CARE UNIT	1,844	357,779	0	551,766	1,844	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
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	14,117	709,767	0	3,066,928	14,117	50.00
51.00	RECOVERY ROOM	418	274,193	0	403,731	418	51.00
53.00	ANESTHESIOLOGY	0	0	0	57,220	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	6,858	1,172,121	0	2,815,582	6,858	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	2,316	621,963	0	1,838,790	2,316	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	3,669	908,340	0	1,346,034	3,669	65.00
66.00	PHYSICAL THERAPY	2,290	872,489	0	1,187,431	2,290	66.00
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
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	6,076	831,772	0	1,815,281	6,076	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	389,211	0	631,430	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	99,270	12,301,810	-4,564,054	23,162,511	59,757	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	22,510	5,252,344	0	7,622,435	22,510	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	ADVERTISING	843	63,734	0	408,572	843	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,016,912	2,194,647		4,564,054	1,851,200	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	16.448073	0.124569		0.146314	22.274095	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		6,777		444,721	222,375	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.000385		0.014257	2.675671	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151313

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

Worksheet B-1  
Date/Time Prepared:  
5/10/2012 10:26 am

Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
	8.00	9.00	10.00	11.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE	2,865					8.00
9.00 HOUSEKEEPING	365	119,290				9.00
10.00 DIETARY	28	295	4,044			10.00
11.00 CAFETERIA	0	2,175	0	19,437		11.00
13.00 NURSING ADMINISTRATION	0	280	0	272	158,819	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	100	0	14.00
15.00 PHARMACY	0	1,080	0	617	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	1,675	0	1,382	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	927	27,575	3,714	5,072	66,978	30.00
31.00 INTENSIVE CARE UNIT	84	5,365	330	663	9,713	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
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	618	24,745	0	2,472	21,751	50.00
51.00 RECOVERY ROOM	0	0	0	612	9,109	51.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	225	7,490	0	2,290	8,199	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	9,555	0	1,478	0	60.00
60.01 BLOOD LABORATORY	0	0	0	1,427	0	60.01
65.00 RESPIRATORY THERAPY	169	6,920	0	0	1,283	65.00
66.00 PHYSICAL THERAPY	56	4,105	0	1,487	0	66.00
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
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 EMERGENCY	393	13,480	0	1,416	28,112	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
99.10 CORF	0	0	0	0	0	99.10
101.00 HOME HEALTH AGENCY	0	0	0	0	13,674	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	2,865	104,740	4,044	19,288	158,819	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	14,275	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 ADVERTISING	0	275	0	149	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	148,041	550,536	285,839	491,811	295,997	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	51.672251	4.615106	70.682245	25.302825	1.863738	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	8,482	15,506	31,351	62,503	5,992	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	2.960558	0.129986	7.752473	3.215671	0.037728	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151313

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

Worksheet B-1  
Date/Time Prepared:  
5/10/2012 10:26 am

Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00 NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00 EMPLOYEE BENEFITS				4.00
5.00 ADMINISTRATIVE & GENERAL				5.00
7.00 OPERATION OF PLANT				7.00
8.00 LAUNDRY & LINEN SERVICE				8.00
9.00 HOUSEKEEPING				9.00
10.00 DIETARY				10.00
11.00 CAFETERIA				11.00
13.00 NURSING ADMINISTRATION				13.00
14.00 CENTRAL SERVICES & SUPPLY	2,227,589			14.00
15.00 PHARMACY	0	100		15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	69,394,687	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00 ADULTS & PEDIATRICS	91,865	0	4,362,591	30.00
31.00 INTENSIVE CARE UNIT	15,322	0	693,187	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
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 OPERATING ROOM	1,623,254	0	10,478,371	50.00
51.00 RECOVERY ROOM	33,672	0	1,216,502	51.00
53.00 ANESTHESIOLOGY	19,141	0	1,137,439	53.00
54.00 RADIOLOGY-DIAGNOSTIC	101,594	0	15,640,604	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	6,231	0	10,460,645	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
65.00 RESPIRATORY THERAPY	19,615	0	5,203,013	65.00
66.00 PHYSICAL THERAPY	15,622	0	2,313,000	66.00
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	100	10,901,983	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00 EMERGENCY	73,027	0	6,987,352	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
96.00 DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
99.10 CORF	0	0	0	99.10
101.00 HOME HEALTH AGENCY	7,514	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00 INTEREST EXPENSE				113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	2,006,857	100	69,394,687	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
191.00 RESEARCH	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	220,732	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	193.00
194.00 ADVERTISING	0	0	0	194.00
200.00 Cross Foot Adjustments				200.00
201.00 Negative Cost Centers				201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	137,215	2,440,125	858,427	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.061598	24,401.250000	0.012370	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	33,578	46,300	42,507	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.015074	463.000000	0.000613	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151313

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/10/2012 10:26 am

		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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS	5,121,513		5,121,513	0	0 30.00
31.00	INTENSIVE CARE UNIT	770,392		770,392	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
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	4,308,933		4,308,933	0	0 50.00
51.00	RECOVERY ROOM	521,697		521,697	0	0 51.00
53.00	ANESTHESIOLOGY	80,841		80,841	0	0 53.00
54.00	RADIOLOGY-DIAGNOSTIC	3,699,461		3,699,461	0	0 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	2,370,695		2,370,695	0	0 60.00
60.01	BLOOD LABORATORY	36,107		36,107	0	0 60.01
65.00	RESPIRATORY THERAPY	1,733,332	0	1,733,332	0	0 65.00
66.00	PHYSICAL THERAPY	1,501,215	0	1,501,215	0	0 66.00
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	2,574,983		2,574,983	0	0 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	RURAL HEALTH CLINIC	0		0	0	0 88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0 89.00
91.00	EMERGENCY	2,477,892		2,477,892	0	0 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	806,509		806,509	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0 96.00
99.10	CORF	0		0	0	0 99.10
101.00	HOME HEALTH AGENCY	749,765		749,765	0	0 101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	26,753,335	0	26,753,335	0	0 200.00
201.00	Less Observation Beds	806,509		806,509		0 201.00
202.00	Total (see instructions)	25,946,826	0	25,946,826	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151313	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/10/2012 10:26 am
		Title XVIII	Hospital	Cost

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	3,577,900		3,577,900			30.00
31.00 INTENSIVE CARE UNIT	693,187		693,187			31.00
41.00 SUBPROVIDER - IRF	0		0			41.00
42.00 SUBPROVIDER	0		0			42.00
43.00 NURSERY	0		0			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	3,265,851	7,212,520	10,478,371	0.411222	0.000000	50.00
51.00 RECOVERY ROOM	203,823	1,012,679	1,216,502	0.428850	0.000000	51.00
53.00 ANESTHESIOLOGY	172,407	965,032	1,137,439	0.071073	0.000000	53.00
54.00 RADIOLOGY-DIAGNOSTIC	915,669	14,724,935	15,640,604	0.236529	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	1,604,504	8,856,141	10,460,645	0.226630	0.000000	60.00
60.01 BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00 RESPIRATORY THERAPY	1,658,031	3,544,982	5,203,013	0.333140	0.000000	65.00
66.00 PHYSICAL THERAPY	342,642	1,970,358	2,313,000	0.649034	0.000000	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0.000000	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	3,018,854	7,883,129	10,901,983	0.236194	0.000000	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 RURAL HEALTH CLINIC	0	0	0			88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
91.00 EMERGENCY	71,778	6,915,574	6,987,352	0.354625	0.000000	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	30,511	754,180	784,691	1.027805	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
99.10 CORF	0	0	0			99.10
101.00 HOME HEALTH AGENCY	0	0	0			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	15,555,157	53,839,530	69,394,687			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	15,555,157	53,839,530	69,394,687			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151313

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/10/2012 10:26 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
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
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.000000			50.00
51.00	RECOVERY ROOM	0.000000			51.00
53.00	ANESTHESIOLOGY	0.000000			53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	CT SCAN	0.000000			57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	LABORATORY	0.000000			60.00
60.01	BLOOD LABORATORY	0.000000			60.01
65.00	RESPIRATORY THERAPY	0.000000			65.00
66.00	PHYSICAL THERAPY	0.000000			66.00
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
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	RURAL HEALTH CLINIC				88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER				89.00
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000			96.00
99.10	CORF				99.10
101.00	HOME HEALTH AGENCY				101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
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: 151313

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/10/2012 10:26 am

		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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS	5,121,513		5,121,513	0	0 30.00
31.00	INTENSIVE CARE UNIT	770,392		770,392	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
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	4,308,933		4,308,933	0	0 50.00
51.00	RECOVERY ROOM	521,697		521,697	0	0 51.00
53.00	ANESTHESIOLOGY	80,841		80,841	0	0 53.00
54.00	RADIOLOGY-DIAGNOSTIC	3,699,461		3,699,461	0	0 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	2,370,695		2,370,695	0	0 60.00
60.01	BLOOD LABORATORY	36,107		36,107	0	0 60.01
65.00	RESPIRATORY THERAPY	1,733,332	0	1,733,332	0	0 65.00
66.00	PHYSICAL THERAPY	1,501,215	0	1,501,215	0	0 66.00
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	2,574,983		2,574,983	0	0 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	RURAL HEALTH CLINIC	0		0	0	0 88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0 89.00
91.00	EMERGENCY	2,477,892		2,477,892	0	0 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	806,509		806,509	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0 96.00
99.10	CORF	0		0	0	0 99.10
101.00	HOME HEALTH AGENCY	749,765		749,765	0	0 101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	26,753,335	0	26,753,335	0	0 200.00
201.00	Less Observation Beds	806,509		806,509		0 201.00
202.00	Total (see instructions)	25,946,826	0	25,946,826	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151313

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/10/2012 10:26 am

		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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	3,577,900		3,577,900			30.00
31.00	INTENSIVE CARE UNIT	693,187		693,187			31.00
41.00	SUBPROVIDER - IRF	0		0			41.00
42.00	SUBPROVIDER	0		0			42.00
43.00	NURSERY	0		0			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	3,265,851	7,212,520	10,478,371	0.411222	0.000000	50.00
51.00	RECOVERY ROOM	203,823	1,012,679	1,216,502	0.428850	0.000000	51.00
53.00	ANESTHESIOLOGY	172,407	965,032	1,137,439	0.071073	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	915,669	14,724,935	15,640,604	0.236529	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	1,604,504	8,856,141	10,460,645	0.226630	0.000000	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	RESPIRATORY THERAPY	1,658,031	3,544,982	5,203,013	0.333140	0.000000	65.00
66.00	PHYSICAL THERAPY	342,642	1,970,358	2,313,000	0.649034	0.000000	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0.000000	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	3,018,854	7,883,129	10,901,983	0.236194	0.000000	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
91.00	EMERGENCY	71,778	6,915,574	6,987,352	0.354625	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	30,511	754,180	784,691	1.027805	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
99.10	CORF	0	0	0			99.10
101.00	HOME HEALTH AGENCY	0	0	0			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	15,555,157	53,839,530	69,394,687			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	15,555,157	53,839,530	69,394,687			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151313

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/10/2012 10:26 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
INPATIENT ROUTINE SERVICE COST CENTERS		11.00			
30.00	ADULTS & PEDIATRICS				30.00
31.00	INTENSIVE CARE UNIT				31.00
41.00	SUBPROVIDER - IRF				41.00
42.00	SUBPROVIDER				42.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000			50.00
51.00	RECOVERY ROOM	0.000000			51.00
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
65.00	RESPIRATORY THERAPY	0.000000			65.00
66.00	PHYSICAL THERAPY	0.000000			66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000			96.00
99.10	CORF				99.10
101.00	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
113.00	INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151313		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part II Date/Time Prepared: 5/10/2012 10:26 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	358,675	10,478,371	0.034230	1,209,115	41,388	50.00
51.00	RECOVERY ROOM	17,421	1,216,502	0.014321	50,129	718	51.00
53.00	ANESTHESIOLOGY	1,802	1,137,439	0.001584	50,319	80	53.00
54.00	RADIOLOGY-DIAGNOSTIC	192,145	15,640,604	0.012285	391,522	4,810	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	83,247	10,460,645	0.007958	713,843	5,681	60.00
60.01	BLOOD LABORATORY	4,589	0	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	94,638	5,203,013	0.018189	798,556	14,525	65.00
66.00	PHYSICAL THERAPY	68,193	2,313,000	0.029482	141,748	4,179	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	52,983	10,901,983	0.004860	1,282,987	6,235	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	EMERGENCY	156,308	6,987,352	0.022370	3,155	71	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	784,691	0.000000	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00	Total (lines 50-199)	1,030,001	65,123,600		4,641,374	77,687	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151313

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/10/2012 10:26 am

Cost Center Description		Title XVIII				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 151313

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/10/2012 10:26 am

Cost Center Description		Title XVIII			Hospital		Cost
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0	10,478,371	0.000000	0.000000	1,209,115	50.00
51.00	RECOVERY ROOM	0	1,216,502	0.000000	0.000000	50,129	51.00
53.00	ANESTHESIOLOGY	0	1,137,439	0.000000	0.000000	50,319	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	15,640,604	0.000000	0.000000	391,522	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	10,460,645	0.000000	0.000000	713,843	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	RESPIRATORY THERAPY	0	5,203,013	0.000000	0.000000	798,556	65.00
66.00	PHYSICAL THERAPY	0	2,313,000	0.000000	0.000000	141,748	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	10,901,983	0.000000	0.000000	1,282,987	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	EMERGENCY	0	6,987,352	0.000000	0.000000	3,155	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	784,691	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00	Total (lines 50-199)	0	65,123,600			4,641,374	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151313	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/10/2012 10:26 am
--	----------------------	---	---

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	Cost
		11.00	12.00	13.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	0	0	0		50.00
51.00	RECOVERY ROOM	0	0	0		51.00
53.00	ANESTHESIOLOGY	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	CT SCAN	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	LABORATORY	0	0	0		60.00
60.01	BLOOD LABORATORY	0	0	0		60.01
65.00	RESPIRATORY THERAPY	0	0	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
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
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	EMERGENCY	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151313	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/10/2012 10:26 am
	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		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	0.411222	0	1,357,468	0		50.00
51.00 RECOVERY ROOM	0.428850	0	176,847	0		51.00
53.00 ANESTHESIOLOGY	0.071073	0	200,342	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.236529	0	3,499,973	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	0.226630	0	2,626,313	0		60.00
60.01 BLOOD LABORATORY	0.000000	0	0	0		60.01
65.00 RESPIRATORY THERAPY	0.333140	0	1,177,855	0		65.00
66.00 PHYSICAL THERAPY	0.649034	0	575,346	0		66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.236194	0	2,845,516	412		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 RURAL HEALTH CLINIC	0.000000					88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
91.00 EMERGENCY	0.354625	0	1,573,007	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.027805	0	265,070	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0		96.00
200.00 Subtotal (see instructions)		0	14,297,737	412		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	14,297,737	412		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151313	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/10/2012 10:26 am
	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		
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 OPERATING ROOM	0	558,221	0		50.00
51.00 RECOVERY ROOM	0	75,841	0		51.00
53.00 ANESTHESIOLOGY	0	14,239	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	827,845	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	595,201	0		60.00
60.01 BLOOD LABORATORY	0	0	0		60.01
65.00 RESPIRATORY THERAPY	0	392,391	0		65.00
66.00 PHYSICAL THERAPY	0	373,419	0		66.00
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	672,094	97		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 RURAL HEALTH CLINIC	0	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00 EMERGENCY	0	557,828	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	272,440	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00 DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00 Subtotal (see instructions)	0	4,339,519	97		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	4,339,519	97		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151313 Component CCN: 15Z313	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/10/2012 10:26 am
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
	1.00	2.00	3.00	4.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	0.411222	0	0	0		50.00
51.00 RECOVERY ROOM	0.428850	0	0	0		51.00
53.00 ANESTHESIOLOGY	0.071073	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.236529	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	0.226630	0	0	0		60.00
60.01 BLOOD LABORATORY	0.000000	0	0	0		60.01
65.00 RESPIRATORY THERAPY	0.333140	0	0	0		65.00
66.00 PHYSICAL THERAPY	0.649034	0	0	0		66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.236194	0	0	0		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 RURAL HEALTH CLINIC	0.000000					88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
91.00 EMERGENCY	0.354625	0	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.027805	0	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
96.00 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0		96.00
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: 151313	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/10/2012 10:26 am
		Component CCN: 15Z313	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		
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 OPERATING ROOM	0	0	0		50.00
51.00 RECOVERY ROOM	0	0	0		51.00
53.00 ANESTHESIOLOGY	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00 CT SCAN	0	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00 LABORATORY	0	0	0		60.00
60.01 BLOOD LABORATORY	0	0	0		60.01
65.00 RESPIRATORY THERAPY	0	0	0		65.00
66.00 PHYSICAL THERAPY	0	0	0		66.00
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
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 RURAL HEALTH CLINIC	0	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00 EMERGENCY	0	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00 DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00 Subtotal (see instructions)	0	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151313	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/10/2012 10:26 am
Cost Center Description		Cost		
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,393	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,169	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)		4,169	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		132	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		92	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)		1,503	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)		132	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
<b>SWING BED ADJUSTMENT</b>				
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		139.61	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)		5,121,513	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)		12,844	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)		169,632	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,951,881	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		4,311,773	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		4,311,773	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.148456	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)		1,034.25	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,951,881	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,187.79	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,785,248	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)		1,785,248	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151313		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1	
Title XVIII		Hospital		Cost		Date/Time Prepared: 5/10/2012 10:26 am	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	770,392	330	2,334.52	142	331,502		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,438,856		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,555,606		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)					156,788		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)					156,788		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)						679	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,187.79	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						806,509	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151313		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 5/10/2012 10:26 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	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: 151313	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/10/2012 10:26 am
Cost Center Description				Cost
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,393	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,169	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)		4,169	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		132	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		92	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)		265	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
<b>SWING BED ADJUSTMENT</b>				
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		139.61	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)		5,121,513	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)		12,844	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)		169,632	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,951,881	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		4,311,773	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		4,311,773	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.148456	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)		1,034.25	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,951,881	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,187.79	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		314,764	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)		314,764	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151313		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1	
Date/Time Prepared: 5/10/2012 10:26 am		Title XIX		Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	770,392	330	2,334.52	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					254,203		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					568,967		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)						679	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,187.79	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						806,509	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151313		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 5/10/2012 10:26 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	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: 151313	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/10/2012 10:26 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS		1,330,134		30.00
31.00	INTENSIVE CARE UNIT		301,285		31.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.411222	1,209,115	497,215	50.00
51.00	RECOVERY ROOM	0.428850	50,129	21,498	51.00
53.00	ANESTHESIOLOGY	0.071073	50,319	3,576	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.236529	391,522	92,606	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	0.226630	713,843	161,778	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0.333140	798,556	266,031	65.00
66.00	PHYSICAL THERAPY	0.649034	141,748	91,999	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.236194	1,282,987	303,034	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	EMERGENCY	0.354625	3,155	1,119	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.027805	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		4,641,374	1,438,856	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		4,641,374		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151313	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3	
		Component CCN: 15Z313		Date/Time Prepared: 5/10/2012 10:26 am	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS		42,938		30.00
31.00	INTENSIVE CARE UNIT		356		31.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.411222	3,346	1,376	50.00
51.00	RECOVERY ROOM	0.428850	1	0	51.00
53.00	ANESTHESIOLOGY	0.071073	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.236529	5,617	1,329	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	0.226630	11,666	2,644	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0.333140	20,083	6,690	65.00
66.00	PHYSICAL THERAPY	0.649034	56,655	36,771	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.236194	35,319	8,342	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	EMERGENCY	0.354625	2	1	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.027805	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		132,689	57,153	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)		132,689		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151313	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/10/2012 10:26 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS		354,439		30.00
31.00	INTENSIVE CARE UNIT		24,845		31.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY		0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.411222	252,924	104,008	50.00
51.00	RECOVERY ROOM	0.428850	29,327	12,577	51.00
53.00	ANESTHESIOLOGY	0.071073	21,824	1,551	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.236529	72,665	17,187	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	0.226630	130,328	29,536	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0.333140	81,285	27,079	65.00
66.00	PHYSICAL THERAPY	0.649034	6,934	4,500	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.236194	180,012	42,518	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
91.00	EMERGENCY	0.354625	42,996	15,247	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.027805	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
96.00	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		818,295	254,203	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)		818,295		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151313	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/10/2012 10:26 am
		Title XVIII	Hospital	Cost
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			4,339,616 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)			4,339,616 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
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
<b>Customary charges</b>				
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)			4,383,012 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
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)			29,608 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,330,568 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			2,022,836 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			2,022,836 30.00
31.00	Primary payer payments			915 31.00
32.00	Subtotal (line 30 minus line 31)			2,021,921 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			678,647 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			678,647 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			485,220 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			2,700,568 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			2,700,568 40.00
41.00	Interim payments			2,890,343 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)			-189,775 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151313

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/10/2012 10:26 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		3,154,322		2,693,836	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	08/30/2011	70,979		0	3.01	
3.02		12/06/2011	13,469		0	3.02	
3.03			48,234		344,718	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0	08/30/2011	108,847	3.50	
3.51			0	12/06/2011	39,364	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)		132,682		196,507	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)		3,287,004		2,890,343	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		50,716		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		189,775	6.02	
7.00	Total Medicare program liability (see instructions)		3,337,720		2,700,568	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: 151313

Period: From 01/01/2011

Worksheet E-1

Component CCN: 15Z313

To 12/31/2011

Part I  
Date/Time Prepared:  
5/10/2012 10:26 am

Title XVIII

Swing Beds - SNF

Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		196,235		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		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	08/30/2011	2,111		0	3.50
3.51		12/06/2011	431		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)		-2,542		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)		193,693		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		20,548		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		214,241		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 - SWING BEDS

Provider CCN: 151313	Period: From 01/01/2011 To 12/31/2011	Worksheet E-2
Component CCN: 15Z313		Date/Time Prepared: 5/10/2012 10:26 am
Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	158,356	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)	57,725	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	132	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)	216,081	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	216,081	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)	216,081	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	1,840	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)	214,241	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	214,241	0	19.00
20.00	Interim payments	193,693	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)	20,548	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151313	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part V Date/Time Prepared: 5/10/2012 10:26 am
		Title XVIII	Hospital	Cost
				1.00
<b>PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)</b>				
1.00	Inpatient services			3,555,606 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)			3,555,606 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5) . For CAH (see instructions)			3,591,162 6.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
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
<b>Customary charges</b>				
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
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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)			3,591,162 19.00
20.00	Deductibles (exclude professional component)			323,720 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			3,267,442 22.00
23.00	Coinsurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			3,267,442 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			70,278 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			70,278 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			50,794 27.00
28.00	Subtotal (sum of lines 24 and 25 or 26)			3,337,720 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)			3,337,720 30.00
31.00	Interim payments			3,287,004 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)			50,716 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: 151313	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part VII Date/Time Prepared: 5/10/2012 10:26 am
		Title XIX	Hospital	Cost
				1.00
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>				
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient hospital/SNF/NF services		568,967	1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		568,967	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)		568,967	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable Charges</b>				
8.00	Routine service charges		379,284	8.00
9.00	Ancillary service charges		818,295	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)		1,197,579	12.00
<b>CUSTOMARY CHRGES</b>				
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)		1,197,579	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		628,612	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)		568,967	21.00
<b>PROSPECTIVE PAYMENT AMOUNT</b>				
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.		568,967	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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)		568,967	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)		568,967	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		568,967	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)		568,967	40.00
41.00	Interim payments		264,669	41.00
42.00	Balance due provider/program (line 40 minus 41)		304,298	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: 151313      Period: From 01/01/2011 To 12/31/2011      Worksheet G  
 Date/Time Prepared: 5/10/2012 10:26 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	2,150,283	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,369,301	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	958,212	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	3,777,111	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)	11,254,907	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	345,223	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	17,329,990	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	17,675,213	0	0	0	30.00
<b>OTHER ASSETS</b>						
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	16,920	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	16,920	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	28,947,040	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	1,360,676	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,818,427	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,730,689	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,909,792	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	11,375,087	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	11,375,087	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	16,284,879	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	12,662,161				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)	12,662,161	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	28,947,040	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151313

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

Worksheet G-1

Date/Time Prepared:  
5/10/2012 10:26 am

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		12,265,465	
2.00	Net income (loss) (From Wkst. G-3, line 29)		396,696			2.00
3.00	Total (sum of line 1 and line 2)		12,662,161		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)		12,662,161		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)		12,662,161		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151313

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

Worksheet G-1

Date/Time Prepared:  
5/10/2012 10:26 am

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151313

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

Worksheet G-2 Parts

Date/Time Prepared:  
5/10/2012 10:26 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	4,311,773		4,311,773	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	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,311,773		4,311,773	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	744,005		744,005	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)	744,005		744,005	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,055,778		5,055,778	17.00
18.00	Ancillary services	11,266,428	54,948,415	66,214,843	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		519,253	519,253	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN OFFICES	0	9,831,783	9,831,783	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	16,322,206	65,299,451	81,621,657	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		38,421,837		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)		38,421,837		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151313

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

Worksheet G-3

Date/Time Prepared:  
5/10/2012 10:26 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	81,621,657	1.00
2.00	Less contractual allowances and discounts on patients' accounts	44,138,690	2.00
3.00	Net patient revenues (line 1 minus line 2)	37,482,967	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	38,421,837	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-938,870	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	1,114,739	24.00
24.01	TOTAL NONOPERATING EXPENSE	-43,173	24.01
24.02	TRANSFERS FROM COUNTY	264,000	24.02
25.00	Total other income (sum of lines 6-24)	1,335,566	25.00
26.00	Total (line 5 plus line 25)	396,696	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)	396,696	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151313

Period: From 01/01/2011

Worksheet H

HHA CCN: 157104

To 12/31/2011

Date/Time Prepared: 5/10/2012 10:26 am

Home Health Agency I

PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures			0		0	1.00
2.00	Capital Related - Movable Equipment			0		0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	71,566	0	21,987	0	164,234	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	201,098	0	0	0	0	6.00
7.00	Physical Therapy	59,361	0	0	0	0	7.00
8.00	Occupational Therapy	4,084	0	0	0	0	8.00
9.00	Speech Pathology	1,827	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	51,275	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	7,514	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	389,211	0	21,987	0	171,748	24.00

Column, 6 line 24 should agree with the Worksheet A, column 7, line 101, or subscript as applicable.

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151313

Period: From 01/01/2011

Worksheet H

HHA CCN: 157104

To 12/31/2011

Date/Time Prepared: 5/10/2012 10:26 am

Home Health Agency I

PPS

		Total (sum of col. 1 thru 5)	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
		6.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	257,787	0	257,787	0	257,787	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	201,098	0	201,098	0	201,098	6.00
7.00	Physical Therapy	59,361	0	59,361	0	59,361	7.00
8.00	Occupational Therapy	4,084	0	4,084	0	4,084	8.00
9.00	Speech Pathology	1,827	0	1,827	0	1,827	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	51,275	0	51,275	0	51,275	11.00
12.00	Supplies (see instructions)	7,514	0	7,514	0	7,514	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	582,946	0	582,946	0	582,946	24.00

Column, 6 line 24 should agree with the Worksheet A, column 7, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST	Provider CCN: 151313	Period: From 01/01/2011	Worksheet H-1 Part I Date/Time Prepared: 5/10/2012 10:26 am
	HHA CCN: 157104	To 12/31/2011	
		Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	
		Bldgs & Fixtures	Movable Equipment			
		1.00	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	Capital Related - Bldg. & Fixtures	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	257,787	0	0	0	5.00
<b>HHA REIMBURSABLE SERVICES</b>						
6.00	Skilled Nursing Care	201,098	0	0	0	6.00
7.00	Physical Therapy	59,361	0	0	0	7.00
8.00	Occupational Therapy	4,084	0	0	0	8.00
9.00	Speech Pathology	1,827	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	10.00
11.00	Home Health Aide	51,275	0	0	0	11.00
12.00	Supplies (see instructions)	7,514	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>						
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	582,946	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 151313	Period: From 01/01/2011	Worksheet H-1 Part I Date/Time Prepared: 5/10/2012 10:26 am
		HHA CCN: 157104	To 12/31/2011	
			Home Health Agency I	PPS

		Subtotal (col s. 0-4)	Administrative & General	Total (col s. 4A + 5)	
		4A.00	5.00	6.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	Capital Related - Bldg. & Fixtures	0			1.00
2.00	Capital Related - Movable Equipment	0			2.00
3.00	Plant Operation & Maintenance	0			3.00
4.00	Transportation				4.00
5.00	Administrative and General	257,787	257,787		5.00
<b>HHA REIMBURSABLE SERVICES</b>					
6.00	Skilled Nursing Care	201,098	159,431	360,529	6.00
7.00	Physical Therapy	59,361	47,062	106,423	7.00
8.00	Occupational Therapy	4,084	3,238	7,322	8.00
9.00	Speech Pathology	1,827	1,448	3,275	9.00
10.00	Medical Social Services	0	0	0	10.00
11.00	Home Health Aide	51,275	40,651	91,926	11.00
12.00	Supplies (see instructions)	7,514	5,957	13,471	12.00
13.00	Drugs	0	0	0	13.00
14.00	DME	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>					
15.00	Home Dialysis Aide Services	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	17.00
18.00	Clinic	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	19.00
20.00	Day Care Program	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	21.00
22.00	Homemaker Service	0	0	0	22.00
23.00	All Others (specify)	0	0	0	23.00
24.00	Total (sum of lines 1-23)	325,159		582,946	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 151313

Period: From 01/01/2011

Worksheet H-1

HHA CCN: 157104

To 12/31/2011

Part II  
Date/Time Prepared:  
5/10/2012 10:26 am

Home Health  
Agency I

PPS

		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)				
		1.00	2.00	3.00	4.00	5A.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation (see instructions)	0	0	0	0	0	4.00
5.00	Administrative and General	0	0	0	0	-257,787	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-257,787	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		26.00

COST ALLOCATION - HHA STATISTICAL BASIS	Provider CCN: 151313	Period: From 01/01/2011	Worksheet H-1 Part II Date/Time Prepared: 5/10/2012 10:26 am
	HHA CCN: 157104	To 12/31/2011	
		Home Health Agency I	PPS

		Administrative & General (ACCUM. COST)	
		5.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	Capital Related - Bldg. & Fixtures		1.00
2.00	Capital Related - Movable Equipment		2.00
3.00	Plant Operation & Maintenance		3.00
4.00	Transportation (see instructions)		4.00
5.00	Administrative and General	325,159	5.00
<b>HHA REIMBURSABLE SERVICES</b>			
6.00	Skilled Nursing Care	201,098	6.00
7.00	Physical Therapy	59,361	7.00
8.00	Occupational Therapy	4,084	8.00
9.00	Speech Pathology	1,827	9.00
10.00	Medical Social Services	0	10.00
11.00	Home Health Aide	51,275	11.00
12.00	Supplies (see instructions)	7,514	12.00
13.00	Drugs	0	13.00
14.00	DME	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>			
15.00	Home Dialysis Aide Services	0	15.00
16.00	Respiratory Therapy	0	16.00
17.00	Private Duty Nursing	0	17.00
18.00	Clinic	0	18.00
19.00	Health Promotion Activities	0	19.00
20.00	Day Care Program	0	20.00
21.00	Home Delivered Meals Program	0	21.00
22.00	Homemaker Service	0	22.00
23.00	All Others (specify)	0	23.00
24.00	Total (sum of lines 1-23)	325,159	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	257,787	25.00
26.00	Unit Cost Multiplier	0.792803	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151313

Period: From 01/01/2011

Worksheet H-2

HHA CCN: 157104

To 12/31/2011

Part I  
Date/Time Prepared:  
5/10/2012 10:26 am

Home Health Agency I

PPS

	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00	4.00		4A	5.00	
1.00 Administrative and General	0	0	0	48,484	48,484	7,094	1.00
2.00 Skilled Nursing Care	360,529	0	0	0	360,529	52,751	2.00
3.00 Physical Therapy	106,423	0	0	0	106,423	15,571	3.00
4.00 Occupational Therapy	7,322	0	0	0	7,322	1,071	4.00
5.00 Speech Pathology	3,275	0	0	0	3,275	479	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	91,926	0	0	0	91,926	13,450	7.00
8.00 Supplies (see instructions)	13,471	0	0	0	13,471	1,971	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	582,946	0	0	48,484	631,430	92,387	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151313

Period:

Worksheet H-2

HHA CCN: 157104

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

Part I  
Date/Time Prepared:  
5/10/2012 10:26 am

Home Health  
Agency I

PPS

		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151313

Period:

Worksheet H-2

HHA CCN: 157104

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

Part I  
Date/Time Prepared:  
5/10/2012 10:26 am

Home Health  
Agency I

PPS

	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
	13.00	14.00	15.00	16.00	24.00	
1.00 Administrative and General	25,485	463	0	0	81,526	1.00
2.00 Skilled Nursing Care	0	0	0	0	413,280	2.00
3.00 Physical Therapy	0	0	0	0	121,994	3.00
4.00 Occupational Therapy	0	0	0	0	8,393	4.00
5.00 Speech Pathology	0	0	0	0	3,754	5.00
6.00 Medical Social Services	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	105,376	7.00
8.00 Supplies (see instructions)	0	0	0	0	15,442	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	25,485	463	0	0	749,765	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151313

Period: From 01/01/2011

Worksheet H-2

HHA CCN: 157104

To 12/31/2011

Part I  
Date/Time Prepared:  
5/10/2012 10:26 am

Home Health Agency I

PPS

	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
	25.00	26.00	27.00	28.00	
1.00 Administrative and General	0	81,526			1.00
2.00 Skilled Nursing Care	0	413,280	50,421	463,701	2.00
3.00 Physical Therapy	0	121,994	14,883	136,877	3.00
4.00 Occupational Therapy	0	8,393	1,024	9,417	4.00
5.00 Speech Pathology	0	3,754	458	4,212	5.00
6.00 Medical Social Services	0	0	0	0	6.00
7.00 Home Health Aide	0	105,376	12,856	118,232	7.00
8.00 Supplies (see instructions)	0	15,442	1,884	17,326	8.00
9.00 Drugs	0	0	0	0	9.00
10.00 DME	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	0	749,765	81,526	749,765	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.122001		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151313  
HHA CCN: 157104

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

Worksheet H-2  
Part II  
Date/Time Prepared:  
5/10/2012 10:26 am  
PPS

	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)	1.00					
	4.00	5A					
1.00	Administrative and General	0	389,211	0	48,484	0	1.00
2.00	Skilled Nursing Care	0	0	0	360,529	0	2.00
3.00	Physical Therapy	0	0	0	106,423	0	3.00
4.00	Occupational Therapy	0	0	0	7,322	0	4.00
5.00	Speech Pathology	0	0	0	3,275	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	91,926	0	7.00
8.00	Supplies (see instructions)	0	0	0	13,471	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	389,211		631,430	0	20.00
21.00	Total cost to be allocated	0	48,484		92,387	0	21.00
22.00	Unit cost multiplier	0.000000	0.124570		0.146314	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 151313 HHA CCN: 157104	Period: From 01/01/2011 To 12/31/2011	Worksheet H-2 Part II Date/Time Prepared: 5/10/2012 10:26 am PPS
		Home Health Agency I	

	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
	8.00	9.00	10.00	11.00	13.00	
1.00 Administrative and General	0	0	0	0	13,674	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	0	0	13,674	20.00
21.00 Total cost to be allocated	0	0	0	0	25,485	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	1.863756	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 151313 HHA CCN: 157104	Period: From 01/01/2011 To 12/31/2011	Worksheet H-2 Part II Date/Time Prepared: 5/10/2012 10:26 am PPS
		Home Health Agency I	

	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
	14.00	15.00	16.00	
1.00 Administrative and General	7,514	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	2.00
3.00 Physical Therapy	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	4.00
5.00 Speech Pathology	0	0	0	5.00
6.00 Medical Social Services	0	0	0	6.00
7.00 Home Health Aide	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	8.00
9.00 Drugs	0	0	0	9.00
10.00 DME	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	13.00
14.00 Clinic	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	15.00
16.00 Day Care Program	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	17.00
18.00 Homemaker Service	0	0	0	18.00
19.00 All Others (specify)	0	0	0	19.00
20.00 Total (sum of lines 1-19)	7,514	0	0	20.00
21.00 Total cost to be allocated	463	0	0	21.00
22.00 Unit cost multiplier	0.061618	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 151313 HHA CCN: 157104		Period: From 01/01/2011 To 12/31/2011		Worksheet H-3 Parts I-III Date/Time Prepared: 5/10/2012 10:26 am	
		Title XVIII		Home Health Agency I		PPS	
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	
		0	1.00	2.00	3.00	4.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	463,701		463,701	1,621	1.00
2.00	Physical Therapy	3.00	136,877	0	136,877	760	2.00
3.00	Occupational Therapy	4.00	9,417	0	9,417	91	3.00
4.00	Speech Pathology	5.00	4,212	0	4,212	37	4.00
5.00	Medical Social Services	6.00	0		0	0	5.00
6.00	Home Health Aide	7.00	118,232		118,232	1,700	6.00
7.00	Total (sum of lines 1-6)		732,439	0	732,439	4,209	7.00
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits		
					Part B		
					Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	
Limitation Cost Computation							
8.00	Skilled Nursing Care			475	357		8.00
9.00	Physical Therapy			212	150		9.00
10.00	Occupational Therapy			33	39		10.00
11.00	Speech Pathology			31	0		11.00
12.00	Medical Social Services			0	0		12.00
13.00	Home Health Aide			272	617		13.00
14.00	Total (sum of lines 8-13)			1,023	1,163		14.00
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	
		0	1.00	2.00	3.00	4.00	
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	17,326	0	17,326	34,282	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	16.00
Cost Center Description		From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)		
		0	1.00	2.00	3.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy		66.00	0.649034	0	0	1.00
2.00	Occupational Therapy						2.00
3.00	Speech Pathology						3.00
4.00	Cost of Medical Supplies		71.00	0.000000	0	0	4.00
5.00	Cost of Drugs		73.00	0.236194	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151313  
HHA CCN: 157104

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

Worksheet H-3  
Parts I-III  
Date/Time Prepared:  
5/10/2012 10:26 am  
PPS

Title XVIII

Home Health  
Agency I

Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Part A	Program Visits			
			Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	5.00	6.00	7.00	8.00		
<b>PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION</b>						
<b>Cost Per Visit Computation</b>						
1.00	Skilled Nursing Care	286.06	475	357		1.00
2.00	Physical Therapy	180.10	212	150		2.00
3.00	Occupational Therapy	103.48	33	39		3.00
4.00	Speech Pathology	113.84	31	0		4.00
5.00	Medical Social Services	0.00	0	0		5.00
6.00	Home Health Aide	69.55	272	617		6.00
7.00	Total (sum of lines 1-6)		1,023	1,163		7.00
<b>Cost Center Description</b>						
		5.00	6.00	7.00	8.00	9.00
<b>Limitation Cost Computation</b>						
8.00	Skilled Nursing Care					8.00
9.00	Physical Therapy					9.00
10.00	Occupational Therapy					10.00
11.00	Speech Pathology					11.00
12.00	Medical Social Services					12.00
13.00	Home Health Aide					13.00
14.00	Total (sum of lines 8-13)					14.00
<b>Program Covered Charges</b>						
Cost Center Description	Ratio (col. 3 ÷ col. 4)	Part A	Part B			
			Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	5.00	6.00	7.00	8.00		
<b>Supplies and Drugs Cost Computations</b>						
15.00	Cost of Medical Supplies	0.505396	0	4,604	0	15.00
16.00	Cost of Drugs	0.000000	0	0	0	16.00
<b>Cost Center Description</b>						
			Transfer to Part I as Indicated			
			4.00			
<b>PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS</b>						
1.00	Physical Therapy		col. 2, line 2.00			1.00
2.00	Occupational Therapy					2.00
3.00	Speech Pathology					3.00
4.00	Cost of Medical Supplies		col. 2, line 15.00			4.00
5.00	Cost of Drugs		col. 2, line 16.00			5.00

APPORTIONMENT OF PATIENT SERVICE COSTS	Provider CCN: 151313	Period: From 01/01/2011	Worksheet H-3 Parts I-III Date/Time Prepared: 5/10/2012 10:26 am
	HHA CCN: 157104	To 12/31/2011	
	Title XVIII	Home Health Agency I	PPS

Cost Center Description	Cost of Services			Total Program Cost (sum of col.s. 9-10)	
	Part A	Part B			
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
9.00	10.00	11.00	12.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION					
Cost Per Visit Computation					
1.00	Skilled Nursing Care	135,879	102,123	238,002	1.00
2.00	Physical Therapy	38,181	27,015	65,196	2.00
3.00	Occupational Therapy	3,415	4,036	7,451	3.00
4.00	Speech Pathology	3,529	0	3,529	4.00
5.00	Medical Social Services	0	0	0	5.00
6.00	Home Health Aide	18,918	42,912	61,830	6.00
7.00	Total (sum of lines 1-6)	199,922	176,086	376,008	7.00
Cost Center Description					
		10.00	11.00	12.00	
Limitation Cost Computation					
8.00	Skilled Nursing Care				8.00
9.00	Physical Therapy				9.00
10.00	Occupational Therapy				10.00
11.00	Speech Pathology				11.00
12.00	Medical Social Services				12.00
13.00	Home Health Aide				13.00
14.00	Total (sum of lines 8-13)				14.00
Cost of Services					
Cost Center Description	Part A	Part B			
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	9.00	10.00	11.00		
Supplies and Drugs Cost Computations					
15.00	Cost of Medical Supplies	0	2,327	0	15.00
16.00	Cost of Drugs	0	0	0	16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 151313 HHA CCN: 157104	Period: From 01/01/2011 To 12/31/2011	Worksheet H-4 Part I-II Date/Time Prepared: 5/10/2012 10:26 am
		Title XVII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
<b>PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES</b>				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	2.00
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount 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(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
<b>PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT</b>				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		120,905	104,332
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	2,288
13.00	Total PPS Reimbursement - LUPA Episodes		1,293	3,203
14.00	Total PPS Reimbursement - PEP Episodes		790	765
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	188
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)			0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		122,988	110,776
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		122,988	110,776
25.00	Coinsurance billed to program patients (from your records)			0
26.00	Net cost (line 24 minus line 25)		122,988	110,776
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		122,988	110,776
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		122,988	110,776
32.00	Interim payments (see instructions)		122,988	110,777
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 32 and 33)		0	-1
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	0

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 151313	Period: From 01/01/2011	Worksheet H-5
	HHA CCN: 157104	To 12/31/2011	Date/Time Prepared: 5/10/2012 10:26 am
		Home Health Agency I	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		122,988		110,777	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			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		122,988		110,777	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1	6.02
7.00	Total Medicare program liability (see instructions)		122,988		110,776	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00