This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Falure 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: 140013	Period: From 01/01/2011 To 12/31/2011	Worksheet S Parts I-III Date/Time Prepared: 5/29/2012 8:27 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2012 Time: 8:27 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [0] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 04
12. [0] 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 PROCTOR 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	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-12,186	-4,405	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	-12,186	-4,405	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Falure 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: 140013	Period: From 01/01/2011 To 12/31/2011	Worksheet S Parts I-III Date/Time Prepared: 5/29/2012 8:27 pm

PART I - COST REPORT STATUS

Provider use only

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3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [0] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
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   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
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10. NPR Date:
11. Contractor's Vendor Code: 04
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CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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

Encryption Information

ECR: Date: 5/29/2012 Time: 8:27 pm
FNcG0McUZ:jgBcqOv9TcviH3:znVK0
7fIpw0VxYWRN8vMCURyAC4fdtooBes
miKW130YaB0YDAP0

PI: Date: 5/29/2012 Time: 8:27 pm
YqC1xhBN8FwAlIq0Ixonqf3rFbipb0
7FSKu0SVJswK1TQkTwGbL3xok3GNZf
gB6uZNwBq00tFVnL

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

_____
Title

_____
Date

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-12,186	-4,405	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	-12,186	-4,405	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2012 8:15 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 5409 N. KNOXVILLE	PO Box:			1.00
2.00	City: PEORIA	State: IL	Zip Code: 61614	County: PEORIA	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	PROCTOR HOSPITAL	140013	37900	1	08/01/1996	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF						N	N	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF	PROCTOR HOSPITAL	145579	37900		11/03/1987	N	P	P	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	PROCTOR HOSPITAL	147049	37900		09/01/1997	N	P	P	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) 1									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2011	12/31/2011	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N		22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.	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.	869	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

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140013	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/29/2012 8:15 pm

		Beginning:	Ending:	
		1.00	2.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	45.00
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME Average	Direct GME Average	
		1.00	2.00	3.00	
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00	61.00
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)				
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings				
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00

	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2012 8:15 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. Use subscripted lines 65.01 through 65.50 for each additional primary care program. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4.			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N		0	71.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140013	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/29/2012 8:15 pm

		1.00	2.00	3.00	
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.	N	80.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	N	86.00

		V	XIX	
		1.00	2.00	
	Title V or XIX Inpatient Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

		1.00	2.00	
	Miscellaneous Cost Reporting Information			
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.	N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0		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.	0	0	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2012 8:15 pm

		1.00	2.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00

		1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

		Part A	Part B	
		1.00	2.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)			
155.00	Hospital	N	N	155.00
156.00	Subprovider - IPF	N	N	156.00
157.00	Subprovider - IRF	N	N	157.00
158.00	SUBPROVIDER	N	N	158.00
159.00	SNF	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	160.00
161.00	CMHC		N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	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)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2012 8:15 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)				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.	N			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.	Y			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?			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.			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.			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.			11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		
		Description	Y/N	Date	
		0	1.00	2.00	
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y		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: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2012 8:15 pm

		Description	Part A Y/N	Part A Date		
		0	1.00	2.00		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N			21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions					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.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					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					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					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.					35.00
			Y/N	Date		
			1.00	2.00		
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?					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: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2012 8:15 pm

		Part B		
		Y/N	Date	
		3.00	4.00	
	PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y		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.			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.			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:			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: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part I Date/Time Prepared: 5/29/2012 8:15 pm

	Cost Center Description	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours		
		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	130	47,450	0.00		1.00
2.00	HMO						2.00
3.00	HMO IPF						3.00
4.00	HMO IRF						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		130	47,450	0.00		7.00
8.00	INTENSIVE CARE UNIT	31.00	12	4,380	0.00		8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00					13.00
14.00	Total (see instructions)		142	51,830	0.00		14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	20	7,300			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
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		162				27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2012 8:15 pm

	Cost Center Description	I/P Days / O/P Visits / Trips					
		Title V	Title XVIII	Title XIX	Total All Patients		
		5.00	6.00	7.00	8.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	12,343	565	22,264		1.00
2.00	HMO		0	0			2.00
3.00	HMO IPF		0	0			3.00
4.00	HMO IRF		0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	12,343	565	22,264		7.00
8.00	INTENSIVE CARE UNIT	0	1,463	39	2,508		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		265	1,327		13.00
14.00	Total (see instructions)	0	13,806	869	26,099		14.00
15.00	CAH visits	0	0	0	0		15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	3,546	0	4,788		19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	2,416	0	5,302		22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)						27.00
28.00	Observation Bed Days	0		0	2,010		28.00
29.00	Ambulance Trips		0				29.00
30.00	Employee discount days (see instruction)				305		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: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part I Date/Time Prepared: 5/29/2012 8:15 pm

	Cost Center Description	Full Time Equivalents			Discharges		
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
		9.00	10.00	11.00	12.00	13.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	2,850	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	791.04	0.00	0	2,850	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00	23.34	0.00			19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00	7.17	0.00			22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00	821.55	0.00			27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2012 8:15 pm

	Cost Center Description	Discharges			
		Title XIX	Total All Patients		
		14.00	15.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	515	5,969		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)	515	5,969		14.00
15.00	CAH visits				15.00
16.00	SUBPROVIDER - IPF				16.00
17.00	SUBPROVIDER - IRF				17.00
18.00	SUBPROVIDER				18.00
19.00	SKILLED NURSING FACILITY				19.00
20.00	NURSING FACILITY				20.00
21.00	OTHER LONG TERM CARE				21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00	HOSPICE				24.00
25.00	CMHC - CMHC				25.00
26.00	RURAL HEALTH CLINIC				26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00	Total (sum of lines 14-26)				27.00
28.00	Observation Bed Days				28.00
29.00	Ambulance Trips				29.00
30.00	Employee discount days (see instruction)				30.00
31.00	Employee discount days - IRF				31.00
32.00	Labor & delivery days (see instructions)				32.00
33.00	LTCH non-covered days				33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part II Date/Time Prepared: 5/29/2012 8:15 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
		1.00	2.00	3.00	4.00	5.00	
	PART II - WAGE DATA						
	SALARIES						
1.00	Total salaries (see instructions)	200.00	39,076,484	0	39,076,484	1,713,032.00	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	3.00
4.00	Physician-Part A		0	0	0	0.00	4.00
4.01	Physicians - Part A - direct teaching		0	0	0	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	7.00
7.01	Contracted interns and residents (in approved programs)		0	0	0	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	8.00
9.00	SNF	44.00	1,052,404	56,709	1,109,113	53,850.00	9.00
10.00	Excluded area salaries (see instructions)		2,286,712	242,985	2,529,697	131,424.00	10.00
	OTHER WAGES & RELATED COSTS						
11.00	Contract labor (see instructions)		1,596,297	0	1,596,297	36,086.00	11.00
12.00	Management and administrative services		0	0	0	0.00	12.00
13.00	Contract labor: physician-Part A		51,786	0	51,786	1,040.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	14.00
15.00	Home office: physician Part A		0	0	0	0.00	15.00
16.00	Teaching physician salaries (see instructions)		0	0	0	0.00	16.00
	WAGE-RELATED COSTS						
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		11,656,946	0	11,656,946		17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV line 25		0	0	0		18.00
19.00	Excluded areas		1,192,495	0	1,192,495		19.00
20.00	Non-physician anesthetist Part A		0	0	0		20.00
21.00	Non-physician anesthetist Part B		0	0	0		21.00
22.00	Physician Part A		0	0	0		22.00
23.00	Physician Part B		0	0	0		23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0		24.00
25.00	Interns & residents (in an approved program)		0	0	0		25.00
	OVERHEAD COSTS - DIRECT SALARIES						
26.00	Employee Benefits	4.00	166,838	0	166,838	2,102.00	26.00
27.00	Administrative & General	5.00	5,813,933	0	5,813,933	236,254.00	27.00
28.00	Administrative & General under contract (see inst.)		428,053	0	428,053	2,805.00	28.00
29.00	Maintenance & Repairs	6.00	733,939	0	733,939	31,364.00	29.00
30.00	Operation of Plant	7.00	391,724	0	391,724	21,425.00	30.00
31.00	Laundry & Linen Service	8.00	38,663	0	38,663	4,094.00	31.00
32.00	Housekeeping	9.00	894,871	0	894,871	81,490.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	33.00
34.00	Dietary	10.00	881,170	-585,706	295,464	24,385.00	34.00
35.00	Dietary under contract (see instructions)		225,275	0	225,275	6,000.00	35.00
36.00	Cafeteria	11.00	0	286,012	286,012	22,999.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	37.00
38.00	Nursing Administration	13.00	943,568	0	943,568	29,592.00	38.00
39.00	Central Services and Supply	14.00	226,275	0	226,275	18,165.00	39.00
40.00	Pharmacy	15.00	1,079,468	0	1,079,468	33,015.00	40.00
41.00	Medical Records & Medical Records Library	16.00	847,572	0	847,572	54,595.00	41.00
42.00	Social Service	17.00	116,984	0	116,984	5,972.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part II Date/Time Prepared: 5/29/2012 8:15 pm

		Average Hourly Wage (col. 4 ÷ col. 5)		
		6.00		
	PART II - WAGE DATA			
	SALARIES			
1.00	Total salaries (see instructions)	22.81		1.00
2.00	Non-physician anesthetist Part A	0.00		2.00
3.00	Non-physician anesthetist Part B	0.00		3.00
4.00	Physician-Part A	0.00		4.00
4.01	Physicians - Part A - direct teaching	0.00		4.01
5.00	Physician-Part B	0.00		5.00
6.00	Non-physician-Part B	0.00		6.00
7.00	Interns & residents (in an approved program)	0.00		7.00
7.01	Contracted interns and residents (in approved programs)	0.00		7.01
8.00	Home office personnel	0.00		8.00
9.00	SNF	20.60		9.00
10.00	Excluded area salaries (see instructions)	19.25		10.00
	OTHER WAGES & RELATED COSTS			
11.00	Contract labor (see instructions)	44.24		11.00
12.00	Management and administrative services	0.00		12.00
13.00	Contract labor: physician-Part A	49.79		13.00
14.00	Home office salaries & wage-related costs	0.00		14.00
15.00	Home office: physician Part A	0.00		15.00
16.00	Teaching physician salaries (see instructions)	0.00		16.00
	WAGE-RELATED COSTS			
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24			17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV line 25			18.00
19.00	Excluded areas			19.00
20.00	Non-physician anesthetist Part A			20.00
21.00	Non-physician anesthetist Part B			21.00
22.00	Physician Part A			22.00
23.00	Physician Part B			23.00
24.00	Wage-related costs (RHC/FQHC)			24.00
25.00	Interns & residents (in an approved program)			25.00
	OVERHEAD COSTS - DIRECT SALARIES			
26.00	Employee Benefits	79.37		26.00
27.00	Administrative & General	24.61		27.00
28.00	Administrative & General under contract (see inst.)	152.60		28.00
29.00	Maintenance & Repairs	23.40		29.00
30.00	Operation of Plant	18.28		30.00
31.00	Laundry & Linen Service	9.44		31.00
32.00	Housekeeping	10.98		32.00
33.00	Housekeeping under contract (see instructions)	0.00		33.00
34.00	Dietary	12.12		34.00
35.00	Dietary under contract (see instructions)	37.55		35.00
36.00	Cafeteria	12.44		36.00
37.00	Maintenance of Personnel	0.00		37.00
38.00	Nursing Administration	31.89		38.00
39.00	Central Services and Supply	12.46		39.00
40.00	Pharmacy	32.70		40.00
41.00	Medical Records & Medical Records Library	15.52		41.00
42.00	Social Service	19.59		42.00
43.00	Other General Service	0.00		43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part III Date/Time Prepared: 5/29/2012 8:15 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
		1.00	2.00	3.00	4.00	5.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY						
1.00	Net salaries (see instructions)		39,729,812	0	39,729,812	1,721,837.00	1.00
2.00	Excluded area salaries (see instructions)		3,339,116	299,694	3,638,810	185,274.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)		36,390,696	-299,694	36,091,002	1,536,563.00	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,648,083	0	1,648,083	37,126.00	4.00
5.00	Subtotal wage-related costs (see inst.)		11,656,946	0	11,656,946	0.00	5.00
6.00	Total (sum of lines 3 thru 5)		49,695,725	-299,694	49,396,031	1,573,689.00	6.00
7.00	Total overhead cost (see instructions)		12,788,333	-299,694	12,488,639	574,257.00	7.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part III Date/Time Prepared: 5/29/2012 8:15 pm

		Average Hourly Wage (col. 4 ÷ col. 5)		
		6.00		
	PART III - HOSPITAL WAGE INDEX SUMMARY			
1.00	Net salaries (see instructions)	23.07		1.00
2.00	Excluded area salaries (see instructions)	19.64		2.00
3.00	Subtotal salaries (line 1 minus line 2)	23.49		3.00
4.00	Subtotal other wages & related costs (see inst.)	44.39		4.00
5.00	Subtotal wage-related costs (see inst.)	32.30		5.00
6.00	Total (sum of lines 3 thru 5)	31.39		6.00
7.00	Total overhead cost (see instructions)	21.75		7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part IV Date/Time Prepared: 5/29/2012 8:15 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,445,141	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	38,100	3.00
4.00	Prior Year Pension Service Cost	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	7,204,010	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	36,729	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	241,286	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	753,061	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,872,786	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	104,798	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation	0	21.00
22.00	Day Care Cost and Allowances	62,827	22.00
23.00	Tuition Reimbursement	90,703	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	12,849,441	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part V Date/Time Prepared: 5/29/2012 8:15 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1,596,297	0	1.00
2.00	Hospital	1,596,297	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00		0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 140013 | Component CCN: 147049 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-4 | Date/Time Prepared: 5/29/2012 8:15 pm

Home Health Agency I | PPS

		1.00	
0.00	County	PEORIA	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	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	261.00	1.00	187.00	449.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	1.00	0.00	1.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		1.16	0.00	1.16	5.00
6.00	Direct Nursing Service		6.11	0.00	6.11	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	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			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		37900			20.00

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,074	74	109	29	1,286	21.00
22.00	Skilled Nursing Visit Charges	252,729	17,316	25,506	6,786	302,337	22.00
23.00	Physical Therapy Visits	955	2	49	22	1,028	23.00
24.00	Physical Therapy Visit Charges	278,686	584	14,308	6,424	300,002	24.00
25.00	Occupational Therapy Visits	85	0	0	7	92	25.00
26.00	Occupational Therapy Visit Charges	24,704	0	0	2,044	26,748	26.00
27.00	Speech Pathology Visits	10	0	0	0	10	27.00
28.00	Speech Pathology Visit Charges	2,920	0	0	0	2,920	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	0	0	0	0	0	31.00
32.00	Home Health Aide Visit Charges	0	0	0	0	0	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,124	76	158	58	2,416	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	559,039	17,900	39,814	15,254	632,007	35.00
36.00	Total Number of Episodes (standard/non outlier)	202		53	6	261	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	16,210	939	2,077	962	20,188	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-7 | Date/Time Prepared: 5/29/2012 8:15 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N		2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	14	0	14	6.00
7.00		RHX	92	0	92	7.00
8.00		RHL	103	0	103	8.00
9.00		RMX	30	0	30	9.00
10.00		RML	35	0	35	10.00
11.00		RLX	2	0	2	11.00
12.00		RUC	8	0	8	12.00
13.00		RUB	88	0	88	13.00
14.00		RUA	41	0	41	14.00
15.00		RVC	86	0	86	15.00
16.00		RVB	522	0	522	16.00
17.00		RVA	302	0	302	17.00
18.00		RHC	311	0	311	18.00
19.00		RHB	759	0	759	19.00
20.00		RHA	491	0	491	20.00
21.00		RMC	117	0	117	21.00
22.00		RMB	153	0	153	22.00
23.00		RMA	124	0	124	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	44	0	44	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	18	0	18	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	18	0	18	32.00
33.00		HC2	5	0	5	33.00
34.00		HC1	25	0	25	34.00
35.00		HB2	7	0	7	35.00
36.00		HB1	73	0	73	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	3	0	3	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	10	0	10	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	3	0	3	48.00
49.00		CC2	6	0	6	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	24	0	24	52.00
53.00		CA2	30	0	30	53.00
54.00		CA1	0	0	0	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-7 | Date/Time Prepared: 5/29/2012 8:15 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	2	0	2	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		3,546	0	3,546	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	37900	37900	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	1,052,404	100.00	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	2,824,693			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140013	Period: From 01/01/2011 To 12/31/2011	Worksheet S-10 Date/Time Prepared: 5/29/2012 8:15 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)	0.266014	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,863,438	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	11,503,190	6.00
7.00	Medicaid cost (line 1 times line 6)	3,060,010	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,196,572	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	17,666	9.00
10.00	Stand-alone SCHIP charges	122,623	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	32,619	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	14,953	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,211,525	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	3,168,522	0	3,168,522	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	842,871	0	842,871	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	842,871	0	842,871	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,296,032	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	364,833	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	3,931,199	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	1,045,754	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	1,888,625	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,100,150	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A | Date/Time Prepared: 5/29/2012 8:15 pm

	Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT		3,572,756	3,572,756	-172,509	3,400,247	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		4,895,514	4,895,514	0	4,895,514	2.00
4.00	EMPLOYEE BENEFITS	166,838	10,557,354	10,724,192	28,111	10,752,303	4.00
5.00	ADMINISTRATIVE & GENERAL	5,813,933	8,998,271	14,812,204	-192,016	14,620,188	5.00
6.00	MAINTENANCE & REPAIRS	733,939	2,128,736	2,862,675	73,101	2,935,776	6.00
7.00	OPERATION OF PLANT	391,724	135,509	527,233	72,335	599,568	7.00
8.00	LAUNDRY & LINEN SERVICE	38,663	398,396	437,059	0	437,059	8.00
9.00	HOUSEKEEPING	894,871	158,229	1,053,100	134,919	1,188,019	9.00
10.00	DIETARY	881,170	933,430	1,814,600	-1,206,148	608,452	10.00
11.00	CAFETERIA	0	0	0	588,987	588,987	11.00
13.00	NURSING ADMINISTRATION	943,568	127,479	1,071,047	0	1,071,047	13.00
14.00	CENTRAL SERVICES & SUPPLY	226,275	196	226,471	-43,477	182,994	14.00
15.00	PHARMACY	1,079,468	387,920	1,467,388	-47,522	1,419,866	15.00
16.00	MEDICAL RECORDS & LIBRARY	847,572	1,690,280	2,537,852	0	2,537,852	16.00
17.00	SOCIAL SERVICE	116,984	14,224	131,208	0	131,208	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	6,860,879	1,302,814	8,163,693	-860,328	7,303,365	30.00
31.00	INTENSIVE CARE UNIT	2,007,193	299,976	2,307,169	-196,342	2,110,827	31.00
43.00	NURSERY	0	0	0	345,037	345,037	43.00
44.00	SKILLED NURSING FACILITY	1,052,404	137,312	1,189,716	46,970	1,236,686	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	4,359,311	13,637,701	17,997,012	-11,933,866	6,063,146	50.00
52.00	DELIVERY ROOM & LABOR ROOM	810,293	1,013,325	1,823,618	-127,917	1,695,701	52.00
53.00	ANESTHESIOLOGY	41,479	390,144	431,623	-289,815	141,808	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,962,310	2,809,998	4,772,308	-435,151	4,337,157	54.00
60.00	LABORATORY	1,570,494	2,908,428	4,478,922	-167,530	4,311,392	60.00
65.00	RESPIRATORY THERAPY	1,063,258	196,668	1,259,926	-53,156	1,206,770	65.00
66.00	PHYSICAL THERAPY	260,206	2,128,626	2,388,832	-355,901	2,032,931	66.00
70.00	ELECTROENCEPHALOGRAPHY	890,506	4,295,062	5,185,568	-2,920,413	2,265,155	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,623,712	6,623,712	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	10,933,713	10,933,713	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	2,565,241	2,565,241	-40,045	2,525,196	73.00
76.97	CARDIAC REHABILITATION	190,456	146,424	336,880	-1,099	335,781	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	1,280,254	1,606,265	2,886,519	-40	2,886,479	90.00
91.00	EMERGENCY	2,305,724	319,219	2,624,943	-303,990	2,320,953	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	419,426	229,371	648,797	0	648,797	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	37,209,198	67,984,868	105,194,066	-500,380	104,693,686	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	MARKETING	0	0	0	0	0	194.02
194.03	GUEST MEALS	0	0	0	111,137	111,137	194.03
194.04	PHYSICIAN/OTHER MEALS	0	0	0	263,892	263,892	194.04
194.05	FOUNDATION	0	0	0	0	0	194.05
194.06	DAYCARE CENTER	394,598	59,566	454,164	110,611	564,775	194.06
194.07	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	ARC BROMENN	647,622	355,889	1,003,511	14,740	1,018,251	194.09
194.10	ARC INGALLS	825,066	230,770	1,055,836	0	1,055,836	194.10
200.00	TOTAL (SUM OF LINES 118-199)	39,076,484	68,631,093	107,707,577	0	107,707,577	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A | Date/Time Prepared: 5/29/2012 8:15 pm

	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	-328,256	3,071,991		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-6,071	4,889,443		2.00
4.00	EMPLOYEE BENEFITS	-2,325,600	8,426,703		4.00
5.00	ADMINISTRATIVE & GENERAL	-1,741,101	12,879,087		5.00
6.00	MAINTENANCE & REPAIRS	-64,158	2,871,618		6.00
7.00	OPERATION OF PLANT	-11,398	588,170		7.00
8.00	LAUNDRY & LINEN SERVICE	-4,095	432,964		8.00
9.00	HOUSEKEEPING	0	1,188,019		9.00
10.00	DIETARY	0	608,452		10.00
11.00	CAFETERIA	0	588,987		11.00
13.00	NURSING ADMINISTRATION	-3,803	1,067,244		13.00
14.00	CENTRAL SERVICES & SUPPLY	0	182,994		14.00
15.00	PHARMACY	0	1,419,866		15.00
16.00	MEDICAL RECORDS & LIBRARY	-530	2,537,322		16.00
17.00	SOCIAL SERVICE	0	131,208		17.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-600,116	6,703,249		30.00
31.00	INTENSIVE CARE UNIT	0	2,110,827		31.00
43.00	NURSERY	0	345,037		43.00
44.00	SKILLED NURSING FACILITY	-6,300	1,230,386		44.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	6,063,146		50.00
52.00	DELIVERY ROOM & LABOR ROOM	-813,828	881,873		52.00
53.00	ANESTHESIOLOGY	0	141,808		53.00
54.00	RADIOLOGY-DIAGNOSTIC	-13,386	4,323,771		54.00
60.00	LABORATORY	-108,002	4,203,390		60.00
65.00	RESPIRATORY THERAPY	-30,510	1,176,260		65.00
66.00	PHYSICAL THERAPY	-1,942	2,030,989		66.00
70.00	ELECTROENCEPHALOGRAPHY	0	2,265,155		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,623,712		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	10,933,713		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	2,525,196		73.00
76.97	CARDIAC REHABILITATION	-73,823	261,958		76.97
	OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	-551,450	2,335,029		90.00
91.00	EMERGENCY	-22,836	2,298,117		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	OTHER REIMBURSABLE COST CENTERS				
101.00	HOME HEALTH AGENCY	-3,505	645,292		101.00
	SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	-6,710,710	97,982,976		118.00
	NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	UN-USED SQR FT - HOSPITAL	0	0		194.00
194.01	MEALS ON WHEELS	0	0		194.01
194.02	MARKETING	0	0		194.02
194.03	GUEST MEALS	0	111,137		194.03
194.04	PHYSICIAN/OTHER MEALS	0	263,892		194.04
194.05	FOUNDATION	0	0		194.05
194.06	DAYCARE CENTER	0	564,775		194.06
194.07	UN-USED SQR FT - POB	0	0		194.07
194.08	SENIOR SERVICES	0	0		194.08
194.09	ARC BROMENN	0	1,018,251		194.09
194.10	ARC INGALLS	0	1,055,836		194.10
200.00	TOTAL (SUM OF LINES 118-199)	-6,710,710	100,996,867		200.00

RECLASSIFICATIONS | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-6 | Date/Time Prepared: 5/29/2012 8:15 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	286,012	302,975	1.00
2.00	SKILLED NURSING FACILITY	44.00	56,709	60,072	2.00
3.00	GUEST MEALS	194.03	53,968	57,169	3.00
4.00	PHYSICIAN/OTHER MEALS	194.04	128,146	135,746	4.00
5.00	DAYCARE CENTER	194.06	53,713	56,898	5.00
6.00	ARC BROMENN	194.09	7,158	7,582	6.00
	TOTALS		585,706	620,442	
	B - POB EXPENSE				
1.00	EMPLOYEE BENEFITS	4.00	0	38,055	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	7,146	2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	73,101	3.00
4.00	OPERATION OF PLANT	7.00	0	72,335	4.00
5.00	HOUSEKEEPING	9.00	0	134,919	5.00
	TOTALS		0	325,556	
	C - NURSERY RECLASS				
1.00	NURSERY	43.00	313,790	31,247	1.00
	TOTALS		313,790	31,247	
	D - INSURANCE RECLASS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	193,566	1.00
	TOTALS		0	193,566	
	E - BENEFITS				
1.00	EMPLOYEE BENEFITS	4.00	0	12,504	1.00
	TOTALS		0	12,504	
	F - DRUGS RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	22,448	1.00
	TOTALS		0	22,448	
	G - MED SUPPLIES RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6,931,613	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
	TOTALS		0	6,931,613	
	H - LEASE EXPENSE RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,908	1.00
2.00	PHARMACY	15.00	0	15,297	2.00
3.00	OPERATING ROOM	50.00	0	18,314	3.00
	TOTALS		0	40,519	
	I - IMPLANTIBLE RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	10,933,713	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
	TOTALS		0	10,933,713	
500.00	Grand Total: Increases		899,496	19,111,608	500.00

RECLASSIFICATIONS | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-6 | Date/Time Prepared: 5/29/2012 8:15 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	585,706	620,442	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	TOTALS		585,706	620,442			
	B - POB EXPENSE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	325,556	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	TOTALS		0	325,556			
	C - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	313,790	31,247	0		1.00
	TOTALS		313,790	31,247			
	D - INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	193,566	9		1.00
	TOTALS		0	193,566			
	E - BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	12,504	0		1.00
	TOTALS		0	12,504			
	F - DRUGS RECLASS						
1.00	EMPLOYEE BENEFITS	4.00	0	22,448	0		1.00
	TOTALS		0	22,448			
	G - MED SUPPLIES RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	43,477	0		1.00
2.00	PHARMACY	15.00	0	62,819	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	510,458	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	191,569	0		4.00
5.00	SKILLED NURSING FACILITY	44.00	0	69,152	0		5.00
6.00	OPERATING ROOM	50.00	0	4,336,182	0		6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	127,315	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	289,815	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	175,994	0		9.00
10.00	LABORATORY	60.00	0	167,530	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	53,156	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	101,347	0		12.00
13.00	ELECTROENCEPHALOGRAPHY	70.00	0	441,614	0		13.00
14.00	DRUGS CHARGED TO PATIENTS	73.00	0	62,493	0		14.00
15.00	CARDIAC REHABILITATION	76.97	0	1,099	0		15.00
16.00	CLINIC	90.00	0	40	0		16.00
17.00	EMERGENCY	91.00	0	297,553	0		17.00
	TOTALS		0	6,931,613			
	H - LEASE EXPENSE RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	40,519	11		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	40,519			
	I - IMPLANTIBLE RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	4,833	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	4,773	0		2.00
3.00	SKILLED NURSING FACILITY	44.00	0	659	0		3.00
4.00	OPERATING ROOM	50.00	0	7,615,998	0		4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	0	602	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	259,157	0		6.00
7.00	PHYSICAL THERAPY	66.00	0	254,554	0		7.00
8.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,478,799	0		8.00
9.00	EMERGENCY	91.00	0	6,437	0		9.00
10.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	307,901	0		10.00
	TOTALS		0	10,933,713			
500.00	Grand Total: Decreases		899,496	19,111,608			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 5/29/2012 8:15 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	773,664	0	0	0	0	1.00
2.00	Land Improvements	11,157,934	1,108	0	1,108	0	2.00
3.00	Buildings and Fixtures	53,143,288	135,568	0	135,568	0	3.00
4.00	Building Improvements	429,739	0	0	0	0	4.00
5.00	Fixed Equipment	18,912,594	247,704	0	247,704	0	5.00
6.00	Movable Equipment	54,103,579	1,480,011	0	1,480,011	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	138,520,798	1,864,391	0	1,864,391	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	138,520,798	1,864,391	0	1,864,391	0	10.00

		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	3,572,756	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4,895,514	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	8,468,270	0	0	0	0	3.00

		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
	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	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	84,801,599	0	84,801,599	0.604064	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	55,583,590	0	55,583,590	0.395936	0	2.00
3.00	Total (sum of lines 1-2)	140,385,189	0	140,385,189	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 5/29/2012 8:15 pm

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	773,664	0	1.00
2.00	Land Improvements	11,159,042	0	2.00
3.00	Buildings and Fixtures	53,278,856	0	3.00
4.00	Building Improvements	429,739	0	4.00
5.00	Fixed Equipment	19,160,298	0	5.00
6.00	Movable Equipment	55,583,590	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	140,385,189	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	140,385,189	0	10.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	3,572,756	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	4,895,514	2.00
3.00	Total (sum of lines 1-2)	0	8,468,270	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	3,434,710	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	4,889,443	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	8,324,153	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 5/29/2012 8:15 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	-307,934	-54,785	0	0	3,071,991	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	4,889,443	2.00
3.00	Total (sum of lines 1-2)	-307,934	-54,785	0	0	7,961,434	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8 | Date/Time Prepared: 5/29/2012 8:15 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)		0		0.00	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	7.00
8.00	Television and radio service (chapter 21)		0		0.00	8.00
9.00	Parking lot (chapter 21)		0		0.00	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,814,516			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	-6,056			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Cafeteria-employees and guests		0		0.00	14.00
15.00	Rental of quarters to employee and others		0		0.00	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	16.00
17.00	Sale of drugs to other than patients		0		0.00	17.00
18.00	Sale of medical records and abstracts		0		0.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00	Vending machines		0		0.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant		0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	0		0.00	32.00
33.00	A&G - MISC REVENUE	B	-131,693	ADMINISTRATIVE & GENERAL	5.00	33.00
33.01	COLLECTION FEE REVENUE - PHYS	B	-399,112	ADMINISTRATIVE & GENERAL	5.00	33.01
33.02	CORPERATE WELLNESS	B	-44,238	ADMINISTRATIVE & GENERAL	5.00	33.02
33.03	MAINTENANCE REV	B	-64,158	MAINTENANCE & REPAIRS	6.00	33.03
33.04	PLANT OP OTHER REV	B	-2,200	OPERATION OF PLANT	7.00	33.04
33.05	LAUNDRY REVENUE	B	-4,095	LAUNDRY & LINEN SERVICE	8.00	33.05
33.06	HEALTH PROMOTIONS	B	-1,149	NURSING ADMINISTRATION	13.00	33.06
33.07	SALE OF MEDICAL RECORDS	B	-530	MEDICAL RECORDS & LIBRARY	16.00	33.07
33.08			0		0.00	33.08
33.09	TRAINING FEES	B	-13,770	ADULTS & PEDIATRICS	30.00	33.09
33.10	MISC INCOME -A&P	B	-12,386	ADULTS & PEDIATRICS	30.00	33.10
33.11			0		0.00	33.11
33.12	LABOR AND DELIVERY REVENUE	B	-4,596	DELIVERY ROOM & LABOR ROOM	52.00	33.12
33.13	RADIOLOGY - MISC REVENUE	B	-13,386	RADIOLOGY-DIAGNOSTIC	54.00	33.13
33.14	LAB - MISC REV	B	-213	LABORATORY	60.00	33.14
33.15			0		0.00	33.15
33.16	CARDIAC REHAB - MISC REV	B	-63,823	CARDIAC REHABILITATION	76.97	33.16
33.17	COUNSELING CTR MISC REV	B	-21,301	CLINIC	90.00	33.17
33.18	EMERGENCY ROOM - MISC REVENUE	B	-22,254	EMERGENCY	91.00	33.18
33.19	HHA - MISC REVENUE	B	-2,150	HOME HEALTH AGENCY	101.00	33.19

ADJUSTMENTS TO EXPENSES | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8 | Date/Time Prepared: 5/29/2012 8:15 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
33.20	INVESTMENT PROPERTY TAXES	A	-114,000	ADMINISTRATIVE & GENERAL	5.00	33.20
33.21	ADVERTISING A&G	A	-853,176	ADMINISTRATIVE & GENERAL	5.00	33.21
33.22	MARKETING A&G	A	-5,188	ADMINISTRATIVE & GENERAL	5.00	33.22
33.23	MARKETING - FAMILY MATERNITY CENTER	A	-6,868	ADULTS & PEDIATRICS	30.00	33.23
33.24	MARKETING - PROCTOR HOME HEALTH	A	-1,355	HOME HEALTH AGENCY	101.00	33.24
33.25	MARKETING - WOUND CARE CLINIC	A	-1,942	PHYSICAL THERAPY	66.00	33.25
33.26	MARKETING - SLEEP LAB/EEG	A	-510	RESPIRATORY THERAPY	65.00	33.26
33.27			0		0.00	33.27
33.28	MARKETING - COMMUNITY OUTREACH	A	-245,728	CLINIC	90.00	33.28
33.29	MARKETING - PATIENT SERVICES	A	-2,389	NURSING ADMINISTRATION	13.00	33.29
33.30	ENTERTAINMENT EXPENSE	A	-18,327	ADMINISTRATIVE & GENERAL	5.00	33.30
33.31	ENTERTAINMENT EXPENSE	A	-265	NURSING ADMINISTRATION	13.00	33.31
33.32	ENTERTAINMENT EXPENSE	A	-318	ADULTS & PEDIATRICS	30.00	33.32
33.33			0		0.00	33.33
33.34	ENTERTAINMENT EXPENSE	A	-582	EMERGENCY	91.00	33.34
33.35			0		0.00	33.35
33.36	INTEREST EXPENSE	A	-267,415	NEW CAP REL COSTS-BLDG & FIXT	1.00	33.36
33.37			0		0.00	33.37
33.38	IHA DUES LOBBYING FFES	A	-24,073	ADMINISTRATIVE & GENERAL	5.00	33.38
33.39	POB SECURITY COST	A	-9,198	OPERATION OF PLANT	7.00	33.39
33.40	POB SECURITY COST	A	-2,483	EMPLOYEE BENEFITS	4.00	33.40
33.41	GRANT EXP OFFSET	A	-48,584	ADMINISTRATIVE & GENERAL	5.00	33.41
33.42	POB PROPERTY INSURANCE	A	-54,785	NEW CAP REL COSTS-BLDG & FIXT	1.00	33.42
33.43	SELF FUNDED INSURANCE	A	-2,322,066	EMPLOYEE BENEFITS	4.00	33.43
33.44	TELEPHONE SERVICES - SALARIES	A	-3,824	ADMINISTRATIVE & GENERAL	5.00	33.44
33.45	TELEPHONE SERVICES - BENEFITS	A	-1,051	EMPLOYEE BENEFITS	4.00	33.45
33.46	TELEPHONE SERVICES - EQUIPMENT	A	-1,649	NEW CAP REL COSTS-MVBLE EQUIP	2.00	33.46
33.47			0		0.00	33.47
33.48	PERSONAL USE OF VEHICLES	A	-4,422	NEW CAP REL COSTS-MVBLE EQUIP	2.00	33.48
33.49	MEDICAL STAFF OFFICER DUES	A	-98,886	ADMINISTRATIVE & GENERAL	5.00	33.49
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,710,710			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8 | Date/Time Prepared: 5/29/2012 8:15 pm

	Cost Center Description	Wkst. A-7 Ref. 5.00		
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0		1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	0		2.00
3.00	Investment income - other (chapter 2)	0		3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0		4.00
5.00	Refunds and rebates of expenses (chapter 8)	0		5.00
6.00	Rental of provider space by suppliers (chapter 8)	0		6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0		7.00
8.00	Television and radio service (chapter 21)	0		8.00
9.00	Parking lot (chapter 21)	0		9.00
10.00	Provider-based physician adjustment	0		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0		11.00
12.00	Related organization transactions (chapter 10)	0		12.00
13.00	Laundry and linen service	0		13.00
14.00	Cafeteria-employees and guests	0		14.00
15.00	Rental of quarters to employee and others	0		15.00
16.00	Sale of medical and surgical supplies to other than patients	0		16.00
17.00	Sale of drugs to other than patients	0		17.00
18.00	Sale of medical records and abstracts	0		18.00
19.00	Nursing school (tuition, fees, books, etc.)	0		19.00
20.00	Vending machines	0		20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0		21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0		22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)			23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)			24.00
25.00	Utilization review - physicians' compensation (chapter 21)			25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0		26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0		27.00
28.00	Non-physician Anesthetist			28.00
29.00	Physicians' assistant	0		29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)			30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)			31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0		32.00
33.00	A&G - MISC REVENUE	0		33.00
33.01	COLLECTION FEE REVENUE - PHYS	0		33.01
33.02	CORPERATE WELLNESS	0		33.02
33.03	MAINTENANCE REV	0		33.03
33.04	PLANT OP OTHER REV	0		33.04
33.05	LAUNDRY REVENUE	0		33.05
33.06	HEALTH PROMOTIONS	0		33.06
33.07	SALE OF MEDICAL RECORDS	0		33.07
33.08		0		33.08
33.09	TRAINING FEES	0		33.09
33.10	MISC INCOME -A&P	0		33.10
33.11		0		33.11
33.12	LABOR AND DELIVERY REVENUE	0		33.12
33.13	RADIOLOGY - MISC REVENUE	0		33.13
33.14	LAB - MISC REV	0		33.14
33.15		0		33.15
33.16	CARDIAC REHAB - MISC REV	0		33.16
33.17	COUNSELING CTR MISC REV	0		33.17
33.18	EMERGENCY ROOM - MISC REVENUE	0		33.18
33.19	HHA - MISC REVENUE	0		33.19
33.20	INVESTMENT PROPERTY TAXES	0		33.20
33.21	ADVERTISING A&G	0		33.21
33.22	MARKETING A&G	0		33.22
33.23	MARKETING - FAMILY MATERNITY CENTER	0		33.23
33.24	MARKETING - PROCTOR HOME HEALTH	0		33.24
33.25	MARKETING - WOUND CARE CLINIC	0		33.25
33.26	MARKETING - SLEEP LAB/EEG	0		33.26
33.27		0		33.27

ADJUSTMENTS TO EXPENSES | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8 | Date/Time Prepared: 5/29/2012 8:15 pm

	Cost Center Description	Wkst. A-7 Ref. 5.00		
33.28	MARKETING - COMMUNITY OUTREACH	0		33.28
33.29	MARKETING - PATIENT SERVICES	0		33.29
33.30	ENTERTAINMENT EXPENSE	0		33.30
33.31	ENTERTAINMENT EXPENSE	0		33.31
33.32	ENTERTAINMENT EXPENSE	0		33.32
33.33		0		33.33
33.34	ENTERTAINMENT EXPENSE	0		33.34
33.35		0		33.35
33.36	INTEREST EXPENSE	11		33.36
33.37		0		33.37
33.38	IHA DUES LOBBYING FFES	0		33.38
33.39	POB SECURITY COST	0		33.39
33.40	POB SECURITY COST	0		33.40
33.41	GRANT EXP OFFSET	0		33.41
33.42	POB PROPERTY INSURANCE	12		33.42
33.43	SELF FUNDED INSURANCE	0		33.43
33.44	TELEPHONE SERVICES - SALARIES	0		33.44
33.45	TELEPHONE SERVICES - BENEFITS	0		33.45
33.46	TELEPHONE SERVICES - EQUIPMENT	9		33.46
33.47		0		33.47
33.48	PERSONAL USE OF VEHICLES	9		33.48
33.49	MEDICAL STAFF OFFICER DUES	0		33.49
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 140013	Period: From 01/01/2011 To 12/31/2011	Worksheet A-8-1 Date/Time Prepared: 5/29/2012 8:15 pm

		Line No.	Cost Center	Expense Items	
		1.00	2.00	3.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00		1.00	NEW CAP REL COSTS-BLDG & FIXT	RENT 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		G	AFFILIATE	100.00		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:		FOUNDATION			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: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2012 8:15 pm

		Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
		4.00	5.00	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00		560,551	566,607	-6,056	9		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.	560,551	566,607	-6,056			5.00

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

		Related Organization(s) and/or Home Office			
		Name	Percentage of Ownership	Type of Business	
		4.00	5.00	6.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				
6.00		PROCTOR HEALTH	100.00	FOUNDATION	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

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.

(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: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2012 8:15 pm

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		30.00	ADULTS & PEDIATRICS	496,905	496,905	1.00
2.00		30.00	ADULTS & PEDIATRICS	69,869	69,869	2.00
3.00		44.00	SKILLED NURSING FACILITY	6,300	6,300	3.00
4.00		52.00	DELIVERY ROOM & LABOR ROOM	809,232	809,232	4.00
5.00		0.00		0	0	5.00
6.00		60.00	LABORATORY	51,786	0	6.00
7.00		60.00	LABORATORY	107,789	107,789	7.00
8.00		65.00	RESPIRATORY THERAPY	30,000	30,000	8.00
9.00		76.97	CARDIAC REHABILITATION	10,000	10,000	9.00
10.00		90.00	CLINIC	2,719	2,719	10.00
11.00		90.00	CLINIC	31,110	31,110	11.00
12.00		90.00	CLINIC	132,883	132,883	12.00
13.00		90.00	CLINIC	79,871	79,871	13.00
14.00		90.00	CLINIC	37,838	37,838	14.00
200.00				1,866,302	1,814,516	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2012 8:15 pm

		Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
		5.00	6.00	7.00	8.00	9.00	
1.00		0	0	0	0	0	1.00
2.00		0	0	0	0	0	2.00
3.00		0	0	0	0	0	3.00
4.00		0	0	0	0	0	4.00
5.00		0	0	0	0	0	5.00
6.00		51,786	219,500	1,040	109,750	5,488	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
11.00		0	0	0	0	0	11.00
12.00		0	0	0	0	0	12.00
13.00		0	0	0	0	0	13.00
14.00		0	0	0	0	0	14.00
200.00		51,786		1,040	109,750	5,488	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2012 8:15 pm

		Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	
		12.00	13.00	14.00	15.00	16.00	
1.00		0	0	0	0	0	1.00
2.00		0	0	0	0	0	2.00
3.00		0	0	0	0	0	3.00
4.00		0	0	0	0	0	4.00
5.00		0	0	0	0	0	5.00
6.00		0	0	0	0	109,750	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
11.00		0	0	0	0	0	11.00
12.00		0	0	0	0	0	12.00
13.00		0	0	0	0	0	13.00
14.00		0	0	0	0	0	14.00
200.00		0	0	0	0	109,750	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2012 8:15 pm

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		0	496,905		1.00
2.00		0	69,869		2.00
3.00		0	6,300		3.00
4.00		0	809,232		4.00
5.00		0	0		5.00
6.00		0	0		6.00
7.00		0	107,789		7.00
8.00		0	30,000		8.00
9.00		0	10,000		9.00
10.00		0	2,719		10.00
11.00		0	31,110		11.00
12.00		0	132,883		12.00
13.00		0	79,871		13.00
14.00		0	37,838		14.00
200.00		0	1,814,516		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part I Date/Time Prepared: 5/29/2012 8:15 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	3,071,991	3,071,991				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4,889,443		4,889,443			2.00
4.00	EMPLOYEE BENEFITS	8,426,703	109,014	173,508	8,709,225		4.00
5.00	ADMINISTRATIVE & GENERAL	12,879,087	332,737	529,590	1,275,859	15,017,273	5.00
6.00	MAINTENANCE & REPAIRS	2,871,618	492,162	783,332	164,890	4,312,002	6.00
7.00	OPERATION OF PLANT	588,170	35,039	55,769	85,940	764,918	7.00
8.00	LAUNDRY & LINEN SERVICE	432,964	28,391	45,188	8,686	515,229	8.00
9.00	HOUSEKEEPING	1,188,019	48,106	76,567	201,046	1,513,738	9.00
10.00	DIETARY	608,452	37,688	59,985	64,486	770,611	10.00
11.00	CAFETERIA	588,987	107,036	170,361	73,024	939,408	11.00
13.00	NURSING ADMINISTRATION	1,067,244	17,250	27,456	211,987	1,323,937	13.00
14.00	CENTRAL SERVICES & SUPPLY	182,994	0	0	50,836	233,830	14.00
15.00	PHARMACY	1,419,866	24,319	38,706	242,519	1,725,410	15.00
16.00	MEDICAL RECORDS & LIBRARY	2,537,322	27,270	43,403	190,420	2,798,415	16.00
17.00	SOCIAL SERVICE	131,208	1,055	1,679	26,282	160,224	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	6,703,249	451,202	718,142	1,473,024	9,345,617	30.00
31.00	INTENSIVE CARE UNIT	2,110,827	67,135	106,853	450,946	2,735,761	31.00
43.00	NURSERY	345,037	8,448	13,446	68,361	435,292	43.00
44.00	SKILLED NURSING FACILITY	1,230,386	119,513	190,219	248,815	1,788,933	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	6,063,146	311,819	496,298	979,385	7,850,648	50.00
52.00	DELIVERY ROOM & LABOR ROOM	881,873	24,459	38,929	182,044	1,127,305	52.00
53.00	ANESTHESIOLOGY	141,808	5,113	8,138	9,319	164,378	53.00
54.00	RADIOLOGY-DIAGNOSTIC	4,323,771	202,193	321,815	440,862	5,288,641	54.00
60.00	LABORATORY	4,203,390	85,934	136,775	352,835	4,778,934	60.00
65.00	RESPIRATORY THERAPY	1,176,260	31,335	49,874	238,877	1,496,346	65.00
66.00	PHYSICAL THERAPY	2,030,989	60,325	96,014	58,459	2,245,787	66.00
70.00	ELECTROENCEPHALOGRAPHY	2,265,155	64,884	103,271	200,066	2,633,376	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,623,712	83,204	132,430	0	6,839,346	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	10,933,713	0	0	0	10,933,713	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,525,196	0	0	0	2,525,196	73.00
76.97	CARDIAC REHABILITATION	261,958	17,892	28,478	42,789	351,117	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	2,335,029	62,235	99,055	287,628	2,783,947	90.00
91.00	EMERGENCY	2,298,117	84,968	135,237	518,015	3,036,337	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	645,292	5,607	8,925	94,230	754,054	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	97,982,976	2,946,333	4,689,443	8,241,630	97,189,723	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	33,453	53,244	0	86,697	190.00
194.00	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	MARKETING	0	1,527	2,431	0	3,958	194.02
194.03	GUEST MEALS	111,137	0	0	10,495	121,632	194.03
194.04	PHYSICIAN/OTHER MEALS	263,892	0	0	19,142	283,034	194.04
194.05	FOUNDATION	0	19,338	30,779	0	50,117	194.05
194.06	DAYCARE CENTER	564,775	67,555	107,522	105,686	845,538	194.06
194.07	UN-USED SQR FT - POB	0	3,785	6,024	0	9,809	194.07
194.08	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	ARC BROMENN	1,018,251	0	0	146,909	1,165,160	194.09
194.10	ARC INGALLS	1,055,836	0	0	185,363	1,241,199	194.10
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)	100,996,867	3,071,991	4,889,443	8,709,225	100,996,867	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part I Date/Time Prepared: 5/29/2012 8:15 pm

	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	15,017,273					5.00
6.00	MAINTENANCE & REPAIRS	753,139	5,065,141				6.00
7.00	OPERATION OF PLANT	133,601	83,008	981,527			7.00
8.00	LAUNDRY & LINEN SERVICE	89,990	67,260	13,251	685,730		8.00
9.00	HOUSEKEEPING	264,391	113,964	22,452	0	1,914,545	9.00
10.00	DIETARY	134,596	89,283	17,590	0	35,605	10.00
11.00	CAFETERIA	164,078	253,570	49,956	0	101,121	11.00
13.00	NURSING ADMINISTRATION	231,240	40,866	8,051	0	16,297	13.00
14.00	CENTRAL SERVICES & SUPPLY	40,841	0	0	0	0	14.00
15.00	PHARMACY	301,362	57,611	11,350	0	22,975	15.00
16.00	MEDICAL RECORDS & LIBRARY	488,774	64,603	12,727	0	25,763	16.00
17.00	SOCIAL SERVICE	27,985	2,500	492	0	997	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,632,315	1,068,902	210,582	493,280	426,263	30.00
31.00	INTENSIVE CARE UNIT	477,831	159,043	31,333	57,555	63,424	31.00
43.00	NURSERY	76,029	20,014	3,943	29,173	7,981	43.00
44.00	SKILLED NURSING FACILITY	312,457	283,127	55,779	105,722	112,908	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,371,202	738,704	145,532	0	294,586	50.00
52.00	DELIVERY ROOM & LABOR ROOM	196,896	57,943	11,415	0	23,107	52.00
53.00	ANESTHESIOLOGY	28,710	12,113	2,386	0	4,831	53.00
54.00	RADIOLOGY-DIAGNOSTIC	923,719	478,998	94,367	0	191,019	54.00
60.00	LABORATORY	834,693	203,580	40,107	0	81,185	60.00
65.00	RESPIRATORY THERAPY	261,353	74,234	14,625	0	29,604	65.00
66.00	PHYSICAL THERAPY	392,251	142,909	28,155	0	56,991	66.00
70.00	ELECTROENCEPHALOGRAPHY	459,948	153,712	30,283	0	61,298	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,194,567	197,112	38,833	0	78,606	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	1,909,686	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	441,053	0	0	0	0	73.00
76.97	CARDIAC REHABILITATION	61,326	42,387	8,351	0	16,903	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	486,247	147,437	29,046	0	58,796	90.00
91.00	EMERGENCY	530,330	201,290	39,656	0	80,272	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	131,704	13,284	2,617	0	5,298	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	14,352,314	4,767,454	922,879	685,730	1,795,830	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,143	79,250	15,613	0	31,604	190.00
194.00	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	MARKETING	691	3,618	713	0	1,443	194.02
194.03	GUEST MEALS	21,244	0	0	0	0	194.03
194.04	PHYSICIAN/OTHER MEALS	49,435	0	0	0	0	194.04
194.05	FOUNDATION	8,753	45,813	9,026	0	18,270	194.05
194.06	DAYCARE CENTER	147,683	160,039	31,529	0	63,822	194.06
194.07	UN-USED SQR FT - POB	1,713	8,967	1,767	0	3,576	194.07
194.08	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	ARC BROMENN	203,508	0	0	0	0	194.09
194.10	ARC INGALLS	216,789	0	0	0	0	194.10
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)	15,017,273	5,065,141	981,527	685,730	1,914,545	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part I Date/Time Prepared: 5/29/2012 8:15 pm

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY	1,047,685					10.00
11.00	CAFETERIA	0	1,508,133				11.00
13.00	NURSING ADMINISTRATION	0	51,382	1,671,773			13.00
14.00	CENTRAL SERVICES & SUPPLY	0	12,322	0	286,993		14.00
15.00	PHARMACY	0	58,782	0	2,603	2,180,093	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	46,155	0	0	0	16.00
17.00	SOCIAL SERVICE	0	6,370	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	938,217	356,525	550,687	22,173	2,608	30.00
31.00	INTENSIVE CARE UNIT	109,468	109,302	168,827	7,939	281	31.00
43.00	NURSERY	0	17,087	26,393	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	60,397	93,289	2,866	896	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	237,386	366,666	179,701	108,144	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	44,125	68,155	5,276	587	52.00
53.00	ANESTHESIOLOGY	0	2,259	3,489	12,011	3,261	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	106,858	165,052	7,294	72,429	54.00
60.00	LABORATORY	0	85,521	0	6,943	3,157	60.00
65.00	RESPIRATORY THERAPY	0	57,900	0	2,203	2,330	65.00
66.00	PHYSICAL THERAPY	0	14,170	0	4,200	5,269	66.00
70.00	ELECTROENCEPHALOGRAPHY	0	48,493	0	18,155	50,190	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	2,590	1,929,407	73.00
76.97	CARDIAC REHABILITATION	0	10,371	0	46	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	35	332	90.00
91.00	EMERGENCY	0	125,558	193,937	12,331	1,137	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	22,840	35,278	509	65	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,047,685	1,473,803	1,671,773	286,875	2,180,093	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	MARKETING	0	0	0	0	0	194.02
194.03	GUEST MEALS	0	2,939	0	0	0	194.03
194.04	PHYSICIAN/OTHER MEALS	0	6,978	0	0	0	194.04
194.05	FOUNDATION	0	0	0	0	0	194.05
194.06	DAYCARE CENTER	0	24,413	0	0	0	194.06
194.07	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	ARC BROMENN	0	0	0	33	0	194.09
194.10	ARC INGALLS	0	0	0	85	0	194.10
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)	1,047,685	1,508,133	1,671,773	286,993	2,180,093	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part I | Date/Time Prepared: 5/29/2012 8:15 pm

	Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
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	3,436,437					16.00
17.00	SOCIAL SERVICE	0	198,568				17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	306,291	149,187	15,502,647	0	15,502,647	30.00
31.00	INTENSIVE CARE UNIT	66,085	17,407	4,004,256	0	4,004,256	31.00
43.00	NURSERY	9,079	0	624,991	0	624,991	43.00
44.00	SKILLED NURSING FACILITY	26,426	31,974	2,874,774	0	2,874,774	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	754,302	0	12,046,871	0	12,046,871	50.00
52.00	DELIVERY ROOM & LABOR ROOM	24,559	0	1,559,368	0	1,559,368	52.00
53.00	ANESTHESIOLOGY	150,394	0	383,832	0	383,832	53.00
54.00	RADIOLOGY-DIAGNOSTIC	474,361	0	7,802,738	0	7,802,738	54.00
60.00	LABORATORY	293,308	0	6,327,428	0	6,327,428	60.00
65.00	RESPIRATORY THERAPY	109,480	0	2,048,075	0	2,048,075	65.00
66.00	PHYSICAL THERAPY	95,009	0	2,984,741	0	2,984,741	66.00
70.00	ELECTROENCEPHALOGRAPHY	267,946	0	3,723,401	0	3,723,401	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	195,776	0	8,544,240	0	8,544,240	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	180,638	0	13,024,037	0	13,024,037	72.00
73.00	DRUGS CHARGED TO PATIENTS	231,301	0	5,129,547	0	5,129,547	73.00
76.97	CARDIAC REHABILITATION	3,286	0	493,787	0	493,787	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	74,160	0	3,580,000	0	3,580,000	90.00
91.00	EMERGENCY	162,881	0	4,383,729	0	4,383,729	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	11,155	0	976,804	0	976,804	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,436,437	198,568	96,015,266	0	96,015,266	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	228,307	0	228,307	190.00
194.00	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	MARKETING	0	0	10,423	0	10,423	194.02
194.03	GUEST MEALS	0	0	145,815	0	145,815	194.03
194.04	PHYSICIAN/OTHER MEALS	0	0	339,447	0	339,447	194.04
194.05	FOUNDATION	0	0	131,979	0	131,979	194.05
194.06	DAYCARE CENTER	0	0	1,273,024	0	1,273,024	194.06
194.07	UN-USED SQR FT - POB	0	0	25,832	0	25,832	194.07
194.08	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	ARC BROMENN	0	0	1,368,701	0	1,368,701	194.09
194.10	ARC INGALLS	0	0	1,458,073	0	1,458,073	194.10
200.00	Cross Foot Adjustments			0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	3,436,437	198,568	100,996,867	0	100,996,867	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part II | Date/Time Prepared: 5/29/2012 8:15 pm

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS	0	109,014	173,508	282,522	282,522	4.00
5.00	ADMINISTRATIVE & GENERAL	0	332,737	529,590	862,327	41,388	5.00
6.00	MAINTENANCE & REPAIRS	0	492,162	783,332	1,275,494	5,349	6.00
7.00	OPERATION OF PLANT	0	35,039	55,769	90,808	2,788	7.00
8.00	LAUNDRY & LINEN SERVICE	0	28,391	45,188	73,579	282	8.00
9.00	HOUSEKEEPING	0	48,106	76,567	124,673	6,522	9.00
10.00	DIETARY	0	37,688	59,985	97,673	2,092	10.00
11.00	CAFETERIA	0	107,036	170,361	277,397	2,369	11.00
13.00	NURSING ADMINISTRATION	0	17,250	27,456	44,706	6,877	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	1,649	14.00
15.00	PHARMACY	0	24,319	38,706	63,025	7,867	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	27,270	43,403	70,673	6,177	16.00
17.00	SOCIAL SERVICE	0	1,055	1,679	2,734	853	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	451,202	718,142	1,169,344	47,785	30.00
31.00	INTENSIVE CARE UNIT	0	67,135	106,853	173,988	14,628	31.00
43.00	NURSERY	0	8,448	13,446	21,894	2,218	43.00
44.00	SKILLED NURSING FACILITY	0	119,513	190,219	309,732	8,071	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	311,819	496,298	808,117	31,771	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	24,459	38,929	63,388	5,905	52.00
53.00	ANESTHESIOLOGY	0	5,113	8,138	13,251	302	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	202,193	321,815	524,008	14,301	54.00
60.00	LABORATORY	0	85,934	136,775	222,709	11,446	60.00
65.00	RESPIRATORY THERAPY	0	31,335	49,874	81,209	7,749	65.00
66.00	PHYSICAL THERAPY	0	60,325	96,014	156,339	1,896	66.00
70.00	ELECTROENCEPHALOGRAPHY	0	64,884	103,271	168,155	6,490	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	83,204	132,430	215,634	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	CARDIAC REHABILITATION	0	17,892	28,478	46,370	1,388	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	62,235	99,055	161,290	9,330	90.00
91.00	EMERGENCY	0	84,968	135,237	220,205	16,804	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	5,607	8,925	14,532	3,057	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,946,333	4,689,443	7,635,776	267,354	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	33,453	53,244	86,697	0	190.00
194.00	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	MARKETING	0	1,527	2,431	3,958	0	194.02
194.03	GUEST MEALS	0	0	0	0	340	194.03
194.04	PHYSICIAN/OTHER MEALS	0	0	0	0	621	194.04
194.05	FOUNDATION	0	19,338	30,779	50,117	0	194.05
194.06	DAYCARE CENTER	0	67,555	107,522	175,077	3,428	194.06
194.07	UN-USED SQR FT - POB	0	3,785	6,024	9,809	0	194.07
194.08	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	ARC BROMENN	0	0	0	0	4,766	194.09
194.10	ARC INGALLS	0	0	0	0	6,013	194.10
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	3,071,991	4,889,443	7,961,434	282,522	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part II Date/Time Prepared: 5/29/2012 8:15 pm

	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	903,715					5.00
6.00	MAINTENANCE & REPAIRS	45,323	1,326,166				6.00
7.00	OPERATION OF PLANT	8,040	21,733	123,369			7.00
8.00	LAUNDRY & LINEN SERVICE	5,416	17,610	1,666	98,553		8.00
9.00	HOUSEKEEPING	15,911	29,838	2,822	0	179,766	9.00
10.00	DIETARY	8,100	23,376	2,211	0	3,343	10.00
11.00	CAFETERIA	9,874	66,390	6,279	0	9,495	11.00
13.00	NURSING ADMINISTRATION	13,916	10,700	1,012	0	1,530	13.00
14.00	CENTRAL SERVICES & SUPPLY	2,458	0	0	0	0	14.00
15.00	PHARMACY	18,136	15,084	1,427	0	2,157	15.00
16.00	MEDICAL RECORDS & LIBRARY	29,414	16,914	1,600	0	2,419	16.00
17.00	SOCIAL SERVICE	1,684	654	62	0	94	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	98,232	279,864	26,467	70,894	40,024	30.00
31.00	INTENSIVE CARE UNIT	28,756	41,641	3,938	8,272	5,955	31.00
43.00	NURSERY	4,575	5,240	496	4,193	749	43.00
44.00	SKILLED NURSING FACILITY	18,803	74,129	7,011	15,194	10,601	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	82,518	193,409	18,292	0	27,660	50.00
52.00	DELIVERY ROOM & LABOR ROOM	11,849	15,171	1,435	0	2,170	52.00
53.00	ANESTHESIOLOGY	1,728	3,171	300	0	454	53.00
54.00	RADIOLOGY-DIAGNOSTIC	55,589	125,412	11,861	0	17,936	54.00
60.00	LABORATORY	50,231	53,302	5,041	0	7,623	60.00
65.00	RESPIRATORY THERAPY	15,728	19,436	1,838	0	2,780	65.00
66.00	PHYSICAL THERAPY	23,605	37,417	3,539	0	5,351	66.00
70.00	ELECTROENCEPHALOGRAPHY	27,679	40,245	3,806	0	5,756	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71,888	51,608	4,881	0	7,381	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	114,910	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	26,542	0	0	0	0	73.00
76.97	CARDIAC REHABILITATION	3,691	11,098	1,050	0	1,587	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	29,262	38,602	3,651	0	5,521	90.00
91.00	EMERGENCY	31,915	52,702	4,984	0	7,537	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	7,926	3,478	329	0	497	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	863,699	1,248,224	115,998	98,553	168,620	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	911	20,750	1,962	0	2,967	190.00
194.00	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	MARKETING	42	947	90	0	135	194.02
194.03	GUEST MEALS	1,278	0	0	0	0	194.03
194.04	PHYSICIAN/OTHER MEALS	2,975	0	0	0	0	194.04
194.05	FOUNDATION	527	11,995	1,134	0	1,715	194.05
194.06	DAYCARE CENTER	8,887	41,902	3,963	0	5,993	194.06
194.07	UN-USED SQR FT - POB	103	2,348	222	0	336	194.07
194.08	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	ARC BROMENN	12,247	0	0	0	0	194.09
194.10	ARC INGALLS	13,046	0	0	0	0	194.10
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)	903,715	1,326,166	123,369	98,553	179,766	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part II | Date/Time Prepared: 5/29/2012 8:15 pm

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY	136,795					10.00
11.00	CAFETERIA	0	371,804				11.00
13.00	NURSING ADMINISTRATION	0	12,667	91,408			13.00
14.00	CENTRAL SERVICES & SUPPLY	0	3,038	0	7,145		14.00
15.00	PHARMACY	0	14,492	0	65	122,253	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	11,379	0	0	0	16.00
17.00	SOCIAL SERVICE	0	1,571	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	122,502	87,892	30,109	552	146	30.00
31.00	INTENSIVE CARE UNIT	14,293	26,947	9,231	198	16	31.00
43.00	NURSERY	0	4,213	1,443	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	14,890	5,101	71	50	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	58,524	20,048	4,473	6,064	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	10,878	3,727	131	33	52.00
53.00	ANESTHESIOLOGY	0	557	191	299	183	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	26,344	9,025	182	4,062	54.00
60.00	LABORATORY	0	21,084	0	173	177	60.00
65.00	RESPIRATORY THERAPY	0	14,274	0	55	131	65.00
66.00	PHYSICAL THERAPY	0	3,493	0	105	295	66.00
70.00	ELECTROENCEPHALOGRAPHY	0	11,955	0	452	2,815	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	64	108,194	73.00
76.97	CARDIAC REHABILITATION	0	2,557	0	1	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	1	19	90.00
91.00	EMERGENCY	0	30,954	10,604	307	64	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	5,631	1,929	13	4	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	136,795	363,340	91,408	7,142	122,253	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	MARKETING	0	0	0	0	0	194.02
194.03	GUEST MEALS	0	725	0	0	0	194.03
194.04	PHYSICIAN/OTHER MEALS	0	1,720	0	0	0	194.04
194.05	FOUNDATION	0	0	0	0	0	194.05
194.06	DAYCARE CENTER	0	6,019	0	0	0	194.06
194.07	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	ARC BROMENN	0	0	0	1	0	194.09
194.10	ARC INGALLS	0	0	0	2	0	194.10
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)	136,795	371,804	91,408	7,145	122,253	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part II | Date/Time Prepared: 5/29/2012 8:15 pm

	Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
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	138,576					16.00
17.00	SOCIAL SERVICE	0	7,652				17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	12,356	5,749	1,991,916	0	1,991,916	30.00
31.00	INTENSIVE CARE UNIT	2,666	671	331,200	0	331,200	31.00
43.00	NURSERY	366	0	45,387	0	45,387	43.00
44.00	SKILLED NURSING FACILITY	1,066	1,232	465,951	0	465,951	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	30,376	0	1,281,252	0	1,281,252	50.00
52.00	DELIVERY ROOM & LABOR ROOM	991	0	115,678	0	115,678	52.00
53.00	ANESTHESIOLOGY	6,067	0	26,503	0	26,503	53.00
54.00	RADIOLOGY-DIAGNOSTIC	19,136	0	807,856	0	807,856	54.00
60.00	LABORATORY	11,832	0	383,618	0	383,618	60.00
65.00	RESPIRATORY THERAPY	4,416	0	147,616	0	147,616	65.00
66.00	PHYSICAL THERAPY	3,833	0	235,873	0	235,873	66.00
70.00	ELECTROENCEPHALOGRAPHY	10,809	0	278,162	0	278,162	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,898	0	359,290	0	359,290	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	7,287	0	122,197	0	122,197	72.00
73.00	DRUGS CHARGED TO PATIENTS	9,331	0	144,131	0	144,131	73.00
76.97	CARDIAC REHABILITATION	133	0	67,875	0	67,875	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	2,992	0	250,668	0	250,668	90.00
91.00	EMERGENCY	6,571	0	382,647	0	382,647	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	450	0	37,846	0	37,846	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	138,576	7,652	7,475,666	0	7,475,666	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	113,287	0	113,287	190.00
194.00	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	MARKETING	0	0	5,172	0	5,172	194.02
194.03	GUEST MEALS	0	0	2,343	0	2,343	194.03
194.04	PHYSICIAN/OTHER MEALS	0	0	5,316	0	5,316	194.04
194.05	FOUNDATION	0	0	65,488	0	65,488	194.05
194.06	DAYCARE CENTER	0	0	245,269	0	245,269	194.06
194.07	UN-USED SQR FT - POB	0	0	12,818	0	12,818	194.07
194.08	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	ARC BROMENN	0	0	17,014	0	17,014	194.09
194.10	ARC INGALLS	0	0	19,061	0	19,061	194.10
200.00	Cross Foot Adjustments			0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	138,576	7,652	7,961,434	0	7,961,434	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B-1 | Date/Time Prepared: 5/29/2012 8:15 pm

	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	416,358					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		416,358				2.00
4.00	EMPLOYEE BENEFITS	14,775	14,775	38,765,456			4.00
5.00	ADMINISTRATIVE & GENERAL	45,097	45,097	5,678,941	-15,017,273	85,979,594	5.00
6.00	MAINTENANCE & REPAIRS	66,704	66,704	733,939	0	4,312,002	6.00
7.00	OPERATION OF PLANT	4,749	4,749	382,526	0	764,918	7.00
8.00	LAUNDRY & LINEN SERVICE	3,848	3,848	38,663	0	515,229	8.00
9.00	HOUSEKEEPING	6,520	6,520	894,871	0	1,513,738	9.00
10.00	DIETARY	5,108	5,108	287,031	0	770,611	10.00
11.00	CAFETERIA	14,507	14,507	325,034	0	939,408	11.00
13.00	NURSING ADMINISTRATION	2,338	2,338	943,568	0	1,323,937	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	226,275	0	233,830	14.00
15.00	PHARMACY	3,296	3,296	1,079,468	0	1,725,410	15.00
16.00	MEDICAL RECORDS & LIBRARY	3,696	3,696	847,572	0	2,798,415	16.00
17.00	SOCIAL SERVICE	143	143	116,984	0	160,224	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	61,153	61,153	6,556,599	0	9,345,617	30.00
31.00	INTENSIVE CARE UNIT	9,099	9,099	2,007,193	0	2,735,761	31.00
43.00	NURSERY	1,145	1,145	304,280	0	435,292	43.00
44.00	SKILLED NURSING FACILITY	16,198	16,198	1,107,494	0	1,788,933	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	42,262	42,262	4,359,311	0	7,850,648	50.00
52.00	DELIVERY ROOM & LABOR ROOM	3,315	3,315	810,293	0	1,127,305	52.00
53.00	ANESTHESIOLOGY	693	693	41,479	0	164,378	53.00
54.00	RADIOLOGY-DIAGNOSTIC	27,404	27,404	1,962,310	0	5,288,641	54.00
60.00	LABORATORY	11,647	11,647	1,570,494	0	4,778,934	60.00
65.00	RESPIRATORY THERAPY	4,247	4,247	1,063,258	0	1,496,346	65.00
66.00	PHYSICAL THERAPY	8,176	8,176	260,206	0	2,245,787	66.00
70.00	ELECTROENCEPHALOGRAPHY	8,794	8,794	890,506	0	2,633,376	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,277	11,277	0	0	6,839,346	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	10,933,713	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,525,196	73.00
76.97	CARDIAC REHABILITATION	2,425	2,425	190,456	0	351,117	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	8,435	8,435	1,280,254	0	2,783,947	90.00
91.00	EMERGENCY	11,516	11,516	2,305,724	0	3,036,337	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	760	760	419,426	0	754,054	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	399,327	399,327	36,684,155	-15,017,273	82,172,450	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,534	4,534	0	0	86,697	190.00
194.00	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	MARKETING	207	207	0	0	3,958	194.02
194.03	GUEST MEALS	0	0	46,712	0	121,632	194.03
194.04	PHYSICIAN/OTHER MEALS	0	0	85,203	0	283,034	194.04
194.05	FOUNDATION	2,621	2,621	0	0	50,117	194.05
194.06	DAYCARE CENTER	9,156	9,156	470,416	0	845,538	194.06
194.07	UN-USED SQR FT - POB	513	513	0	0	9,809	194.07
194.08	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	ARC BROMENN	0	0	653,904	0	1,165,160	194.09
194.10	ARC INGALLS	0	0	825,066	0	1,241,199	194.10
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	3,071,991	4,889,443	8,709,225		15,017,273	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	7.378244	11.743363	0.224665		0.174661	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			282,522		903,715	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.007288		0.010511	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B-1 | Date/Time Prepared: 5/29/2012 8:15 pm

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS	289,782					6.00
7.00	OPERATION OF PLANT	4,749	285,033				7.00
8.00	LAUNDRY & LINEN SERVICE	3,848	3,848	31,192			8.00
9.00	HOUSEKEEPING	6,520	6,520	0	274,665		9.00
10.00	DIETARY	5,108	5,108	0	5,108	25,056	10.00
11.00	CAFETERIA	14,507	14,507	0	14,507	0	11.00
13.00	NURSING ADMINISTRATION	2,338	2,338	0	2,338	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	3,296	3,296	0	3,296	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	3,696	3,696	0	3,696	0	16.00
17.00	SOCIAL SERVICE	143	143	0	143	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	61,153	61,153	22,438	61,153	22,438	30.00
31.00	INTENSIVE CARE UNIT	9,099	9,099	2,618	9,099	2,618	31.00
43.00	NURSERY	1,145	1,145	1,327	1,145	0	43.00
44.00	SKILLED NURSING FACILITY	16,198	16,198	4,809	16,198	0	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	42,262	42,262	0	42,262	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	3,315	3,315	0	3,315	0	52.00
53.00	ANESTHESIOLOGY	693	693	0	693	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	27,404	27,404	0	27,404	0	54.00
60.00	LABORATORY	11,647	11,647	0	11,647	0	60.00
65.00	RESPIRATORY THERAPY	4,247	4,247	0	4,247	0	65.00
66.00	PHYSICAL THERAPY	8,176	8,176	0	8,176	0	66.00
70.00	ELECTROENCEPHALOGRAPHY	8,794	8,794	0	8,794	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,277	11,277	0	11,277	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	CARDIAC REHABILITATION	2,425	2,425	0	2,425	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	8,435	8,435	0	8,435	0	90.00
91.00	EMERGENCY	11,516	11,516	0	11,516	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	760	760	0	760	0	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	272,751	268,002	31,192	257,634	25,056	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,534	4,534	0	4,534	0	190.00
194.00	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	MARKETING	207	207	0	207	0	194.02
194.03	GUEST MEALS	0	0	0	0	0	194.03
194.04	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	FOUNDATION	2,621	2,621	0	2,621	0	194.05
194.06	DAYCARE CENTER	9,156	9,156	0	9,156	0	194.06
194.07	UN-USED SQR FT - POB	513	513	0	513	0	194.07
194.08	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	ARC BROMENN	0	0	0	0	0	194.09
194.10	ARC INGALLS	0	0	0	0	0	194.10
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)	5,065,141	981,527	685,730	1,914,545	1,047,685	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	17.479143	3.443556	21.984163	6.970473	41.813737	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,326,166	123,369	98,553	179,766	136,795	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	4.576426	0.432824	3.159560	0.654492	5.459571	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B-1 | Date/Time Prepared: 5/29/2012 8:15 pm

	Cost Center Description	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
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	27,694,940					11.00
13.00	NURSING ADMINISTRATION	943,568	19,875,728				13.00
14.00	CENTRAL SERVICES & SUPPLY	226,275	0	6,925,113			14.00
15.00	PHARMACY	1,079,468	0	62,819	3,082,443		15.00
16.00	MEDICAL RECORDS & LIBRARY	847,572	0	0	0	365,766,749	16.00
17.00	SOCIAL SERVICE	116,984	0	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	6,547,089	6,547,089	535,029	3,687	32,601,527	30.00
31.00	INTENSIVE CARE UNIT	2,007,193	2,007,193	191,569	398	7,034,037	31.00
43.00	NURSERY	313,790	313,790	0	0	966,365	43.00
44.00	SKILLED NURSING FACILITY	1,109,113	1,109,113	69,152	1,267	2,812,738	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	4,359,311	4,359,311	4,336,182	152,905	80,281,255	50.00
52.00	DELIVERY ROOM & LABOR ROOM	810,293	810,293	127,315	830	2,614,001	52.00
53.00	ANESTHESIOLOGY	41,479	41,479	289,815	4,611	16,007,848	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,962,310	1,962,310	175,994	102,408	50,490,824	54.00
60.00	LABORATORY	1,570,494	0	167,530	4,463	31,219,631	60.00
65.00	RESPIRATORY THERAPY	1,063,258	0	53,156	3,294	11,653,022	65.00
66.00	PHYSICAL THERAPY	260,206	0	101,347	7,450	10,112,768	66.00
70.00	ELECTROENCEPHALOGRAPHY	890,506	0	438,076	70,964	28,520,047	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	20,838,328	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	19,227,078	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	62,493	2,727,996	24,619,600	73.00
76.97	CARDIAC REHABILITATION	190,456	0	1,099	0	349,777	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	844	470	7,893,587	90.00
91.00	EMERGENCY	2,305,724	2,305,724	297,553	1,608	17,336,995	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	419,426	419,426	12,281	92	1,187,321	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	27,064,515	19,875,728	6,922,254	3,082,443	365,766,749	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	MARKETING	0	0	0	0	0	194.02
194.03	GUEST MEALS	53,968	0	0	0	0	194.03
194.04	PHYSICIAN/OTHER MEALS	128,146	0	0	0	0	194.04
194.05	FOUNDATION	0	0	0	0	0	194.05
194.06	DAYCARE CENTER	448,311	0	0	0	0	194.06
194.07	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	ARC BROMENN	0	0	806	0	0	194.09
194.10	ARC INGALLS	0	0	2,053	0	0	194.10
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,508,133	1,671,773	286,993	2,180,093	3,436,437	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.054455	0.084111	0.041442	0.707261	0.009395	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	371,804	91,408	7,145	122,253	138,576	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.013425	0.004599	0.001032	0.039661	0.000379	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B-1 | Date/Time Prepared: 5/29/2012 8:15 pm

	Cost Center Description	SOCIAL SERVICE (PATIENT DAYS)		
		17.00		
	GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	EMPLOYEE BENEFITS			4.00
5.00	ADMINISTRATIVE & GENERAL			5.00
6.00	MAINTENANCE & REPAIRS			6.00
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
17.00	SOCIAL SERVICE	29,865		17.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	22,438		30.00
31.00	INTENSIVE CARE UNIT	2,618		31.00
43.00	NURSERY	0		43.00
44.00	SKILLED NURSING FACILITY	4,809		44.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	ANESTHESIOLOGY	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0		54.00
60.00	LABORATORY	0		60.00
65.00	RESPIRATORY THERAPY	0		65.00
66.00	PHYSICAL THERAPY	0		66.00
70.00	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0		73.00
76.97	CARDIAC REHABILITATION	0		76.97
	OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	0		90.00
91.00	EMERGENCY	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
	OTHER REIMBURSABLE COST CENTERS			
101.00	HOME HEALTH AGENCY	0		101.00
	SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	29,865		118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
194.00	UN-USED SQR FT - HOSPITAL	0		194.00
194.01	MEALS ON WHEELS	0		194.01
194.02	MARKETING	0		194.02
194.03	GUEST MEALS	0		194.03
194.04	PHYSICIAN/OTHER MEALS	0		194.04
194.05	FOUNDATION	0		194.05
194.06	DAYCARE CENTER	0		194.06
194.07	UN-USED SQR FT - POB	0		194.07
194.08	SENIOR SERVICES	0		194.08
194.09	ARC BROMENN	0		194.09
194.10	ARC INGALLS	0		194.10
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)	198,568		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	6.648853		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	7,652		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.256220		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/29/2012 8:15 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	15,502,647		15,502,647	0	15,502,647	30.00
31.00	INTENSIVE CARE UNIT	4,004,256		4,004,256	0	4,004,256	31.00
43.00	NURSERY	624,991		624,991	0	624,991	43.00
44.00	SKILLED NURSING FACILITY	2,874,774		2,874,774	0	2,874,774	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	12,046,871		12,046,871	0	12,046,871	50.00
52.00	DELIVERY ROOM & LABOR ROOM	1,559,368		1,559,368	0	1,559,368	52.00
53.00	ANESTHESIOLOGY	383,832		383,832	0	383,832	53.00
54.00	RADIOLOGY-DIAGNOSTIC	7,802,738		7,802,738	0	7,802,738	54.00
60.00	LABORATORY	6,327,428		6,327,428	0	6,327,428	60.00
65.00	RESPIRATORY THERAPY	2,048,075	0	2,048,075	0	2,048,075	65.00
66.00	PHYSICAL THERAPY	2,984,741	0	2,984,741	0	2,984,741	66.00
70.00	ELECTROENCEPHALOGRAPHY	3,723,401		3,723,401	0	3,723,401	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,544,240		8,544,240	0	8,544,240	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	13,024,037		13,024,037	0	13,024,037	72.00
73.00	DRUGS CHARGED TO PATIENTS	5,129,547		5,129,547	0	5,129,547	73.00
76.97	CARDIAC REHABILITATION	493,787		493,787	0	493,787	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	3,580,000		3,580,000	0	3,580,000	90.00
91.00	EMERGENCY	4,383,729		4,383,729	0	4,383,729	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1,283,687		1,283,687		1,283,687	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	976,804		976,804		976,804	101.00
200.00	Subtotal (see instructions)	97,298,953	0	97,298,953	0	97,298,953	200.00
201.00	Less Observation Beds	1,283,687		1,283,687		1,283,687	201.00
202.00	Total (see instructions)	96,015,266	0	96,015,266	0	96,015,266	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/29/2012 8:15 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	30,943,199		30,943,199			30.00
31.00	INTENSIVE CARE UNIT	7,034,037		7,034,037			31.00
43.00	NURSERY	966,365		966,365			43.00
44.00	SKILLED NURSING FACILITY	2,812,738		2,812,738			44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	27,843,340	52,437,915	80,281,255	0.150058	0.000000	50.00
52.00	DELIVERY ROOM & LABOR ROOM	2,435,967	178,034	2,614,001	0.596545	0.000000	52.00
53.00	ANESTHESIOLOGY	7,738,841	8,269,007	16,007,848	0.023978	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	11,893,522	38,597,302	50,490,824	0.154538	0.000000	54.00
60.00	LABORATORY	11,744,099	19,475,532	31,219,631	0.202675	0.000000	60.00
65.00	RESPIRATORY THERAPY	5,997,130	5,655,892	11,653,022	0.175755	0.000000	65.00
66.00	PHYSICAL THERAPY	5,764,642	4,348,126	10,112,768	0.295146	0.000000	66.00
70.00	ELECTROENCEPHALOGRAPHY	11,404,005	17,116,042	28,520,047	0.130554	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,945,773	6,892,555	20,838,328	0.410025	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	12,377,155	6,849,923	19,227,078	0.677380	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	18,576,285	6,043,315	24,619,600	0.208352	0.000000	73.00
76.97	CARDIAC REHABILITATION	451	349,326	349,777	1.411719	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	7,893,587	7,893,587	0.453533	0.000000	90.00
91.00	EMERGENCY	4,699,797	12,637,198	17,336,995	0.252854	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	320,133	1,338,195	1,658,328	0.774085	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	1,187,321	1,187,321			101.00
200.00	Subtotal (see instructions)	176,497,479	189,269,270	365,766,749			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	176,497,479	189,269,270	365,766,749			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/29/2012 8:15 pm

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	Cost Center Description	PPS Inpatient Ratio
		11.00
	INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	ADULTS & PEDIATRICS	30.00
31.00	INTENSIVE CARE UNIT	31.00
43.00	NURSERY	43.00
44.00	SKILLED NURSING FACILITY	44.00
	ANCILLARY SERVICE COST CENTERS	
50.00	OPERATING ROOM	0.150058 50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.596545 52.00
53.00	ANESTHESIOLOGY	0.023978 53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.154538 54.00
60.00	LABORATORY	0.202675 60.00
65.00	RESPIRATORY THERAPY	0.175755 65.00
66.00	PHYSICAL THERAPY	0.295146 66.00
70.00	ELECTROENCEPHALOGRAPHY	0.130554 70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.410025 71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.677380 72.00
73.00	DRUGS CHARGED TO PATIENTS	0.208352 73.00
76.97	CARDIAC REHABILITATION	1.411719 76.97
	OUTPATIENT SERVICE COST CENTERS	
90.00	CLINIC	0.453533 90.00
91.00	EMERGENCY	0.252854 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.774085 92.00
	OTHER REIMBURSABLE COST CENTERS	
101.00	HOME HEALTH AGENCY	101.00
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: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/29/2012 8:15 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	15,502,647		15,502,647	0	15,502,647	30.00
31.00	INTENSIVE CARE UNIT	4,004,256		4,004,256	0	4,004,256	31.00
43.00	NURSERY	624,991		624,991	0	624,991	43.00
44.00	SKILLED NURSING FACILITY	2,874,774		2,874,774	0	2,874,774	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	12,046,871		12,046,871	0	12,046,871	50.00
52.00	DELIVERY ROOM & LABOR ROOM	1,559,368		1,559,368	0	1,559,368	52.00
53.00	ANESTHESIOLOGY	383,832		383,832	0	383,832	53.00
54.00	RADIOLOGY-DIAGNOSTIC	7,802,738		7,802,738	0	7,802,738	54.00
60.00	LABORATORY	6,327,428		6,327,428	0	6,327,428	60.00
65.00	RESPIRATORY THERAPY	2,048,075	0	2,048,075	0	2,048,075	65.00
66.00	PHYSICAL THERAPY	2,984,741	0	2,984,741	0	2,984,741	66.00
70.00	ELECTROENCEPHALOGRAPHY	3,723,401		3,723,401	0	3,723,401	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,544,240		8,544,240	0	8,544,240	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	13,024,037		13,024,037	0	13,024,037	72.00
73.00	DRUGS CHARGED TO PATIENTS	5,129,547		5,129,547	0	5,129,547	73.00
76.97	CARDIAC REHABILITATION	493,787		493,787	0	493,787	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	3,580,000		3,580,000	0	3,580,000	90.00
91.00	EMERGENCY	4,383,729		4,383,729	0	4,383,729	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1,283,687		1,283,687		1,283,687	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	976,804		976,804		976,804	101.00
200.00	Subtotal (see instructions)	97,298,953	0	97,298,953	0	97,298,953	200.00
201.00	Less Observation Beds	1,283,687		1,283,687		1,283,687	201.00
202.00	Total (see instructions)	96,015,266	0	96,015,266	0	96,015,266	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/29/2012 8:15 pm

Title XIX | Hospital | PPS

	Cost Center Description	Charges					
		Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	30,943,199		30,943,199			30.00
31.00	INTENSIVE CARE UNIT	7,034,037		7,034,037			31.00
43.00	NURSERY	966,365		966,365			43.00
44.00	SKILLED NURSING FACILITY	2,812,738		2,812,738			44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	27,843,340	52,437,915	80,281,255	0.150058	0.000000	50.00
52.00	DELIVERY ROOM & LABOR ROOM	2,435,967	178,034	2,614,001	0.596545	0.000000	52.00
53.00	ANESTHESIOLOGY	7,738,841	8,269,007	16,007,848	0.023978	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	11,893,522	38,597,302	50,490,824	0.154538	0.000000	54.00
60.00	LABORATORY	11,744,099	19,475,532	31,219,631	0.202675	0.000000	60.00
65.00	RESPIRATORY THERAPY	5,997,130	5,655,892	11,653,022	0.175755	0.000000	65.00
66.00	PHYSICAL THERAPY	5,764,642	4,348,126	10,112,768	0.295146	0.000000	66.00
70.00	ELECTROENCEPHALOGRAPHY	11,404,005	17,116,042	28,520,047	0.130554	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,945,773	6,892,555	20,838,328	0.410025	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	12,377,155	6,849,923	19,227,078	0.677380	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	18,576,285	6,043,315	24,619,600	0.208352	0.000000	73.00
76.97	CARDIAC REHABILITATION	451	349,326	349,777	1.411719	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	7,893,587	7,893,587	0.453533	0.000000	90.00
91.00	EMERGENCY	4,699,797	12,637,198	17,336,995	0.252854	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	320,133	1,338,195	1,658,328	0.774085	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	1,187,321	1,187,321			101.00
200.00	Subtotal (see instructions)	176,497,479	189,269,270	365,766,749			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	176,497,479	189,269,270	365,766,749			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/29/2012 8:15 pm

Title XIX | Hospital | PPS

	Cost Center Description	PPS Inpatient Ratio		
		11.00		
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS			30.00
31.00	INTENSIVE CARE UNIT			31.00
43.00	NURSERY			43.00
44.00	SKILLED NURSING FACILITY			44.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	0.150058		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.596545		52.00
53.00	ANESTHESIOLOGY	0.023978		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.154538		54.00
60.00	LABORATORY	0.202675		60.00
65.00	RESPIRATORY THERAPY	0.175755		65.00
66.00	PHYSICAL THERAPY	0.295146		66.00
70.00	ELECTROENCEPHALOGRAPHY	0.130554		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.410025		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.677380		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.208352		73.00
76.97	CARDIAC REHABILITATION	1.411719		76.97
	OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	0.453533		90.00
91.00	EMERGENCY	0.252854		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.774085		92.00
	OTHER REIMBURSABLE COST CENTERS			
101.00	HOME HEALTH AGENCY			101.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part II | Date/Time Prepared: 5/29/2012 8:15 pm

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	Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	12,046,871	1,281,252	10,765,619	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	1,559,368	115,678	1,443,690	0	0	52.00
53.00	ANESTHESIOLOGY	383,832	26,503	357,329	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	7,802,738	807,856	6,994,882	0	0	54.00
60.00	LABORATORY	6,327,428	383,618	5,943,810	0	0	60.00
65.00	RESPIRATORY THERAPY	2,048,075	147,616	1,900,459	0	0	65.00
66.00	PHYSICAL THERAPY	2,984,741	235,873	2,748,868	0	0	66.00
70.00	ELECTROENCEPHALOGRAPHY	3,723,401	278,162	3,445,239	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,544,240	359,290	8,184,950	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	13,024,037	122,197	12,901,840	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	5,129,547	144,131	4,985,416	0	0	73.00
76.97	CARDIAC REHABILITATION	493,787	67,875	425,912	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	3,580,000	250,668	3,329,332	0	0	90.00
91.00	EMERGENCY	4,383,729	382,647	4,001,082	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1,283,687	164,940	1,118,747	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	976,804	37,846	938,958	0	0	101.00
200.00	Subtotal (sum of lines 50 thru 199)	74,292,285	4,806,152	69,486,133	0	0	200.00
201.00	Less Observation Beds	1,283,687	164,940	1,118,747	0	0	201.00
202.00	Total (line 200 minus line 201)	73,008,598	4,641,212	68,367,386	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part II | Date/Time Prepared: 5/29/2012 8:15 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
		6.00	7.00	8.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	12,046,871	80,281,255	0.150058		50.00
52.00	DELIVERY ROOM & LABOR ROOM	1,559,368	2,614,001	0.596545		52.00
53.00	ANESTHESIOLOGY	383,832	16,007,848	0.023978		53.00
54.00	RADIOLOGY-DIAGNOSTIC	7,802,738	50,490,824	0.154538		54.00
60.00	LABORATORY	6,327,428	31,219,631	0.202675		60.00
65.00	RESPIRATORY THERAPY	2,048,075	11,653,022	0.175755		65.00
66.00	PHYSICAL THERAPY	2,984,741	10,112,768	0.295146		66.00
70.00	ELECTROENCEPHALOGRAPHY	3,723,401	28,520,047	0.130554		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,544,240	20,838,328	0.410025		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	13,024,037	19,227,078	0.677380		72.00
73.00	DRUGS CHARGED TO PATIENTS	5,129,547	24,619,600	0.208352		73.00
76.97	CARDIAC REHABILITATION	493,787	349,777	1.411719		76.97
	OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	3,580,000	7,893,587	0.453533		90.00
91.00	EMERGENCY	4,383,729	17,336,995	0.252854		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1,283,687	1,658,328	0.774085		92.00
	OTHER REIMBURSABLE COST CENTERS					
101.00	HOME HEALTH AGENCY	976,804	1,187,321	0.822696		101.00
200.00	Subtotal (sum of lines 50 thru 199)	74,292,285	0			200.00
201.00	Less Observation Beds	1,283,687	0			201.00
202.00	Total (line 200 minus line 201)	73,008,598	324,010,410			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part I Date/Time Prepared: 5/29/2012 8:15 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,991,916	0	1,991,916	24,274	82.06	30.00
31.00	INTENSIVE CARE UNIT	331,200		331,200	2,508	132.06	31.00
43.00	NURSERY	45,387		45,387	1,327	34.20	43.00
44.00	SKILLED NURSING FACILITY	465,951		465,951	4,788	97.32	44.00
200.00	Total (lines 30-199)	2,834,454		2,834,454	32,897		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part I Date/Time Prepared: 5/29/2012 8:15 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	12,343	1,012,867		30.00
31.00	INTENSIVE CARE UNIT	1,463	193,204		31.00
43.00	NURSERY	0	0		43.00
44.00	SKILLED NURSING FACILITY	3,546	345,097		44.00
200.00	Total (lines 30-199)	17,352	1,551,168		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part II Date/Time Prepared: 5/29/2012 8:15 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,281,252	80,281,255	0.015960	13,273,308	211,842	50.00
52.00	DELIVERY ROOM & LABOR ROOM	115,678	2,614,001	0.044253	0	0	52.00
53.00	ANESTHESIOLOGY	26,503	16,007,848	0.001656	3,526,053	5,839	53.00
54.00	RADIOLOGY-DIAGNOSTIC	807,856	50,490,824	0.016000	7,395,901	118,334	54.00
60.00	LABORATORY	383,618	31,219,631	0.012288	6,654,169	81,766	60.00
65.00	RESPIRATORY THERAPY	147,616	11,653,022	0.012668	3,705,371	46,940	65.00
66.00	PHYSICAL THERAPY	235,873	10,112,768	0.023324	2,011,184	46,909	66.00
70.00	ELECTROENCEPHALOGRAPHY	278,162	28,520,047	0.009753	6,497,380	63,369	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	359,290	20,838,328	0.017242	7,154,628	123,360	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	122,197	19,227,078	0.006355	6,998,875	44,478	72.00
73.00	DRUGS CHARGED TO PATIENTS	144,131	24,619,600	0.005854	9,069,835	53,095	73.00
76.97	CARDIAC REHABILITATION	67,875	349,777	0.194052	451	88	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	250,668	7,893,587	0.031756	0	0	90.00
91.00	EMERGENCY	382,647	17,336,995	0.022071	3,024,619	66,756	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	164,940	1,658,328	0.099462	320,133	31,841	92.00
200.00	Total (lines 50-199)	4,768,306	322,823,089		69,631,907	894,617	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part III Date/Time Prepared: 5/29/2012 8:15 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	0		0	31.00
43.00	NURSERY	0	0	0		0	43.00
44.00	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00	Total (lines 30-199)	0	0	0		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part III Date/Time Prepared: 5/29/2012 8:15 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
		6.00	7.00	8.00	9.00	11.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	24,274	0.00	12,343	0	0	30.00
31.00	INTENSIVE CARE UNIT	2,508	0.00	1,463	0	0	31.00
43.00	NURSERY	1,327	0.00	0	0	0	43.00
44.00	SKILLED NURSING FACILITY	4,788	0.00	3,546	0	0	44.00
200.00	Total (lines 30-199)	32,897		17,352	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part III Date/Time Prepared: 5/29/2012 8:15 pm

Title XVIII | Hospital | PPS

	Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost	
		12.00	13.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	0	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30-199)	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/29/2012 8:15 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	CARDIAC REHABILITATION	0	0	0	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/29/2012 8:15 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	80,281,255	0.000000	0.000000	13,273,308	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	2,614,001	0.000000	0.000000	0	52.00
53.00	ANESTHESIOLOGY	0	16,007,848	0.000000	0.000000	3,526,053	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	50,490,824	0.000000	0.000000	7,395,901	54.00
60.00	LABORATORY	0	31,219,631	0.000000	0.000000	6,654,169	60.00
65.00	RESPIRATORY THERAPY	0	11,653,022	0.000000	0.000000	3,705,371	65.00
66.00	PHYSICAL THERAPY	0	10,112,768	0.000000	0.000000	2,011,184	66.00
70.00	ELECTROENCEPHALOGRAPHY	0	28,520,047	0.000000	0.000000	6,497,380	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	20,838,328	0.000000	0.000000	7,154,628	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	19,227,078	0.000000	0.000000	6,998,875	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	24,619,600	0.000000	0.000000	9,069,835	73.00
76.97	CARDIAC REHABILITATION	0	349,777	0.000000	0.000000	451	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	7,893,587	0.000000	0.000000	0	90.00
91.00	EMERGENCY	0	17,336,995	0.000000	0.000000	3,024,619	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,658,328	0.000000	0.000000	320,133	92.00
200.00	Total (lines 50-199)	0	322,823,089			69,631,907	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/29/2012 8:15 pm

Title XVIII | Hospital | PPS

	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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	13,241,572	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	1,421,854	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	12,333,167	0	0	0	54.00
60.00	LABORATORY	0	1,466,935	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	1,923,484	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	2,392,586	0	0	0	66.00
70.00	ELECTROENCEPHALOGRAPHY	0	9,434,256	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,994,167	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	3,304,713	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,967,851	0	0	0	73.00
76.97	CARDIAC REHABILITATION	0	165,961	0	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	113,154	0	0	0	90.00
91.00	EMERGENCY	0	3,185,298	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	981,945	0	0	0	92.00
200.00	Total (lines 50-199)	0	53,926,943	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/29/2012 8:15 pm

Title XVIII | Hospital | PPS

	Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
		23.00	24.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	ANESTHESIOLOGY	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	LABORATORY	0	0		60.00
65.00	RESPIRATORY THERAPY	0	0		65.00
66.00	PHYSICAL THERAPY	0	0		66.00
70.00	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97	CARDIAC REHABILITATION	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0	0		90.00
91.00	EMERGENCY	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part V Date/Time Prepared: 5/29/2012 8:15 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
		1.00	2.00	3.00	4.00		
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.150058	13,241,572	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.596545	0	0	0		52.00
53.00	ANESTHESIOLOGY	0.023978	1,421,854	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.154538	12,333,167	0	0		54.00
60.00	LABORATORY	0.202675	1,466,935	0	0		60.00
65.00	RESPIRATORY THERAPY	0.175755	1,923,484	0	0		65.00
66.00	PHYSICAL THERAPY	0.295146	2,392,586	0	0		66.00
70.00	ELECTROENCEPHALOGRAPHY	0.130554	9,434,256	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.410025	1,994,167	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.677380	3,304,713	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.208352	1,967,851	0	31,147		73.00
76.97	CARDIAC REHABILITATION	1.411719	165,961	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0.453533	113,154	0	0		90.00
91.00	EMERGENCY	0.252854	3,185,298	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.774085	981,945	0	0		92.00
200.00	Subtotal (see instructions)		53,926,943	0	31,147		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		53,926,943	0	31,147		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part V Date/Time Prepared: 5/29/2012 8:15 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Costs: PPS Services (see instructions)	Costs: Cost Services Subject To Ded. & Coins. (see instructions)	Costs: Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	1,987,004	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	ANESTHESIOLOGY	34,093	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,905,943	0	0		54.00
60.00	LABORATORY	297,311	0	0		60.00
65.00	RESPIRATORY THERAPY	338,062	0	0		65.00
66.00	PHYSICAL THERAPY	706,162	0	0		66.00
70.00	ELECTROENCEPHALOGRAPHY	1,231,680	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	817,658	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	2,238,546	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	410,006	0	6,490		73.00
76.97	CARDIAC REHABILITATION	234,290	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	51,319	0	0		90.00
91.00	EMERGENCY	805,415	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	760,109	0	0		92.00
200.00	Subtotal (see instructions)	11,817,598	0	6,490		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	11,817,598	0	6,490		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/29/2012 8:15 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	CARDIAC REHABILITATION	0	0	0	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 140013 Component CCN: 145579 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV Date/Time Prepared: 5/29/2012 8:15 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	80,281,255	0.000000	0.000000	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	2,614,001	0.000000	0.000000	0	52.00
53.00	ANESTHESIOLOGY	0	16,007,848	0.000000	0.000000	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	50,490,824	0.000000	0.000000	94,523	54.00
60.00	LABORATORY	0	31,219,631	0.000000	0.000000	220,744	60.00
65.00	RESPIRATORY THERAPY	0	11,653,022	0.000000	0.000000	339,904	65.00
66.00	PHYSICAL THERAPY	0	10,112,768	0.000000	0.000000	1,929,108	66.00
70.00	ELECTROENCEPHALOGRAPHY	0	28,520,047	0.000000	0.000000	39,916	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	20,838,328	0.000000	0.000000	291,642	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	19,227,078	0.000000	0.000000	855	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	24,619,600	0.000000	0.000000	1,138,464	73.00
76.97	CARDIAC REHABILITATION	0	349,777	0.000000	0.000000	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	7,893,587	0.000000	0.000000	0	90.00
91.00	EMERGENCY	0	17,336,995	0.000000	0.000000	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,658,328	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	322,823,089			4,055,156	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/29/2012 8:15 pm

Title XVIII | Skilled Nursing Facility | PPS

	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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	CARDIAC REHABILITATION	0	0	0	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 140013 | Component CCN: 145579 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/29/2012 8:15 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
		23.00	24.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	ANESTHESIOLOGY	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	LABORATORY	0	0		60.00
65.00	RESPIRATORY THERAPY	0	0		65.00
66.00	PHYSICAL THERAPY	0	0		66.00
70.00	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97	CARDIAC REHABILITATION	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0	0		90.00
91.00	EMERGENCY	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part I Date/Time Prepared: 5/29/2012 8:15 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,991,916	0	1,991,916	24,274	82.06	30.00
31.00	INTENSIVE CARE UNIT	331,200		331,200	2,508	132.06	31.00
43.00	NURSERY	45,387		45,387	1,327	34.20	43.00
44.00	SKILLED NURSING FACILITY	465,951		465,951	4,788	97.32	44.00
200.00	Total (lines 30-199)	2,834,454		2,834,454	32,897		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part I Date/Time Prepared: 5/29/2012 8:15 pm

Title XIX | Hospital | PPS

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	565	46,364		30.00
31.00	INTENSIVE CARE UNIT	39	5,150		31.00
43.00	NURSERY	265	9,063		43.00
44.00	SKILLED NURSING FACILITY	0	0		44.00
200.00	Total (lines 30-199)	869	60,577		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part II Date/Time Prepared: 5/29/2012 8:15 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,281,252	80,281,255	0.015960	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	115,678	2,614,001	0.044253	0	0	52.00
53.00	ANESTHESIOLOGY	26,503	16,007,848	0.001656	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	807,856	50,490,824	0.016000	0	0	54.00
60.00	LABORATORY	383,618	31,219,631	0.012288	0	0	60.00
65.00	RESPIRATORY THERAPY	147,616	11,653,022	0.012668	0	0	65.00
66.00	PHYSICAL THERAPY	235,873	10,112,768	0.023324	0	0	66.00
70.00	ELECTROENCEPHALOGRAPHY	278,162	28,520,047	0.009753	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	359,290	20,838,328	0.017242	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	122,197	19,227,078	0.006355	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	144,131	24,619,600	0.005854	0	0	73.00
76.97	CARDIAC REHABILITATION	67,875	349,777	0.194052	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	250,668	7,893,587	0.031756	0	0	90.00
91.00	EMERGENCY	382,647	17,336,995	0.022071	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	164,940	1,658,328	0.099462	0	0	92.00
200.00	Total (lines 50-199)	4,768,306	322,823,089		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part III Date/Time Prepared: 5/29/2012 8:15 pm

Title XIX | Hospital | PPS

	Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	0		0	31.00
43.00	NURSERY	0	0	0		0	43.00
44.00	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00	Total (lines 30-199)	0	0	0		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part III Date/Time Prepared: 5/29/2012 8:15 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
		6.00	7.00	8.00	9.00	11.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	24,274	0.00	565	0	0	30.00
31.00	INTENSIVE CARE UNIT	2,508	0.00	39	0	0	31.00
43.00	NURSERY	1,327	0.00	265	0	0	43.00
44.00	SKILLED NURSING FACILITY	4,788	0.00	0	0	0	44.00
200.00	Total (lines 30-199)	32,897		869	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part III Date/Time Prepared: 5/29/2012 8:15 pm

Title XIX | Hospital | PPS

	Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost	
		12.00	13.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	0	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30-199)	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/29/2012 8:15 pm

Title XIX | Hospital | PPS

	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	CARDIAC REHABILITATION	0	0	0	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/29/2012 8:15 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	80,281,255	0.000000	0.000000	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	2,614,001	0.000000	0.000000	0	52.00
53.00	ANESTHESIOLOGY	0	16,007,848	0.000000	0.000000	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	50,490,824	0.000000	0.000000	0	54.00
60.00	LABORATORY	0	31,219,631	0.000000	0.000000	0	60.00
65.00	RESPIRATORY THERAPY	0	11,653,022	0.000000	0.000000	0	65.00
66.00	PHYSICAL THERAPY	0	10,112,768	0.000000	0.000000	0	66.00
70.00	ELECTROENCEPHALOGRAPHY	0	28,520,047	0.000000	0.000000	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	20,838,328	0.000000	0.000000	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	19,227,078	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	24,619,600	0.000000	0.000000	0	73.00
76.97	CARDIAC REHABILITATION	0	349,777	0.000000	0.000000	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	7,893,587	0.000000	0.000000	0	90.00
91.00	EMERGENCY	0	17,336,995	0.000000	0.000000	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,658,328	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	322,823,089			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/29/2012 8:15 pm

Title XIX | Hospital | PPS

	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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	CARDIAC REHABILITATION	0	0	0	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/29/2012 8:15 pm

Title XIX | Hospital | PPS

	Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
		23.00	24.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	ANESTHESIOLOGY	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	LABORATORY	0	0		60.00
65.00	RESPIRATORY THERAPY	0	0		65.00
66.00	PHYSICAL THERAPY	0	0		66.00
70.00	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97	CARDIAC REHABILITATION	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0	0		90.00
91.00	EMERGENCY	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/29/2012 8:15 pm

Title XIX | Skilled Nursing Facility | PPS

	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	CARDIAC REHABILITATION	0	0	0	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 140013 Component CCN: 145579 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV Date/Time Prepared: 5/29/2012 8:15 pm

Title XIX | Skilled Nursing Facility | PPS

	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	80,281,255	0.000000	0.000000	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	2,614,001	0.000000	0.000000	0	52.00
53.00	ANESTHESIOLOGY	0	16,007,848	0.000000	0.000000	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	50,490,824	0.000000	0.000000	0	54.00
60.00	LABORATORY	0	31,219,631	0.000000	0.000000	0	60.00
65.00	RESPIRATORY THERAPY	0	11,653,022	0.000000	0.000000	0	65.00
66.00	PHYSICAL THERAPY	0	10,112,768	0.000000	0.000000	0	66.00
70.00	ELECTROENCEPHALOGRAPHY	0	28,520,047	0.000000	0.000000	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	20,838,328	0.000000	0.000000	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	19,227,078	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	24,619,600	0.000000	0.000000	0	73.00
76.97	CARDIAC REHABILITATION	0	349,777	0.000000	0.000000	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	7,893,587	0.000000	0.000000	0	90.00
91.00	EMERGENCY	0	17,336,995	0.000000	0.000000	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,658,328	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	322,823,089			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/29/2012 8:15 pm

Title XIX | Skilled Nursing Facility | PPS

	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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	CARDIAC REHABILITATION	0	0	0	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 140013 | Component CCN: 145579 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/29/2012 8:15 pm

Title XIX | Skilled Nursing Facility | PPS

	Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
		23.00	24.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	ANESTHESIOLOGY	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	LABORATORY	0	0		60.00
65.00	RESPIRATORY THERAPY	0	0		65.00
66.00	PHYSICAL THERAPY	0	0		66.00
70.00	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97	CARDIAC REHABILITATION	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0	0		90.00
91.00	EMERGENCY	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Total (lines 50-199)	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/29/2012 8:15 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	24,274	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	24,274	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)	24,274	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	12,343	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	15,502,647	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	15,502,647	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	34,566,921	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	34,566,921	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.448482	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)	1,424.03	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)	15,502,647	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	638.65	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	7,882,857	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)	7,882,857	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/29/2012 8:15 pm

Title XVIII | Hospital | PPS

	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	4,004,256	2,508	1,596.59	1,463	2,335,811	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)	17,238,411	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	27,457,079	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)	1,206,071	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	894,617	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,100,688	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	25,356,391	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)	2,010	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	638.65	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,283,687	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/29/2012 8:15 pm

Title XVIII | Hospital | PPS

	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	1,991,916	15,502,647	0.128489	1,283,687	164,940	90.00
91.00	Nursing School cost	0	15,502,647	0.000000	1,283,687	0	91.00
92.00	Allied health cost	0	15,502,647	0.000000	1,283,687	0	92.00
93.00	All other Medical Education	0	15,502,647	0.000000	1,283,687	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140013 Component CCN: 145579	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/29/2012 8:15 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,788	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,788	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)	4,788	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,546	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,874,774	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,874,774	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	2,824,693	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	2,824,693	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.017730	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)	589.95	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,874,774	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/29/2012 8:15 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	2,874,774	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	600.41	71.00
72.00	Program routine service cost (line 9 x line 71)	2,129,054	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	2,129,054	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	2,129,054	83.00
84.00	Program inpatient ancillary services (see instructions)	1,051,027	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	3,180,081	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1

Component CCN: 145579 | Date/Time Prepared: 5/29/2012 8:15 pm

Title XVIII | Skilled Nursing Facility | PPS

	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: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/29/2012 8:15 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	24,274	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	24,274	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)	24,274	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	565	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)	1,327	15.00
16.00	Nursery days (title V or XIX only)	265	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	15,502,647	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	15,502,647	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	34,566,921	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	34,566,921	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.448482	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)	1,424.03	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)	15,502,647	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	638.65	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	360,837	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)	360,837	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/29/2012 8:15 pm

Title XIX | Hospital | PPS

	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)	624,991	1,327	470.98	265	124,810	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,004,256	2,508	1,596.59	39	62,267	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)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	547,914	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)	60,577	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)	60,577	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	487,337	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)	2,010	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	638.65	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,283,687	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/29/2012 8:15 pm

Title XIX | Hospital | PPS

	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	1,991,916	15,502,647	0.128489	1,283,687	164,940	90.00
91.00	Nursing School cost	0	15,502,647	0.000000	1,283,687	0	91.00
92.00	Allied health cost	0	15,502,647	0.000000	1,283,687	0	92.00
93.00	All other Medical Education	0	15,502,647	0.000000	1,283,687	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140013 Component CCN: 145579	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/29/2012 8:15 pm
	Title XIX	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,788	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,788	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)	4,788	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	0	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)	1,327	15.00
16.00	Nursery days (title V or XIX only)	265	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,874,774	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,874,774	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	2,824,693	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	2,824,693	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.017730	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)	589.95	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,874,774	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/29/2012 8:15 pm

Title XIX | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	2,874,774	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	600.41	71.00
72.00	Program routine service cost (line 9 x line 71)	0	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	465,951	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	97.32	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	0	83.00
84.00	Program inpatient ancillary services (see instructions)	0	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	0	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140013 Component CCN: 145579	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/29/2012 8:15 pm
	Title XIX	Skilled Nursing Facility	PPS

	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: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-3 | Date/Time Prepared: 5/29/2012 8:15 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		11,283,304		30.00
31.00	INTENSIVE CARE UNIT		4,305,471		31.00
43.00	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.150058	13,273,308	1,991,766	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.596545	0	0	52.00
53.00	ANESTHESIOLOGY	0.023978	3,526,053	84,548	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.154538	7,395,901	1,142,948	54.00
60.00	LABORATORY	0.202675	6,654,169	1,348,634	60.00
65.00	RESPIRATORY THERAPY	0.175755	3,705,371	651,237	65.00
66.00	PHYSICAL THERAPY	0.295146	2,011,184	593,593	66.00
70.00	ELECTROENCEPHALOGRAPHY	0.130554	6,497,380	848,259	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.410025	7,154,628	2,933,576	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.677380	6,998,875	4,740,898	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.208352	9,069,835	1,889,718	73.00
76.97	CARDIAC REHABILITATION	1.411719	451	637	76.97
	OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0.453533	0	0	90.00
91.00	EMERGENCY	0.252854	3,024,619	764,787	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.774085	320,133	247,810	92.00
200.00	Total (sum of lines 50-94 and 96-98)		69,631,907	17,238,411	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		69,631,907		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-3 | Date/Time Prepared: 5/29/2012 8:15 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
43.00	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.150058	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.596545	0	0	52.00
53.00	ANESTHESIOLOGY	0.023978	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.154538	94,523	14,607	54.00
60.00	LABORATORY	0.202675	220,744	44,739	60.00
65.00	RESPIRATORY THERAPY	0.175755	339,904	59,740	65.00
66.00	PHYSICAL THERAPY	0.295146	1,929,108	569,369	66.00
70.00	ELECTROENCEPHALOGRAPHY	0.130554	39,916	5,211	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.410025	291,642	119,581	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.677380	855	579	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.208352	1,138,464	237,201	73.00
76.97	CARDIAC REHABILITATION	1.411719	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0.453533	0	0	90.00
91.00	EMERGENCY	0.252854	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.774085	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		4,055,156	1,051,027	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		4,055,156		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140013	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part A Date/Time Prepared: 5/29/2012 8:15 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS		
1.00	DRG Amounts Other than Outlier Payments	21,354,841	1.00
2.00	Outlier payments for discharges. (see instructions)	155,634	2.00
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	136.49	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjusment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment. (see instructions)	0.000000	27.00
28.00	IME Adjustment (see instructions)	0	28.00
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.00	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)	0.00	31.00
32.00	Sum of lines 30 and 31	0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)	0.00	33.00
34.00	Disproportionate share adjustment (see instructions)	0	34.00
	Additional payment for high percentage of ESRD beneficiary discharges		
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)	0	46.00
47.00	Subtotal (see instructions)	21,510,475	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	21,510,475	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)	1,765,709	50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)	0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)	0	56.00
57.00	Routine service other pass through costs	0	57.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140013	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part A Date/Time Prepared: 5/29/2012 8:15 pm
	Title XVIII	Hospital	PPS

		1.00	
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	23,276,184	59.00
60.00	Primary payer payments	1,868	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	23,274,316	61.00
62.00	Deductibles billed to program beneficiaries	2,446,456	62.00
63.00	Coinsurance billed to program beneficiaries	47,261	63.00
64.00	Allowable bad debts (see instructions)	243,622	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	170,535	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	148,770	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	20,951,134	67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)	0	68.00
69.00	Outlier payments reconciliation	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.95	Recovery of Accelerated Depreciation	0	70.95
70.96	Low Volume Payment-1	0	70.96
70.97	Low Volume Payment-2	0	70.97
70.98	Low Volume Payment-3	0	70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)	20,951,134	71.00
72.00	Interim payments	20,963,320	72.00
73.00	Tentative settlement (for contractor use only)	0	73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)	-12,186	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	177,461	75.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Operating outlier amount from Worksheet E, Part A line 2	0	90.00
91.00	Capital outlier from Worksheet L, Part I, line 2	0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)	0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)	0	93.00
94.00	The rate used to calculate the Time Value of Money	0.00	94.00
95.00	Time Value of Money for operating expenses(see instructions)	0	95.00
96.00	Time Value of Money for capital related expenses (see instructions)	0	96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140013	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/29/2012 8:15 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,490	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	11,817,598	2.00
3.00	PPS payments	9,908,564	3.00
4.00	Outlier payment (see instructions)	21,079	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.762	5.00
6.00	Line 2 times line 5	9,005,010	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)	6,490	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	31,147	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)	31,147	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis 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)	31,147	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	24,657	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)	6,490	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)	9,929,643	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,300,962	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)	7,635,171	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)	7,635,171	30.00
31.00	Primary payer payments	78	31.00
32.00	Subtotal (line 30 minus line 31)	7,635,093	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	277,569	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	194,298	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	189,204	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	7,829,391	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)	7,829,391	40.00
41.00	Interim payments	7,833,796	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)	-4,405	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140013	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/29/2012 8:15 pm
	Title XVIII	Hospital	PPS

		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140013 Component CCN: 145579	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/29/2012 8:15 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		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)	0	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)	0	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	0	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	0	37.00
38.00	MSP-LCC reconciliation amount from PS&R		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)	0	40.00
41.00	Interim payments	0	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)	0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140013 Component CCN: 145579	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/29/2012 8:15 pm
	Title XVIII	Skilled Nursing Facility	PPS

		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2012 8:15 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		20,943,494		7,785,155	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	07/29/2011	19,826	07/29/2011	48,641	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		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)		19,826		48,641	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)		20,963,320		7,833,796	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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		12,186		4,405	6.02
7.00	Total Medicare program liability (see instructions)		20,951,134		7,829,391	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: 140013 Component CCN: 145579	Period: From 01/01/2011 To 12/31/2011	Worksheet E-1 Part I Date/Time Prepared: 5/29/2012 8:15 pm
Title XVIII	Skilled Nursing Facility	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		1,430,405		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		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. E or Wkst. E-3, line and column as appropriate)		1,430,405		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,430,405		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	Provider CCN: 140013 Component CCN: 145579	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part VI Date/Time Prepared: 5/29/2012 8:15 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,464,976	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,464,976	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	34,571	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Allowable reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)	1,430,405	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14	1,430,405	15.00
16.00	Interim payments	1,430,405	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus the sum of lines 16 and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet G | Date/Time Prepared: 5/29/2012 8:15 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURENT ASSETS					
1.00	Cash on hand in banks	646,928	0	0	0	1.00
2.00	Temporary investments	5,951,538	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	17,524,227	0	0	0	4.00
5.00	Other receivable	1,211,209	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	3,619,589	0	0	0	7.00
8.00	Prepaid expenses	1,755,972	0	0	0	8.00
9.00	Other current assets	1,382,367	0	0	0	9.00
10.00	Due from other funds	13,272,658	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	45,364,488	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	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	44,106,057	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)	44,106,057	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	11,821,788	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	11,821,788	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	101,292,333	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	16,393,903	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	5,408,650	0	0	0	40.00
41.00	Deferred income	3,497,444	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	5,034,803	0	0	0	43.00
44.00	Other current liabilities	380,031	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	30,714,831	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	32,454,401	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	25,448,746	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	57,903,147	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	88,617,978	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	12,674,355				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)	12,674,355	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	101,292,333	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet G-1 | Date/Time Prepared: 5/29/2012 8:15 pm

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		24,796,812		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-197,330				2.00
3.00	Total (sum of line 1 and line 2)		24,599,482		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	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		24,599,482		0		11.00
12.00	PENSION RELATED CHANGES	11,925,127		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)		11,925,127		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		12,674,355		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet G-1 | Date/Time Prepared: 5/29/2012 8:15 pm

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 140013 | Period: From 01/01/2011 To 12/31/2011 | Worksheet G-2 Parts | Date/Time Prepared: 5/29/2012 8:15 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	34,566,921		34,566,921	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	2,824,693		2,824,693	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)	37,391,614		37,391,614	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	7,202,066		7,202,066	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)	7,202,066		7,202,066	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	44,593,680		44,593,680	17.00
18.00	Ancillary services	130,691,231	167,160,183	297,851,414	18.00
19.00	Outpatient services	4,748,494	20,796,330	25,544,824	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		1,191,653	1,191,653	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	DIETARY REV	0	5,301	5,301	27.00
27.12	NURSING ADMIN	0	2,298	2,298	27.12
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	180,033,405	189,155,765	369,189,170	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		107,707,577		29.00
30.00	PROVISION FOR DOUBTFUL ACCOUNTS	4,291,024			30.00
31.00	EXP VARI	25,110			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)		4,316,134		36.00
37.00	PROPERTY TAXES (INCLUDED IN OTHER NE	114,000			37.00
38.00	CHILD CARE REVENUE (IN EXP ON AFS)	432,349			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)		546,349		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		111,477,362		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140013	Period: From 01/01/2011 To 12/31/2011	Worksheet G-3 Date/Time Prepared: 5/29/2012 8:15 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	369,189,170	1.00
2.00	Less contractual allowances and discounts on patients' accounts	262,822,647	2.00
3.00	Net patient revenues (line 1 minus line 2)	106,366,523	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	111,477,362	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,110,839	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	190	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 OP	4,334,443	24.00
24.01	NET ASSEST RELEASED	811,368	24.01
24.02	ROUNDING	220	24.02
24.03		0	24.03
24.04		0	24.04
25.00	Total other income (sum of lines 6-24)	5,146,221	25.00
26.00	Total (line 5 plus line 25)	35,382	26.00
27.00	INVESTMENT LOSSES	148,960	27.00
27.01	OTHER NET	83,752	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	232,712	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-197,330	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140013 | HHA CCN: 147049 | Period: From 01/01/2011 To 12/31/2011 | Worksheet H | Date/Time Prepared: 5/29/2012 8:15 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
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	104,811	0	0	12,500	17,333	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	314,615	0	19,404	0	0	6.00
7.00	Physical Therapy	0	0	0	93,389	0	7.00
8.00	Occupational Therapy	0	0	0	73,970	0	8.00
9.00	Speech Pathology	0	0	0	403	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	12,281	12.00
13.00	Drugs	0	0	0	0	92	13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
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)	419,426	0	19,404	180,262	29,706	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: 140013 | HHA CCN: 147049 | Period: From 01/01/2011 To 12/31/2011 | Worksheet H | Date/Time Prepared: 5/29/2012 8:15 pm

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		Total (sum of cols. 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	
	GENERAL SERVICE COST CENTERS						
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	134,644	0	134,644	0	134,644	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	334,019	0	334,019	0	334,019	6.00
7.00	Physical Therapy	93,389	0	93,389	0	93,389	7.00
8.00	Occupational Therapy	73,970	0	73,970	0	73,970	8.00
9.00	Speech Pathology	403	0	403	0	403	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)	12,281	0	12,281	0	12,281	12.00
13.00	Drugs	92	0	92	0	92	13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
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	-3,506	-3,506	23.00
24.00	Total (sum of lines 1-23)	648,798	0	648,798	-3,506	645,292	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: 140013 HHA CCN: 147049

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

Worksheet H-1 Part I Date/Time Prepared: 5/29/2012 8:15 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	
			Bldgs & Fixtures	Movable Equipment			
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
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	0	0	0	0	0	4.00
5.00	Administrative and General	134,644	0	0	0	0	5.00
	HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	334,019	0	0	0	0	6.00
7.00	Physical Therapy	93,389	0	0	0	0	7.00
8.00	Occupational Therapy	73,970	0	0	0	0	8.00
9.00	Speech Pathology	403	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)	12,281	0	0	0	0	12.00
13.00	Drugs	92	0	0	0		13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
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)	-3,506	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	645,292	0	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 140013 HHA CCN: 147049

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

Worksheet H-1 Part I Date/Time Prepared: 5/29/2012 8:15 pm

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		Subtotal (cols. 0-4)	Administrative & General	Total (cols. 4A + 5)		
		4A.00	5.00	6.00		
	GENERAL SERVICE COST CENTERS					
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	134,644	134,644			5.00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	334,019	88,072	422,091		6.00
7.00	Physical Therapy	93,389	24,624	118,013		7.00
8.00	Occupational Therapy	73,970	19,504	93,474		8.00
9.00	Speech Pathology	403	106	509		9.00
10.00	Medical Social Services	0	0	0		10.00
11.00	Home Health Aide	0	0	0		11.00
12.00	Supplies (see instructions)	12,281	3,238	15,519		12.00
13.00	Drugs	92	24	116		13.00
14.00	DME	0	0	0		14.00
	HHA NONREIMBURSABLE SERVICES					
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)	-3,506	-924	-4,430		23.00
24.00	Total (sum of lines 1-23)	510,648		645,292		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 140013 | HHA CCN: 147049 | Period: From 01/01/2011 To 12/31/2011 | Worksheet H-1 Part II | Date/Time Prepared: 5/29/2012 8:15 pm

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		Capital Related Costs					
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	
		1.00	2.00	3.00	4.00	5A.00	
	GENERAL SERVICE COST CENTERS						
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		4.00
5.00	Administrative and General	0	0	0	0	-134,644	5.00
	HHA REIMBURSABLE SERVICES						
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	13.00
14.00	DME	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES						
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	-134,644	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: 140013 | HHA CCN: 147049 | Period: From 01/01/2011 To 12/31/2011 | Worksheet H-1 Part II | Date/Time Prepared: 5/29/2012 8:15 pm

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		Administrative & General (ACCUM. COST)		
		5.00		
	GENERAL SERVICE COST CENTERS			
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	510,648		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	334,019		6.00
7.00	Physical Therapy	93,389		7.00
8.00	Occupational Therapy	73,970		8.00
9.00	Speech Pathology	403		9.00
10.00	Medical Social Services	0		10.00
11.00	Home Health Aide	0		11.00
12.00	Supplies (see instructions)	12,281		12.00
13.00	Drugs	92		13.00
14.00	DME	0		14.00
	HHA NONREIMBURSABLE SERVICES			
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)	-3,506		23.00
24.00	Total (sum of lines 1-23)	510,648		24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	134,644		25.00
26.00	Unit Cost Multiplier	0.263673		26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140013 HHA CCN: 147049

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

Worksheet H-2 Part I Date/Time Prepared: 5/29/2012 8:15 pm

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			CAPITAL RELATED COSTS				
		HHA Trial Balance (1)	NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		0	1.00	2.00	4.00	4A	
1.00	Administrative and General	0	5,607	8,925	94,230	108,762	1.00
2.00	Skilled Nursing Care	422,091	0	0	0	422,091	2.00
3.00	Physical Therapy	118,013	0	0	0	118,013	3.00
4.00	Occupational Therapy	93,474	0	0	0	93,474	4.00
5.00	Speech Pathology	509	0	0	0	509	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)	15,519	0	0	0	15,519	8.00
9.00	Drugs	116	0	0	0	116	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)	-4,430	0	0	0	-4,430	19.00
20.00	Total (sum of lines 1-19) (2)	645,292	5,607	8,925	94,230	754,054	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: 140013 HHA CCN: 147049

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

Worksheet H-2 Part I Date/Time Prepared: 5/29/2012 8:15 pm

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		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
1.00	Administrative and General	18,996	13,284	2,617	0	5,298	1.00
2.00	Skilled Nursing Care	73,724	0	0	0	0	2.00
3.00	Physical Therapy	20,612	0	0	0	0	3.00
4.00	Occupational Therapy	16,326	0	0	0	0	4.00
5.00	Speech Pathology	89	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)	2,711	0	0	0	0	8.00
9.00	Drugs	20	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)	-774	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	131,704	13,284	2,617	0	5,298	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: 140013 | HHA CCN: 147049 | Period: From 01/01/2011 To 12/31/2011 | Worksheet H-2 Part I | Date/Time Prepared: 5/29/2012 8:15 pm

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		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	0	22,840	35,278	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	509	0	8.00
9.00	Drugs	0	0	0	0	65	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	22,840	35,278	509	65	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: 140013 | HHA CCN: 147049 | Period: From 01/01/2011 To 12/31/2011 | Worksheet H-2 Part I | Date/Time Prepared: 5/29/2012 8:15 pm

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		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		16.00	17.00	24.00	25.00	26.00	
1.00	Administrative and General	11,155	0	218,230	0	218,230	1.00
2.00	Skilled Nursing Care	0	0	495,815	0	495,815	2.00
3.00	Physical Therapy	0	0	138,625	0	138,625	3.00
4.00	Occupational Therapy	0	0	109,800	0	109,800	4.00
5.00	Speech Pathology	0	0	598	0	598	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	18,739	0	18,739	8.00
9.00	Drugs	0	0	201	0	201	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	-5,204	0	-5,204	19.00
20.00	Total (sum of lines 1-19) (2)	11,155	0	976,804	0	976,804	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: 140013 | HHA CCN: 147049 | Period: From 01/01/2011 To 12/31/2011 | Worksheet H-2 Part I | Date/Time Prepared: 5/29/2012 8:15 pm

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		Allocated HHA A&G (see Part II)	Total HHA Costs		
		27.00	28.00		
1.00	Administrative and General				1.00
2.00	Skilled Nursing Care	142,638	638,453		2.00
3.00	Physical Therapy	39,880	178,505		3.00
4.00	Occupational Therapy	31,588	141,388		4.00
5.00	Speech Pathology	172	770		5.00
6.00	Medical Social Services	0	0		6.00
7.00	Home Health Aide	0	0		7.00
8.00	Supplies (see instructions)	5,391	24,130		8.00
9.00	Drugs	58	259		9.00
10.00	DME	0	0		10.00
11.00	Home Dialysis Aide Services	0	0		11.00
12.00	Respiratory Therapy	0	0		12.00
13.00	Private Duty Nursing	0	0		13.00
14.00	Clinic	0	0		14.00
15.00	Health Promotion Activities	0	0		15.00
16.00	Day Care Program	0	0		16.00
17.00	Home Delivered Meals Program	0	0		17.00
18.00	Homemaker Service	0	0		18.00
19.00	All Others (specify)	-1,497	-6,701		19.00
20.00	Total (sum of lines 1-19) (2)	218,230	976,804		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.	0.287685			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: 140013 HHA CCN: 147049

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

Worksheet H-2 Part II Date/Time Prepared: 5/29/2012 8:15 pm

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		CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
1.00	Administrative and General	760	760	419,426	0	108,762	1.00
2.00	Skilled Nursing Care	0	0	0	0	422,091	2.00
3.00	Physical Therapy	0	0	0	0	118,013	3.00
4.00	Occupational Therapy	0	0	0	0	93,474	4.00
5.00	Speech Pathology	0	0	0	0	509	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	15,519	8.00
9.00	Drugs	0	0	0	0	116	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	-4,430	19.00
20.00	Total (sum of lines 1-19)	760	760	419,426		754,054	20.00
21.00	Total cost to be allocated	5,607	8,925	94,230		131,704	21.00
22.00	Unit cost multiplier	7.377632	11.743421	0.224664		0.174661	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140013
HHA CCN: 147049

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

Worksheet H-2
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		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
		6.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	760	760	0	760	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)	760	760	0	760	0	20.00
21.00	Total cost to be allocated	13,284	2,617	0	5,298	0	21.00
22.00	Unit cost multiplier	17.478947	3.443421	0.000000	6.971053	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140013 HHA CCN: 147049

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

Worksheet H-2 Part II Date/Time Prepared: 5/29/2012 8:15 pm

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		CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	419,426	419,426	0	0	1,187,321	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	12,281	0	0	8.00
9.00	Drugs	0	0	0	92	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)	419,426	419,426	12,281	92	1,187,321	20.00
21.00	Total cost to be allocated	22,840	35,278	509	65	11,155	21.00
22.00	Unit cost multiplier	0.054455	0.084110	0.041446	0.706522	0.009395	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140013 HHA CCN: 147049

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

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		SOCIAL SERVICE (PATIENT DAYS) 17.00		
1.00	Administrative and General	0		1.00
2.00	Skilled Nursing Care	0		2.00
3.00	Physical Therapy	0		3.00
4.00	Occupational Therapy	0		4.00
5.00	Speech Pathology	0		5.00
6.00	Medical Social Services	0		6.00
7.00	Home Health Aide	0		7.00
8.00	Supplies (see instructions)	0		8.00
9.00	Drugs	0		9.00
10.00	DME	0		10.00
11.00	Home Dialysis Aide Services	0		11.00
12.00	Respiratory Therapy	0		12.00
13.00	Private Duty Nursing	0		13.00
14.00	Clinic	0		14.00
15.00	Health Promotion Activities	0		15.00
16.00	Day Care Program	0		16.00
17.00	Home Delivered Meals Program	0		17.00
18.00	Homemaker Service	0		18.00
19.00	All Others (specify)	0		19.00
20.00	Total (sum of lines 1-19)	0		20.00
21.00	Total cost to be allocated	0		21.00
22.00	Unit cost multiplier	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 140013 | HHA CCN: 147049 | Period: From 01/01/2011 To 12/31/2011 | Worksheet H-3 Parts I-II | Date/Time Prepared: 5/29/2012 8:15 pm

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	638,453		638,453	1,138	1.00
2.00	Physical Therapy	3.00	178,505	0	178,505	2,318	2.00
3.00	Occupational Therapy	4.00	141,388	0	141,388	1,836	3.00
4.00	Speech Pathology	5.00	770	0	770	10	4.00
5.00	Medical Social Services	6.00	0		0	0	5.00
6.00	Home Health Aide	7.00	0		0	0	6.00
7.00	Total (sum of lines 1-6)		959,116	0	959,116	5,302	7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B: Not Subject to Deductibles & Coinsurance	Program Visits Part B: Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	
	Limitation Cost Computation						
8.00	Skilled Nursing Care		37900	850	436		8.00
9.00	Physical Therapy		37900	839	189		9.00
10.00	Occupational Therapy		37900	62	30		10.00
11.00	Speech Pathology		37900	7	3		11.00
12.00	Medical Social Services		37900	0	0		12.00
13.00	Home Health Aide		37900	0	0		13.00
14.00	Total (sum of lines 8-13)			1,758	658		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	24,130	0	24,130	20,189	15.00
16.00	Cost of Drugs	9.00	259	0	259	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	0.295146	0	0	1.00
2.00	Occupational Therapy					2.00
3.00	Speech Pathology					3.00
4.00	Cost of Medical Supplies	71.00	0.410025	0	0	4.00
5.00	Cost of Drugs	73.00	0.208352	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140013 | HHA CCN: 147049 | Period: From 01/01/2011 To 12/31/2011 | Worksheet H-3 Parts I-II | Date/Time Prepared: 5/29/2012 8:15 pm

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	Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance		
		5.00	6.00	7.00	8.00		
	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	561.03	850	436			1.00
2.00	Physical Therapy	77.01	839	189			2.00
3.00	Occupational Therapy	77.01	62	30			3.00
4.00	Speech Pathology	77.00	7	3			4.00
5.00	Medical Social Services	0.00	0	0			5.00
6.00	Home Health Aide	0.00	0	0			6.00
7.00	Total (sum of lines 1-6)		1,758	658			7.00
	Cost Center Description						
		5.00	6.00	7.00	8.00	9.00	
	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 Center Description	Ratio (col. 3 ÷ col. 4)	Program Covered Charges: Part A	Program Covered Charges: Part B Not Subject to Deductibles & Coinsurance	Program Covered Charges: Part B Subject to Deductibles & Coinsurance		
		5.00	6.00	7.00	8.00		
	Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	1.195205	12,324	7,864	0		15.00
16.00	Cost of Drugs	0.000000	0	0	0		16.00

	Cost Center Description	Transfer to Part I as Indicated		
		4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS			
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: 140013 HHA CCN: 147049 | Period: From 01/01/2011 To 12/31/2011 | Worksheet H-3 Parts I-II Date/Time Prepared: 5/29/2012 8:15 pm

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	Cost Center Description	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	Total Program Cost (sum of cols. 9-10)		
		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	476,876	244,609		721,485		1.00
2.00	Physical Therapy	64,611	14,555		79,166		2.00
3.00	Occupational Therapy	4,775	2,310		7,085		3.00
4.00	Speech Pathology	539	231		770		4.00
5.00	Medical Social Services	0	0		0		5.00
6.00	Home Health Aide	0	0		0		6.00
7.00	Total (sum of lines 1-6)	546,801	261,705		808,506		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 Center Description	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance			
		9.00	10.00	11.00			
	Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	14,730	9,399	0			15.00
16.00	Cost of Drugs	0	0	0			16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 140013 | HHA CCN: 147049 | Period: From 01/01/2011 To 12/31/2011 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/29/2012 8:15 pm

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	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	3.00
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	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	340,684	103,594	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	1,554	2,167	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	12,663	7,910	13.00
14.00	Total PPS Reimbursement - PEP Episodes	1,721	1,612	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	171	996	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	356,793	116,279	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	356,793	116,279	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	356,793	116,279	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	356,793	116,279	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	356,793	116,279	31.00
32.00	Interim payments (see instructions)	356,793	116,279	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 32 and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 140013 HHA CCN: 147049 | Period: From 01/01/2011 To 12/31/2011 | Worksheet H-5 | Date/Time Prepared: 5/29/2012 8:15 pm

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		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		356,793		116,279	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)		356,793		116,279	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		0	6.02
7.00	Total Medicare program liability (see instructions)		356,793		116,279	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140013	Period: From 01/01/2011 To 12/31/2011	Worksheet L Parts I-III Date/Time Prepared: 5/29/2012 8:15 pm
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		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,722,895	1.00
2.00	Capital DRG outlier payments	18,521	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	68.70	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	3.64	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)	3.29	8.00
9.00	Sum of lines 7 and 8	6.93	9.00
10.00	Allowable disproportionate share percentage (see instructions)	1.41	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)	24,293	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)	1,765,709	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00