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: 141346	Period: From 01/01/2011 To 12/31/2011	Worksheet S Parts I-III Date/Time Prepared: 5/15/2012 12:50 pm

PART I - COST REPORT STATUS

Provider use only

1. [ ] Electronically filed cost report — Date: 5/15/2012 Time: 12:50 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. [ ] 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: 4
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 FAYETTE COUNTY 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	69,712	-195,697	0	2,140,094	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	-67,481	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	2,231	-195,697	0	2,140,094	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part I | Date/Time Prepared: 5/15/2012 11:39 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: SEVENTH & TAYLOR	PO Box:			1.00
2.00	City: VANDALIA	State: IL	Zip Code: 62471-	County: FAYETTE	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	FAYETTE COUNTY HOSPITAL	141346	14999	1	04/01/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	FAYETTE COUNTY SNF	14Z346	14999		04/01/2005	N	O	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF	FAYETTE COUNTY SNF	145499	14999		07/01/1983	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) 1									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of State Medicaid paid days	Out-of State Medicaid eligible days	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.	0	0	0	0	0	0	25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.	2		26.00
27.00	For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification (in column 2).	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141346	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/15/2012 11:39 am

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

		Y/N	IME Average	Direct GME Average	
		1.00	2.00	3.00	
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	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: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part I Date/Time Prepared: 5/15/2012 11:39 am

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

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	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)			0	71.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part I | Date/Time Prepared: 5/15/2012 11:39 am

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

		Physical	Occupational	Speech	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

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

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	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: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part II | Date/Time Prepared: 5/15/2012 11:39 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C	03/31/2012	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

			Part A		
		Description	Y/N	Date	
		0	1.00	2.00	
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	04/03/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part II Date/Time Prepared: 5/15/2012 11:39 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part II Date/Time Prepared: 5/15/2012 11:39 am

		Part B		
		Y/N	Date	
		3.00	4.00	
	PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/03/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part I | Date/Time Prepared: 5/15/2012 11:39 am

	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	21	7,665	67,632.00		1.00
2.00	HMO						2.00
3.00	HMO IPF						3.00
4.00	HMO IRF						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	67,632.00		7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	6,336.00		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						13.00
14.00	Total (see instructions)		25	9,125	73,968.00		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	85	31,025			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)		110				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: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part I | Date/Time Prepared: 5/15/2012 11:39 am

	Cost Center Description	I/P Days / O/P Visits / Trips					
		Title V	Title XVIII	Title XIX	Total All Patients		
		5.00	6.00	7.00	8.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	2,153	313	2,818		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	2,410	0	2,410		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		0	101		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	4,563	313	5,329		7.00
8.00	INTENSIVE CARE UNIT	0	210	0	264		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	4,773	313	5,593		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	786	9,345	19,299		19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)						27.00
28.00	Observation Bed Days	0		0	391		28.00
29.00	Ambulance Trips		553				29.00
30.00	Employee discount days (see instruction)				0		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)			0	0		32.00
33.00	LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part I | Date/Time Prepared: 5/15/2012 11:39 am

	Cost Center Description	Full Time Equivalents			Discharges		
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
		9.00	10.00	11.00	12.00	13.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	701	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	165.98	0.00	0	701	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	33.23	0.00			19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00	199.21	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: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part I | Date/Time Prepared: 5/15/2012 11:39 am

	Cost Center Description	Discharges			
		Title XIX	Total All Patients		
		14.00	15.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	101	930		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)	101	930		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 RELATED COSTS | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part IV Date/Time Prepared: 5/15/2012 11:39 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	78,802	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	0	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)	1,636,609	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	42,539	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	-1,708	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)	39,750	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	192,328	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	647,644	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	90,492	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	0	22.00
23.00	Tuition Reimbursement	42,548	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	2,769,004	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-7 | Date/Time Prepared: 5/15/2012 11:39 am

		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.	Y	04/01/2005	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	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	1	0	1	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	14	0	14	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	40	0	40	15.00
16.00		RVB	0	0	0	16.00
17.00		RVA	15	0	15	17.00
18.00		RHC	85	0	85	18.00
19.00		RHB	14	0	14	19.00
20.00		RHA	87	0	87	20.00
21.00		RMC	81	0	81	21.00
22.00		RMB	44	0	44	22.00
23.00		RMA	85	0	85	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	4	0	4	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	41	0	41	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	19	0	19	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	34	0	34	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	4	0	4	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	1	0	1	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	39	0	39	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	5	0	5	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	23	0	23	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	45	0	45	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	38	0	38	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	42	0	42	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	24	0	24	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: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-7 | Date/Time Prepared: 5/15/2012 11:39 am

		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	1	0	1	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	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		786	0	786	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).	14999	14999	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	0	0.00		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)	207,363			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-10 | Date/Time Prepared: 5/15/2012 11:39 am

		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)	0.339358	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,089,288	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	1,102,264	5.00
6.00	Medicaid charges	9,692,790	6.00
7.00	Medicaid cost (line 1 times line 6)	3,289,326	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)	1,097,774	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	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)	1,097,774	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	789,118	0	789,118	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	267,794	0	267,794	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)	267,794	0	267,794	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?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,753,455	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	976,054	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	1,777,401	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	603,175	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	870,969	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,968,743	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A | Date/Time Prepared: 5/15/2012 11:39 am

	Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT		686,710	686,710	-495,931	190,779	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		0	0	502,045	502,045	2.00
4.00	EMPLOYEE BENEFITS	75,383	2,222,198	2,297,581	10,139	2,307,720	4.00
5.00	ADMINISTRATIVE & GENERAL	574,053	3,129,526	3,703,579	34,915	3,738,494	5.00
7.00	OPERATION OF PLANT	226,859	62,088	288,947	16,234	305,181	7.00
7.01	OPERATION OF PLANT HOSP ONLY	0	600,038	600,038	0	600,038	7.01
7.02	OPERATION OF PLANT ANNEX ONLY	0	6,029	6,029	0	6,029	7.02
8.00	LAUNDRY & LINEN SERVICE	77,720	57,425	135,145	0	135,145	8.00
9.00	HOUSEKEEPING	385,629	89,941	475,570	0	475,570	9.00
10.00	DIETARY	321,503	379,936	701,439	-259,179	442,260	10.00
11.00	CAFETERIA	0	0	0	259,179	259,179	11.00
13.00	NURSING ADMINISTRATION	271,929	22,546	294,475	0	294,475	13.00
14.00	CENTRAL SERVICES & SUPPLY	54,169	46,817	100,986	0	100,986	14.00
15.00	PHARMACY	187,484	119,324	306,808	0	306,808	15.00
16.00	MEDICAL RECORDS & LIBRARY	253,521	100,942	354,463	0	354,463	16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	286,350	286,350	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,184,008	199,894	1,383,902	-55,776	1,328,126	30.00
31.00	INTENSIVE CARE UNIT	258,891	34,380	293,271	-8,459	284,812	31.00
44.00	SKILLED NURSING FACILITY	1,301,566	302,932	1,604,498	-62,803	1,541,695	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	314,797	392,296	707,093	-301,842	405,251	50.00
53.00	ANESTHESIOLOGY	0	295,847	295,847	-292,564	3,283	53.00
54.00	RADIOLOGY-DIAGNOSTIC	416,921	722,788	1,139,709	-59,996	1,079,713	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	191,369	191,369	-3,395	187,974	55.00
60.00	LABORATORY	460,337	731,024	1,191,361	-45,828	1,145,533	60.00
65.00	RESPIRATORY THERAPY	242,939	132,085	375,024	-36,931	338,093	65.00
66.00	PHYSICAL THERAPY	366,770	45,957	412,727	-5,927	406,800	66.00
68.00	SPEECH PATHOLOGY	27,486	1,999	29,485	-355	29,130	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	138,080	138,080	516,105	654,185	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	78,228	78,228	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	731,140	731,140	33,827	764,967	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	595,031	595,031	-215	594,816	90.00
91.00	EMERGENCY	462,013	1,204,047	1,666,060	263,690	1,929,750	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	357,448	100,965	458,413	-297,150	161,263	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	7,821,426	13,343,354	21,164,780	74,361	21,239,141	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	588,972	90,990	679,962	-17,098	662,864	192.00
192.01	FAYETTE COUNTY ANNEX	0	57,262	57,262	-57,263	-1	192.01
192.02	PUBLIC RELATIONS	0	25,480	25,480	0	25,480	192.02
192.03	PERSONAL LAUNDRY	0	0	0	0	0	192.03
192.04	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
200.00	TOTAL (SUM OF LINES 118-199)	8,410,398	13,517,086	21,927,484	0	21,927,484	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A | Date/Time Prepared: 5/15/2012 11:39 am

	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	-16,247	174,532		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	502,045		2.00
4.00	EMPLOYEE BENEFITS	-1,401	2,306,319		4.00
5.00	ADMINISTRATIVE & GENERAL	-26,112	3,712,382		5.00
7.00	OPERATION OF PLANT	-2,112	303,069		7.00
7.01	OPERATION OF PLANT HOSP ONLY	0	600,038		7.01
7.02	OPERATION OF PLANT ANNEX ONLY	0	6,029		7.02
8.00	LAUNDRY & LINEN SERVICE	0	135,145		8.00
9.00	HOUSEKEEPING	0	475,570		9.00
10.00	DIETARY	-45,296	396,964		10.00
11.00	CAFETERIA	0	259,179		11.00
13.00	NURSING ADMINISTRATION	0	294,475		13.00
14.00	CENTRAL SERVICES & SUPPLY	0	100,986		14.00
15.00	PHARMACY	0	306,808		15.00
16.00	MEDICAL RECORDS & LIBRARY	-7,465	346,998		16.00
19.00	NONPHYSICIAN ANESTHETISTS	-286,350	0		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	1,328,126		30.00
31.00	INTENSIVE CARE UNIT	0	284,812		31.00
44.00	SKILLED NURSING FACILITY	-492,000	1,049,695		44.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	405,251		50.00
53.00	ANESTHESIOLOGY	0	3,283		53.00
54.00	RADIOLOGY-DIAGNOSTIC	-1,310	1,078,403		54.00
55.00	RADIOLOGY-THERAPEUTIC	0	187,974		55.00
60.00	LABORATORY	0	1,145,533		60.00
65.00	RESPIRATORY THERAPY	0	338,093		65.00
66.00	PHYSICAL THERAPY	0	406,800		66.00
68.00	SPEECH PATHOLOGY	0	29,130		68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	654,185		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	78,228		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	764,967		73.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0	594,816		90.00
91.00	EMERGENCY	-796,519	1,133,231		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	0	161,263		95.00
	SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	-1,674,812	19,564,329		118.00
	NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	662,864		192.00
192.01	FAYETTE COUNTY ANNEX	0	-1		192.01
192.02	PUBLIC RELATIONS	0	25,480		192.02
192.03	PERSONAL LAUNDRY	0	0		192.03
192.04	VIS MEALS & MEALS ON WHEELS	0	0		192.04
200.00	TOTAL (SUM OF LINES 118-199)	-1,674,812	20,252,672		200.00

RECLASSIFICATIONS | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-6 | Date/Time Prepared: 5/15/2012 11:39 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	118,794	140,385		1.00
	TOTALS		118,794	140,385		
	B - CRNA					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	286,350		1.00
	TOTALS		0	286,350		
	D - DEPRECIATION					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	502,045		1.00
	TOTALS		0	502,045		
	E - ER					
1.00	EMERGENCY	91.00	291,851	0		1.00
	TOTALS		291,851	0		
	F - INTEREST					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	16,247		1.00
	TOTALS		0	16,247		
	G - INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	18,439		1.00
	TOTALS		0	18,439		
	H - EMPLOYEE OCC HEALTH PROCEDURES					
1.00	EMPLOYEE BENEFITS	4.00	7,660	2,479		1.00
	TOTALS		7,660	2,479		
	I - WELLNESS DEPR AND UTIL					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	40,800		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	229		2.00
3.00	OPERATION OF PLANT	7.00	0	16,234		3.00
	TOTALS		0	57,263		
	J - MED SUPPLY					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	516,105		1.00
2.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	78,228		2.00
3.00		0.00	0	0		3.00
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
	TOTALS		0	594,333		
	K - PHARMACY					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	33,827		1.00
2.00		0.00	0	0		2.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
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
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
	TOTALS		0	33,827		
500.00	Grand Total: Increases		418,305	1,651,368		500.00

RECLASSIFICATIONS | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-6 | Date/Time Prepared: 5/15/2012 11:39 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	118,794	140,385	0		1.00
	TOTALS		118,794	140,385			
	B - CRNA						
1.00	ANESTHESIOLOGY	53.00	0	286,350	0		1.00
	TOTALS		0	286,350			
	D - DEPRECIATION						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	502,045	9		1.00
	TOTALS		0	502,045			
	E - ER						
1.00	AMBULANCE SERVICES	95.00	291,851	0	0		1.00
	TOTALS		291,851	0			
	F - INTEREST						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	16,247	9		1.00
	TOTALS		0	16,247			
	G - INSURANCE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	18,439	9		1.00
	TOTALS		0	18,439			
	H - EMPLOYEE OCC HEALTH PROCEDURES						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	7,660	2,479	0		1.00
	TOTALS		7,660	2,479			
	I - WELLNESS DEPR AND UTIL						
1.00	FAYETTE COUNTY ANNEX	192.01	0	57,263	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	57,263			
	J - MED SUPPLY						
1.00	ADULTS & PEDIATRICS	30.00	0	50,949	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	7,560	0		2.00
3.00	SKILLED NURSING FACILITY	44.00	0	48,075	0		3.00
5.00	OPERATING ROOM	50.00	0	299,040	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	6,214	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	58,185	0		7.00
8.00	RADIOLOGY-THERAPEUTIC	55.00	0	302	0		8.00
9.00	LABORATORY	60.00	0	45,628	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	36,901	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	5,923	0		11.00
12.00	SPEECH PATHOLOGY	68.00	0	355	0		12.00
13.00	CLINIC	90.00	0	215	0		13.00
14.00	EMERGENCY	91.00	0	26,732	0		14.00
15.00	AMBULANCE SERVICES	95.00	0	2,858	0		15.00
16.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	5,396	0		16.00
	TOTALS		0	594,333			
	K - PHARMACY						
1.00	ADULTS & PEDIATRICS	30.00	0	4,827	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	899	0		2.00
4.00	SKILLED NURSING FACILITY	44.00	0	14,728	0		4.00
5.00	OPERATING ROOM	50.00	0	2,802	0		5.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,811	0		7.00
8.00	RADIOLOGY-THERAPEUTIC	55.00	0	3,093	0		8.00
9.00	LABORATORY	60.00	0	200	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	30	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	4	0		11.00
13.00	EMERGENCY	91.00	0	1,429	0		13.00
14.00	AMBULANCE SERVICES	95.00	0	2,441	0		14.00
15.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,563	0		15.00
	TOTALS		0	33,827			
500.00	Grand Total: Decreases		418,305	1,651,368			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 5/15/2012 11:39 am

			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	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	1,109,949	2,539,627	0	2,539,627	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	1,109,949	2,539,627	0	2,539,627	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	1,109,949	2,539,627	0	2,539,627	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	686,710	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	686,710	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	0	0	0	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 5/15/2012 11:39 am

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	3,649,576	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	3,649,576	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	3,649,576	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	686,710				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	686,710				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	174,532	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	502,045	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	676,577	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 5/15/2012 11:39 am

	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	0	0	0	0	174,532	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	502,045	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	676,577	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8 | Date/Time Prepared: 5/15/2012 11:39 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-16,247	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)	A	-1,966	ADMINISTRATIVE & GENERAL	5.00	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	-796,519			10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Cafeteria-employees and guests	B	-45,296	DIETARY	10.00	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	B	-7,465	MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00	Vending machines	B	-2,112	OPERATION OF PLANT	7.00	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	A	-286,350	NONPHYSICIAN ANESTHETISTS	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	SPEECH PATHOLOGY	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	0		0.00	32.00
33.00			0		0.00	33.00
33.01	MISCELLANEOUS REVENUE	B	-12,430	ADMINISTRATIVE & GENERAL	5.00	33.01
33.02	NURSING HOME DISTRICT PAYMENT	B	-492,000	SKILLED NURSING FACILITY	44.00	33.02
33.03	AHA/IHA	A	-11,716	ADMINISTRATIVE & GENERAL	5.00	33.03
33.04	EMPLOYEE BENEFIT OTHER REVENUE	A	-1,401	EMPLOYEE BENEFITS	4.00	33.04
33.07	RADIOLOGY OTHER REVENUE	A	-1,310	RADIOLOGY-DIAGNOSTIC	54.00	33.07
34.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	34.00
35.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	35.00
36.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	36.00
37.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	37.00
38.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	38.00
39.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	39.00
40.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	41.00
42.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	42.00
43.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	43.00
44.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	44.00
45.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,674,812			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8 | Date/Time Prepared: 5/15/2012 11:39 am

	Cost Center Description	Wkst. A-7 Ref. 5.00		
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	9		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		0		33.00
33.01	MISCELLANEOUS REVENUE	0		33.01
33.02	NURSING HOME DISTRICT PAYMENT	0		33.02
33.03	AHA/IHA	0		33.03
33.04	EMPLOYEE BENEFIT OTHER REVENUE	0		33.04
33.07	RADIOLOGY OTHER REVENUE	0		33.07
34.00	OTHER ADJUSTMENTS (SPECIFY)	0		34.00
35.00	OTHER ADJUSTMENTS (SPECIFY)	0		35.00
36.00	OTHER ADJUSTMENTS (SPECIFY)	0		36.00
37.00	OTHER ADJUSTMENTS (SPECIFY)	0		37.00
38.00	OTHER ADJUSTMENTS (SPECIFY)	0		38.00
39.00	OTHER ADJUSTMENTS (SPECIFY)	0		39.00
40.00	OTHER ADJUSTMENTS (SPECIFY)	0		40.00
41.00	OTHER ADJUSTMENTS (SPECIFY)	0		41.00
42.00	OTHER ADJUSTMENTS (SPECIFY)	0		42.00
43.00	OTHER ADJUSTMENTS (SPECIFY)	0		43.00
44.00	OTHER ADJUSTMENTS (SPECIFY)	0		44.00
45.00	OTHER ADJUSTMENTS (SPECIFY)	0		45.00
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: 141346	Period: From 01/01/2011 To 12/31/2011	Worksheet A-8-1 Date/Time Prepared: 5/15/2012 11:39 am

		Line No.	Cost Center	Expense Items	
		1.00	2.00	3.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00		5.00	ADMINISTRATIVE & GENERAL	ALLIANT MANAGEMENT	1.00
2.00		54.00	RADIOLOGY-DIAGNOSTIC	BLUE GRASS LEASING	2.00
3.00		5.00	ADMINISTRATIVE & GENERAL	ALLIANT PURCHASING	3.00
4.00		5.00	ADMINISTRATIVE & GENERAL	BLUE	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				5.00

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

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

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

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

6.00		B	ALLIANT MGT	0.00		6.00
7.00		B	BLUEGRASS LEAS	0.00		7.00
8.00		B	ALLIANT PURCH	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:		OTHER			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: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8-1 | Date/Time Prepared: 5/15/2012 11:39 am

		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		481,689	481,689	0	0		1.00
2.00		84,022	84,022	0	0		2.00
3.00		7,605	7,605	0	0		3.00
4.00		50,070	50,070	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.	623,386	623,386	0			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 5/15/2012 11:39 am

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		91.00	EMERGENCY	1,092,126	796,519	1.00
2.00		0.00		0	0	2.00
3.00		0.00		0	0	3.00
4.00		0.00		0	0	4.00
5.00		0.00		0	0	5.00
6.00		0.00		0	0	6.00
7.00		0.00		0	0	7.00
8.00		0.00		0	0	8.00
9.00		0.00		0	0	9.00
10.00		0.00		0	0	10.00
200.00				1,092,126	796,519	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 5/15/2012 11:39 am

		Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
		5.00	6.00	7.00	8.00	9.00	
1.00		295,607	0	0	0	0	1.00
2.00		0	0	0	0	0	2.00
3.00		0	0	0	0	0	3.00
4.00		0	0	0	0	0	4.00
5.00		0	0	0	0	0	5.00
6.00		0	0	0	0	0	6.00
7.00		0	0	0	0	0	7.00
8.00		0	0	0	0	0	8.00
9.00		0	0	0	0	0	9.00
10.00		0	0	0	0	0	10.00
200.00		295,607		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 5/15/2012 11:39 am

		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	0	6.00
7.00		0	0	0	0	0	7.00
8.00		0	0	0	0	0	8.00
9.00		0	0	0	0	0	9.00
10.00		0	0	0	0	0	10.00
200.00		0	0	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 5/15/2012 11:39 am

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		0	796,519		1.00
2.00		0	0		2.00
3.00		0	0		3.00
4.00		0	0		4.00
5.00		0	0		5.00
6.00		0	0		6.00
7.00		0	0		7.00
8.00		0	0		8.00
9.00		0	0		9.00
10.00		0	0		10.00
200.00		0	796,519		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part I Date/Time Prepared: 5/15/2012 11:39 am

	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	174,532	174,532				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	502,045		502,045			2.00
4.00	EMPLOYEE BENEFITS	2,306,319	1,566	6,914	2,314,799		4.00
5.00	ADMINISTRATIVE & GENERAL	3,712,382	17,617	51,241	159,572	3,940,812	5.00
7.00	OPERATION OF PLANT	303,069	21,765	15,308	63,061	403,203	7.00
7.01	OPERATION OF PLANT HOSP ONLY	600,038	0	0	0	600,038	7.01
7.02	OPERATION OF PLANT ANNEX ONLY	6,029	0	0	0	6,029	7.02
8.00	LAUNDRY & LINEN SERVICE	135,145	4,012	416	21,604	161,177	8.00
9.00	HOUSEKEEPING	475,570	727	0	107,195	583,492	9.00
10.00	DIETARY	396,964	2,178	4,194	56,348	459,684	10.00
11.00	CAFETERIA	259,179	3,657	0	33,022	295,858	11.00
13.00	NURSING ADMINISTRATION	294,475	910	0	75,589	370,974	13.00
14.00	CENTRAL SERVICES & SUPPLY	100,986	1,035	0	15,058	117,079	14.00
15.00	PHARMACY	306,808	1,723	11,951	52,116	372,598	15.00
16.00	MEDICAL RECORDS & LIBRARY	346,998	6,079	6,106	70,472	429,655	16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,328,126	15,160	24,706	329,125	1,697,117	30.00
31.00	INTENSIVE CARE UNIT	284,812	1,782	0	71,965	358,559	31.00
44.00	SKILLED NURSING FACILITY	1,049,695	32,645	5,129	361,807	1,449,276	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	405,251	9,914	63,573	87,506	566,244	50.00
53.00	ANESTHESIOLOGY	3,283	0	0	0	3,283	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,078,403	7,823	190,041	115,894	1,392,161	54.00
55.00	RADIOLOGY-THERAPEUTIC	187,974	0	0	0	187,974	55.00
60.00	LABORATORY	1,145,533	3,102	55,947	127,962	1,332,544	60.00
65.00	RESPIRATORY THERAPY	338,093	5,171	25,644	67,531	436,439	65.00
66.00	PHYSICAL THERAPY	406,800	6,379	7,269	101,953	522,401	66.00
68.00	SPEECH PATHOLOGY	29,130	327	0	7,640	37,097	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	654,185	0	0	0	654,185	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	78,228	0	0	0	78,228	72.00
73.00	DRUGS CHARGED TO PATIENTS	764,967	0	0	0	764,967	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	594,816	9,262	0	0	604,078	90.00
91.00	EMERGENCY	1,133,231	6,385	21,658	209,555	1,370,829	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	161,263	1,839	4,236	18,234	185,572	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	19,564,329	161,058	494,333	2,153,209	19,381,553	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	847	0	0	847	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	662,864	11,623	1,230	161,590	837,307	192.00
192.01	FAYETTE COUNTY ANNEX	-1	1,004	6,482	0	7,485	192.01
192.02	PUBLIC RELATIONS	25,480	0	0	0	25,480	192.02
192.03	PERSONAL LAUNDRY	0	0	0	0	0	192.03
192.04	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
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)	20,252,672	174,532	502,045	2,314,799	20,252,672	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part I | Date/Time Prepared: 5/15/2012 11:39 am

	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT HOSP ONLY	OPERATION OF PLANT ANNEX ONLY	LAUNDRY & LINEN SERVICE	
		5.00	7.00	7.01	7.02	8.00	
	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	3,940,812					5.00
7.00	OPERATION OF PLANT	97,411	500,614				7.00
7.01	OPERATION OF PLANT HOSP ONLY	144,964	0	745,002			7.01
7.02	OPERATION OF PLANT ANNEX ONLY	1,457	0	0	7,486		7.02
8.00	LAUNDRY & LINEN SERVICE	38,939	15,246	24,043	0	239,405	8.00
9.00	HOUSEKEEPING	140,967	2,764	4,358	0	15,880	9.00
10.00	DIETARY	111,056	8,277	13,054	0	1,471	10.00
11.00	CAFETERIA	71,477	13,897	21,916	0	0	11.00
13.00	NURSING ADMINISTRATION	89,624	3,458	5,453	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	28,285	3,934	6,204	0	0	14.00
15.00	PHARMACY	90,017	6,545	10,322	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	103,801	23,100	36,430	0	0	16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	410,008	57,605	90,844	0	63,850	30.00
31.00	INTENSIVE CARE UNIT	86,625	6,770	10,677	0	0	31.00
44.00	SKILLED NURSING FACILITY	350,133	124,049	195,627	0	119,698	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	136,800	37,672	59,409	0	5,217	50.00
53.00	ANESTHESIOLOGY	793	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	336,335	29,725	46,877	0	5,069	54.00
55.00	RADIOLOGY-THERAPEUTIC	45,413	0	0	0	0	55.00
60.00	LABORATORY	321,932	11,788	18,590	0	0	60.00
65.00	RESPIRATORY THERAPY	105,440	19,649	30,987	0	431	65.00
66.00	PHYSICAL THERAPY	126,208	24,237	38,223	0	525	66.00
68.00	SPEECH PATHOLOGY	8,962	1,243	1,960	0	0	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	158,046	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	18,899	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	184,810	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	145,940	35,192	0	7,486	0	90.00
91.00	EMERGENCY	331,181	24,264	38,265	0	15,402	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	44,833	0	11,021	0	0	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,730,356	449,415	664,260	7,486	227,543	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	205	3,220	5,078	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	202,287	44,164	69,648	0	78	192.00
192.01	FAYETTE COUNTY ANNEX	1,808	3,815	6,016	0	18	192.01
192.02	PUBLIC RELATIONS	6,156	0	0	0	0	192.02
192.03	PERSONAL LAUNDRY	0	0	0	0	11,766	192.03
192.04	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
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)	3,940,812	500,614	745,002	7,486	239,405	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part I | Date/Time Prepared: 5/15/2012 11:39 am

	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
	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
7.00	OPERATION OF PLANT						7.00
7.01	OPERATION OF PLANT HOSP ONLY						7.01
7.02	OPERATION OF PLANT ANNEX ONLY						7.02
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING	747,461					9.00
10.00	DIETARY	12,637	606,179				10.00
11.00	CAFETERIA	21,217	0	424,365			11.00
13.00	NURSING ADMINISTRATION	5,279	0	20,580	495,368		13.00
14.00	CENTRAL SERVICES & SUPPLY	6,006	0	6,177	0	167,685	14.00
15.00	PHARMACY	9,993	0	7,929	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	35,267	0	18,442	0	0	16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	87,945	125,472	75,845	249,688	0	30.00
31.00	INTENSIVE CARE UNIT	10,336	5,813	11,908	39,203	0	31.00
44.00	SKILLED NURSING FACILITY	189,386	450,492	101,383	0	0	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	57,513	0	10,037	33,044	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	45,381	0	23,906	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	LABORATORY	17,997	0	30,885	0	0	60.00
65.00	RESPIRATORY THERAPY	29,998	0	11,671	0	0	65.00
66.00	PHYSICAL THERAPY	37,003	0	18,056	0	0	66.00
68.00	SPEECH PATHOLOGY	1,898	0	1,099	0	0	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	149,775	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	17,910	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	53,728	24,402	0	0	0	90.00
91.00	EMERGENCY	37,043	0	47,099	155,053	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	10,669	0	5,583	18,380	0	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	669,296	606,179	390,600	495,368	167,685	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,916	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	67,425	0	33,765	0	0	192.00
192.01	FAYETTE COUNTY ANNEX	5,824	0	0	0	0	192.01
192.02	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	PERSONAL LAUNDRY	0	0	0	0	0	192.03
192.04	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
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)	747,461	606,179	424,365	495,368	167,685	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part I Date/Time Prepared: 5/15/2012 11:39 am

	Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		15.00	16.00	19.00	24.00	25.00	
	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
7.00	OPERATION OF PLANT						7.00
7.01	OPERATION OF PLANT HOSP ONLY						7.01
7.02	OPERATION OF PLANT ANNEX ONLY						7.02
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	497,404					15.00
16.00	MEDICAL RECORDS & LIBRARY	0	646,695				16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	48,670	0	2,907,044	0	30.00
31.00	INTENSIVE CARE UNIT	0	3,958	0	533,849	0	31.00
44.00	SKILLED NURSING FACILITY	0	33,644	0	3,013,688	0	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	19,964	0	925,900	0	50.00
53.00	ANESTHESIOLOGY	0	7,676	0	11,752	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	122,986	0	2,002,440	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	9,409	0	242,796	0	55.00
60.00	LABORATORY	0	117,154	0	1,850,890	0	60.00
65.00	RESPIRATORY THERAPY	0	28,770	0	663,385	0	65.00
66.00	PHYSICAL THERAPY	0	18,138	0	784,791	0	66.00
68.00	SPEECH PATHOLOGY	0	503	0	52,762	0	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	23,363	0	985,369	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	2,081	0	117,118	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	497,404	99,347	0	1,546,528	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	16,998	0	887,824	0	90.00
91.00	EMERGENCY	0	72,385	0	2,091,521	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	14,410	0	290,468	0	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	497,404	639,456	0	18,908,125	0	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	14,266	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	7,239	0	1,261,913	0	192.00
192.01	FAYETTE COUNTY ANNEX	0	0	0	24,966	0	192.01
192.02	PUBLIC RELATIONS	0	0	0	31,636	0	192.02
192.03	PERSONAL LAUNDRY	0	0	0	11,766	0	192.03
192.04	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
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)	497,404	646,695	0	20,252,672	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part I | Date/Time Prepared: 5/15/2012 11:39 am

	Cost Center Description	Total		
		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
7.00	OPERATION OF PLANT			7.00
7.01	OPERATION OF PLANT HOSP ONLY			7.01
7.02	OPERATION OF PLANT ANNEX ONLY			7.02
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
19.00	NONPHYSICIAN ANESTHETISTS			19.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	2,907,044		30.00
31.00	INTENSIVE CARE UNIT	533,849		31.00
44.00	SKILLED NURSING FACILITY	3,013,688		44.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	925,900		50.00
53.00	ANESTHESIOLOGY	11,752		53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,002,440		54.00
55.00	RADIOLOGY-THERAPEUTIC	242,796		55.00
60.00	LABORATORY	1,850,890		60.00
65.00	RESPIRATORY THERAPY	663,385		65.00
66.00	PHYSICAL THERAPY	784,791		66.00
68.00	SPEECH PATHOLOGY	52,762		68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	985,369		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	117,118		72.00
73.00	DRUGS CHARGED TO PATIENTS	1,546,528		73.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	887,824		90.00
91.00	EMERGENCY	2,091,521		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	AMBULANCE SERVICES	290,468		95.00
	SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	18,908,125		118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,266		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	1,261,913		192.00
192.01	FAYETTE COUNTY ANNEX	24,966		192.01
192.02	PUBLIC RELATIONS	31,636		192.02
192.03	PERSONAL LAUNDRY	11,766		192.03
192.04	VIS MEALS & MEALS ON WHEELS	0		192.04
200.00	Cross Foot Adjustments	0		200.00
201.00	Negative Cost Centers	0		201.00
202.00	TOTAL (sum lines 118-201)	20,252,672		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part II | Date/Time Prepared: 5/15/2012 11:39 am

	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	1,566	6,914	8,480	8,480	4.00
5.00	ADMINISTRATIVE & GENERAL	0	17,617	51,241	68,858	584	5.00
7.00	OPERATION OF PLANT	0	21,765	15,308	37,073	231	7.00
7.01	OPERATION OF PLANT HOSP ONLY	0	0	0	0	0	7.01
7.02	OPERATION OF PLANT ANNEX ONLY	0	0	0	0	0	7.02
8.00	LAUNDRY & LINEN SERVICE	0	4,012	416	4,428	79	8.00
9.00	HOUSEKEEPING	0	727	0	727	393	9.00
10.00	DIETARY	0	2,178	4,194	6,372	206	10.00
11.00	CAFETERIA	0	3,657	0	3,657	121	11.00
13.00	NURSING ADMINISTRATION	0	910	0	910	277	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	1,035	0	1,035	55	14.00
15.00	PHARMACY	0	1,723	11,951	13,674	191	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	6,079	6,106	12,185	258	16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	15,160	24,706	39,866	1,205	30.00
31.00	INTENSIVE CARE UNIT	0	1,782	0	1,782	264	31.00
44.00	SKILLED NURSING FACILITY	0	32,645	5,129	37,774	1,329	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	9,914	63,573	73,487	320	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	7,823	190,041	197,864	424	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	LABORATORY	0	3,102	55,947	59,049	469	60.00
65.00	RESPIRATORY THERAPY	0	5,171	25,644	30,815	247	65.00
66.00	PHYSICAL THERAPY	0	6,379	7,269	13,648	373	66.00
68.00	SPEECH PATHOLOGY	0	327	0	327	28	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	9,262	0	9,262	0	90.00
91.00	EMERGENCY	0	6,385	21,658	28,043	767	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	1,839	4,236	6,075	67	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	161,058	494,333	655,391	7,888	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	847	0	847	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	11,623	1,230	12,853	592	192.00
192.01	FAYETTE COUNTY ANNEX	0	1,004	6,482	7,486	0	192.01
192.02	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	PERSONAL LAUNDRY	0	0	0	0	0	192.03
192.04	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
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	174,532	502,045	676,577	8,480	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part II | Date/Time Prepared: 5/15/2012 11:39 am

	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT HOSP ONLY	OPERATION OF PLANT ANNEX ONLY	LAUNDRY & LINEN SERVICE	
		5.00	7.00	7.01	7.02	8.00	
	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	69,442					5.00
7.00	OPERATION OF PLANT	1,716	39,020				7.00
7.01	OPERATION OF PLANT HOSP ONLY	2,554	0	2,554			7.01
7.02	OPERATION OF PLANT ANNEX ONLY	26	0	0	26		7.02
8.00	LAUNDRY & LINEN SERVICE	686	1,188	82	0	6,463	8.00
9.00	HOUSEKEEPING	2,484	215	15	0	429	9.00
10.00	DIETARY	1,957	645	45	0	40	10.00
11.00	CAFETERIA	1,259	1,083	75	0	0	11.00
13.00	NURSING ADMINISTRATION	1,579	270	19	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	498	307	21	0	0	14.00
15.00	PHARMACY	1,586	510	35	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	1,829	1,801	125	0	0	16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	7,228	4,490	311	0	1,724	30.00
31.00	INTENSIVE CARE UNIT	1,526	528	37	0	0	31.00
44.00	SKILLED NURSING FACILITY	6,170	9,669	670	0	3,230	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	2,411	2,936	204	0	141	50.00
53.00	ANESTHESIOLOGY	14	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	5,926	2,317	161	0	137	54.00
55.00	RADIOLOGY-THERAPEUTIC	800	0	0	0	0	55.00
60.00	LABORATORY	5,673	919	64	0	0	60.00
65.00	RESPIRATORY THERAPY	1,858	1,532	106	0	12	65.00
66.00	PHYSICAL THERAPY	2,224	1,889	131	0	14	66.00
68.00	SPEECH PATHOLOGY	158	97	7	0	0	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,785	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	333	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	3,256	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	2,572	2,743	0	26	0	90.00
91.00	EMERGENCY	5,836	1,891	131	0	416	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	790	0	38	0	0	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	65,734	35,030	2,277	26	6,143	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4	251	17	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	3,564	3,442	239	0	2	192.00
192.01	FAYETTE COUNTY ANNEX	32	297	21	0	0	192.01
192.02	PUBLIC RELATIONS	108	0	0	0	0	192.02
192.03	PERSONAL LAUNDRY	0	0	0	0	318	192.03
192.04	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
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)	69,442	39,020	2,554	26	6,463	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part II | Date/Time Prepared: 5/15/2012 11:39 am

	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
	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
7.00	OPERATION OF PLANT						7.00
7.01	OPERATION OF PLANT HOSP ONLY						7.01
7.02	OPERATION OF PLANT ANNEX ONLY						7.02
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING	4,263					9.00
10.00	DIETARY	72	9,337				10.00
11.00	CAFETERIA	121	0	6,316			11.00
13.00	NURSING ADMINISTRATION	30	0	306	3,391		13.00
14.00	CENTRAL SERVICES & SUPPLY	34	0	92	0	2,042	14.00
15.00	PHARMACY	57	0	118	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	201	0	274	0	0	16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	502	1,933	1,129	1,710	0	30.00
31.00	INTENSIVE CARE UNIT	59	90	177	268	0	31.00
44.00	SKILLED NURSING FACILITY	1,080	6,938	1,509	0	0	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	328	0	149	226	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	259	0	356	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	LABORATORY	103	0	460	0	0	60.00
65.00	RESPIRATORY THERAPY	171	0	174	0	0	65.00
66.00	PHYSICAL THERAPY	211	0	269	0	0	66.00
68.00	SPEECH PATHOLOGY	11	0	16	0	0	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,824	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	218	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	306	376	0	0	0	90.00
91.00	EMERGENCY	211	0	701	1,061	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	61	0	83	126	0	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,817	9,337	5,813	3,391	2,042	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	28	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	385	0	503	0	0	192.00
192.01	FAYETTE COUNTY ANNEX	33	0	0	0	0	192.01
192.02	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	PERSONAL LAUNDRY	0	0	0	0	0	192.03
192.04	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
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)	4,263	9,337	6,316	3,391	2,042	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part II Date/Time Prepared: 5/15/2012 11:39 am

	Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		15.00	16.00	19.00	24.00	25.00	
	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
7.00	OPERATION OF PLANT						7.00
7.01	OPERATION OF PLANT HOSP ONLY						7.01
7.02	OPERATION OF PLANT ANNEX ONLY						7.02
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	16,171					15.00
16.00	MEDICAL RECORDS & LIBRARY	0	16,673				16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	1,254		61,352	0	30.00
31.00	INTENSIVE CARE UNIT	0	102		4,833	0	31.00
44.00	SKILLED NURSING FACILITY	0	867		69,236	0	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	514		80,716	0	50.00
53.00	ANESTHESIOLOGY	0	198		212	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	3,183		210,627	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	242		1,042	0	55.00
60.00	LABORATORY	0	3,018		69,755	0	60.00
65.00	RESPIRATORY THERAPY	0	741		35,656	0	65.00
66.00	PHYSICAL THERAPY	0	467		19,226	0	66.00
68.00	SPEECH PATHOLOGY	0	13		657	0	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	602		5,211	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	54		605	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	16,171	2,559		21,986	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	438		15,723	0	90.00
91.00	EMERGENCY	0	1,864		40,921	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	371		7,611	0	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	16,171	16,487	0	645,369	0	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		1,147	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	186		21,766	0	192.00
192.01	FAYETTE COUNTY ANNEX	0	0		7,869	0	192.01
192.02	PUBLIC RELATIONS	0	0		108	0	192.02
192.03	PERSONAL LAUNDRY	0	0		318	0	192.03
192.04	VIS MEALS & MEALS ON WHEELS	0	0		0	0	192.04
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)	16,171	16,673	0	676,577	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part II | Date/Time Prepared: 5/15/2012 11:39 am

	Cost Center Description	Total		
		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
7.00	OPERATION OF PLANT			7.00
7.01	OPERATION OF PLANT HOSP ONLY			7.01
7.02	OPERATION OF PLANT ANNEX ONLY			7.02
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
19.00	NONPHYSICIAN ANESTHETISTS			19.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	61,352		30.00
31.00	INTENSIVE CARE UNIT	4,833		31.00
44.00	SKILLED NURSING FACILITY	69,236		44.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	80,716		50.00
53.00	ANESTHESIOLOGY	212		53.00
54.00	RADIOLOGY-DIAGNOSTIC	210,627		54.00
55.00	RADIOLOGY-THERAPEUTIC	1,042		55.00
60.00	LABORATORY	69,755		60.00
65.00	RESPIRATORY THERAPY	35,656		65.00
66.00	PHYSICAL THERAPY	19,226		66.00
68.00	SPEECH PATHOLOGY	657		68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,211		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	605		72.00
73.00	DRUGS CHARGED TO PATIENTS	21,986		73.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	15,723		90.00
91.00	EMERGENCY	40,921		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	AMBULANCE SERVICES	7,611		95.00
	SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	645,369		118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,147		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	21,766		192.00
192.01	FAYETTE COUNTY ANNEX	7,869		192.01
192.02	PUBLIC RELATIONS	108		192.02
192.03	PERSONAL LAUNDRY	318		192.03
192.04	VIS MEALS & MEALS ON WHEELS	0		192.04
200.00	Cross Foot Adjustments	0		200.00
201.00	Negative Cost Centers	0		201.00
202.00	TOTAL (sum lines 118-201)	676,577		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B-1 | Date/Time Prepared: 5/15/2012 11:39 am

	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS NEW MVBLE EQUIP (DOLLAR VALUE)	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	100,311					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		502,045				2.00
4.00	EMPLOYEE BENEFITS	900	6,914	8,327,355			4.00
5.00	ADMINISTRATIVE & GENERAL	10,125	51,241	574,053	-3,940,812	16,311,860	5.00
7.00	OPERATION OF PLANT	12,509	15,308	226,859	0	403,203	7.00
7.01	OPERATION OF PLANT HOSP ONLY	0	0	0	0	600,038	7.01
7.02	OPERATION OF PLANT ANNEX ONLY	0	0	0	0	6,029	7.02
8.00	LAUNDRY & LINEN SERVICE	2,306	416	77,720	0	161,177	8.00
9.00	HOUSEKEEPING	418	0	385,629	0	583,492	9.00
10.00	DIETARY	1,252	4,194	202,709	0	459,684	10.00
11.00	CAFETERIA	2,102	0	118,794	0	295,858	11.00
13.00	NURSING ADMINISTRATION	523	0	271,929	0	370,974	13.00
14.00	CENTRAL SERVICES & SUPPLY	595	0	54,169	0	117,079	14.00
15.00	PHARMACY	990	11,951	187,484	0	372,598	15.00
16.00	MEDICAL RECORDS & LIBRARY	3,494	6,106	253,521	0	429,655	16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	8,713	24,706	1,184,008	0	1,697,117	30.00
31.00	INTENSIVE CARE UNIT	1,024	0	258,891	0	358,559	31.00
44.00	SKILLED NURSING FACILITY	18,763	5,129	1,301,566	0	1,449,276	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	5,698	63,573	314,797	0	566,244	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	3,283	53.00
54.00	RADIOLOGY-DIAGNOSTIC	4,496	190,041	416,921	0	1,392,161	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	187,974	55.00
60.00	LABORATORY	1,783	55,947	460,337	0	1,332,544	60.00
65.00	RESPIRATORY THERAPY	2,972	25,644	242,939	0	436,439	65.00
66.00	PHYSICAL THERAPY	3,666	7,269	366,770	0	522,401	66.00
68.00	SPEECH PATHOLOGY	188	0	27,486	0	37,097	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	654,185	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	78,228	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	764,967	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	5,323	0	0	0	604,078	90.00
91.00	EMERGENCY	3,670	21,658	753,864	0	1,370,829	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	1,057	4,236	65,597	0	185,572	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	92,567	494,333	7,746,043	-3,940,812	15,440,741	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	487	0	0	0	847	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	6,680	1,230	581,312	0	837,307	192.00
192.01	FAYETTE COUNTY ANNEX	577	6,482	0	0	7,485	192.01
192.02	PUBLIC RELATIONS	0	0	0	0	25,480	192.02
192.03	PERSONAL LAUNDRY	0	0	0	0	0	192.03
192.04	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
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)	174,532	502,045	2,314,799		3,940,812	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1.739909	1.000000	0.277975		0.241592	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			8,480		69,442	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001018		0.004257	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B-1 | Date/Time Prepared: 5/15/2012 11:39 am

	Cost Center Description	OPERATION OF PLANT (SQ FT)	OPERATION OF PLANT HOSP ONLY (SQ FT)	OPERATION OF PLANT ANNEX ONLY (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		7.00	7.01	7.02	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						5.00
7.00	OPERATION OF PLANT	75,720					7.00
7.01	OPERATION OF PLANT HOSP ONLY	0	71,454				7.01
7.02	OPERATION OF PLANT ANNEX ONLY	0	0	5,323			7.02
8.00	LAUNDRY & LINEN SERVICE	2,306	2,306	0	475,325		8.00
9.00	HOUSEKEEPING	418	418	0	31,529	74,053	9.00
10.00	DIETARY	1,252	1,252	0	2,920	1,252	10.00
11.00	CAFETERIA	2,102	2,102	0	0	2,102	11.00
13.00	NURSING ADMINISTRATION	523	523	0	0	523	13.00
14.00	CENTRAL SERVICES & SUPPLY	595	595	0	0	595	14.00
15.00	PHARMACY	990	990	0	0	990	15.00
16.00	MEDICAL RECORDS & LIBRARY	3,494	3,494	0	0	3,494	16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	8,713	8,713	0	126,770	8,713	30.00
31.00	INTENSIVE CARE UNIT	1,024	1,024	0	0	1,024	31.00
44.00	SKILLED NURSING FACILITY	18,763	18,763	0	237,655	18,763	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	5,698	5,698	0	10,359	5,698	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	4,496	4,496	0	10,065	4,496	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	LABORATORY	1,783	1,783	0	0	1,783	60.00
65.00	RESPIRATORY THERAPY	2,972	2,972	0	855	2,972	65.00
66.00	PHYSICAL THERAPY	3,666	3,666	0	1,042	3,666	66.00
68.00	SPEECH PATHOLOGY	188	188	0	0	188	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	5,323	0	5,323	0	5,323	90.00
91.00	EMERGENCY	3,670	3,670	0	30,580	3,670	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	1,057	0	0	1,057	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	67,976	63,710	5,323	451,775	66,309	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	487	487	0	0	487	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	6,680	6,680	0	154	6,680	192.00
192.01	FAYETTE COUNTY ANNEX	577	577	0	35	577	192.01
192.02	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	PERSONAL LAUNDRY	0	0	0	23,361	0	192.03
192.04	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
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)	500,614	745,002	7,486	239,405	747,461	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	6.611384	10.426316	1.406350	0.503666	10.093595	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	39,020	2,554	26	6,463	4,263	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.515320	0.035743	0.004884	0.013597	0.057567	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B-1 | Date/Time Prepared: 5/15/2012 11:39 am

	Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER OF FTE'S)	NURSING ADMINISTRATION (NUMBER OF FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQUISITIONS)	PHARMACY (COSTED REQUISITIONS)	
		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
7.00	OPERATION OF PLANT						7.00
7.01	OPERATION OF PLANT HOSP ONLY						7.01
7.02	OPERATION OF PLANT ANNEX ONLY						7.02
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY	78,101					10.00
11.00	CAFETERIA	0	14,290				11.00
13.00	NURSING ADMINISTRATION	0	693	5,067			13.00
14.00	CENTRAL SERVICES & SUPPLY	0	208	0	732,413		14.00
15.00	PHARMACY	0	267	0	0	100	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	621	0	0	0	16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	16,166	2,554	2,554	0	0	30.00
31.00	INTENSIVE CARE UNIT	749	401	401	0	0	31.00
44.00	SKILLED NURSING FACILITY	58,042	3,414	0	0	0	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	338	338	0	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	805	0	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	LABORATORY	0	1,040	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	393	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	608	0	0	0	66.00
68.00	SPEECH PATHOLOGY	0	37	0	0	0	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	654,185	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	78,228	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	3,144	0	0	0	0	90.00
91.00	EMERGENCY	0	1,586	1,586	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	188	188	0	0	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	78,101	13,153	5,067	732,413	100	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	1,137	0	0	0	192.00
192.01	FAYETTE COUNTY ANNEX	0	0	0	0	0	192.01
192.02	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	PERSONAL LAUNDRY	0	0	0	0	0	192.03
192.04	VIS MEALS & MEALS ON WHEELS	0	0	0	0	0	192.04
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)	606,179	424,365	495,368	167,685	497,404	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	7.761476	29.696641	97.763568	0.228949	4,974.040000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	9,337	6,316	3,391	2,042	16,171	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.119550	0.441987	0.669232	0.002788	161.710000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B-1 | Date/Time Prepared: 5/15/2012 11:39 am

	Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
		16.00	19.00		
	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
7.00	OPERATION OF PLANT				7.00
7.01	OPERATION OF PLANT HOSP ONLY				7.01
7.02	OPERATION OF PLANT ANNEX ONLY				7.02
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	57,636,949			16.00
19.00	NONPHYSICIAN ANESTHETISTS	0	100		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	4,337,780			30.00
31.00	INTENSIVE CARE UNIT	352,782			31.00
44.00	SKILLED NURSING FACILITY	2,998,582			44.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	1,779,335	0		50.00
53.00	ANESTHESIOLOGY	684,107	100		53.00
54.00	RADIOLOGY-DIAGNOSTIC	10,960,584	0		54.00
55.00	RADIOLOGY-THERAPEUTIC	838,549	0		55.00
60.00	LABORATORY	10,441,573	0		60.00
65.00	RESPIRATORY THERAPY	2,564,161	0		65.00
66.00	PHYSICAL THERAPY	1,616,560	0		66.00
68.00	SPEECH PATHOLOGY	44,843	0		68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,082,286	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	185,437	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	8,854,429	0		73.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	1,514,983	0		90.00
91.00	EMERGENCY	6,451,431	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	1,284,311	0		95.00
	SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	56,991,733	100		118.00
	NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	645,216	0		192.00
192.01	FAYETTE COUNTY ANNEX	0	0		192.01
192.02	PUBLIC RELATIONS	0	0		192.02
192.03	PERSONAL LAUNDRY	0	0		192.03
192.04	VIS MEALS & MEALS ON WHEELS	0	0		192.04
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)	646,695	0		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.011220	0.000000		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	16,673	0		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000289	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/15/2012 11:39 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,907,044		2,907,044	0	2,907,044	30.00
31.00	INTENSIVE CARE UNIT	533,849		533,849	0	533,849	31.00
44.00	SKILLED NURSING FACILITY	3,013,688		3,013,688	0	3,013,688	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	925,900		925,900	0	925,900	50.00
53.00	ANESTHESIOLOGY	11,752		11,752	0	11,752	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,002,440		2,002,440	0	2,002,440	54.00
55.00	RADIOLOGY-THERAPEUTIC	242,796		242,796	0	242,796	55.00
60.00	LABORATORY	1,850,890		1,850,890	0	1,850,890	60.00
65.00	RESPIRATORY THERAPY	663,385	0	663,385	0	663,385	65.00
66.00	PHYSICAL THERAPY	784,791	0	784,791	0	784,791	66.00
68.00	SPEECH PATHOLOGY	52,762	0	52,762	0	52,762	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	985,369		985,369	0	985,369	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	117,118		117,118	0	117,118	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,546,528		1,546,528	0	1,546,528	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	887,824		887,824	0	887,824	90.00
91.00	EMERGENCY	2,091,521		2,091,521	0	2,091,521	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	201,142		201,142		201,142	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	290,468		290,468	0	290,468	95.00
200.00	Subtotal (see instructions)	19,109,267	0	19,109,267	0	19,109,267	200.00
201.00	Less Observation Beds	201,142		201,142		201,142	201.00
202.00	Total (see instructions)	18,908,125	0	18,908,125	0	18,908,125	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/15/2012 11:39 am

Title XVIII | Hospital | Cost

	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	3,636,462		3,636,462			30.00
31.00	INTENSIVE CARE UNIT	352,782		352,782			31.00
44.00	SKILLED NURSING FACILITY	2,998,582		2,998,582			44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	39,572	1,739,763	1,779,335	0.520363	0.000000	50.00
53.00	ANESTHESIOLOGY	642	1,846	2,488	4.723473	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,018,924	9,941,660	10,960,584	0.182695	0.000000	54.00
55.00	RADIOLOGY-THERAPEUTIC	86,542	752,007	838,549	0.289543	0.000000	55.00
60.00	LABORATORY	2,060,266	8,381,307	10,441,573	0.177262	0.000000	60.00
65.00	RESPIRATORY THERAPY	1,234,332	1,329,829	2,564,161	0.258714	0.000000	65.00
66.00	PHYSICAL THERAPY	502,119	1,114,441	1,616,560	0.485470	0.000000	66.00
68.00	SPEECH PATHOLOGY	19,915	24,928	44,843	1.176594	0.000000	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,460,118	622,168	2,082,286	0.473215	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	124,681	60,756	185,437	0.631578	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	5,926,407	2,928,022	8,854,429	0.174662	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	1,514,983	1,514,983	0.586029	0.000000	90.00
91.00	EMERGENCY	135,795	6,315,636	6,451,431	0.324195	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	60,005	641,313	701,318	0.286806	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	1,284,311	1,284,311	0.226166	0.000000	95.00
200.00	Subtotal (see instructions)	19,657,144	36,652,970	56,310,114			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	19,657,144	36,652,970	56,310,114			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/15/2012 11:39 am

Title XVIII | Hospital | Cost

	Cost Center Description	PPS Inpatient Ratio		
		11.00		
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS			30.00
31.00	INTENSIVE CARE UNIT			31.00
44.00	SKILLED NURSING FACILITY			44.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	0.000000		50.00
53.00	ANESTHESIOLOGY	0.000000		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	RADIOLOGY-THERAPEUTIC	0.000000		55.00
60.00	LABORATORY	0.000000		60.00
65.00	RESPIRATORY THERAPY	0.000000		65.00
66.00	PHYSICAL THERAPY	0.000000		66.00
68.00	SPEECH PATHOLOGY	0.000000		68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	0.000000		90.00
91.00	EMERGENCY	0.000000		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	AMBULANCE SERVICES	0.000000		95.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/15/2012 11:39 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,907,044		2,907,044	0	0	30.00
31.00	INTENSIVE CARE UNIT	533,849		533,849	0	0	31.00
44.00	SKILLED NURSING FACILITY	3,013,688		3,013,688	0	0	44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	925,900		925,900	0	0	50.00
53.00	ANESTHESIOLOGY	11,752		11,752	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,002,440		2,002,440	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	242,796		242,796	0	0	55.00
60.00	LABORATORY	1,850,890		1,850,890	0	0	60.00
65.00	RESPIRATORY THERAPY	663,385	0	663,385	0	0	65.00
66.00	PHYSICAL THERAPY	784,791	0	784,791	0	0	66.00
68.00	SPEECH PATHOLOGY	52,762	0	52,762	0	0	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	985,369		985,369	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	117,118		117,118	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,546,528		1,546,528	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	887,824		887,824	0	0	90.00
91.00	EMERGENCY	2,091,521		2,091,521	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	201,142		201,142		0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	290,468		290,468	0	0	95.00
200.00	Subtotal (see instructions)	19,109,267	0	19,109,267	0	0	200.00
201.00	Less Observation Beds	201,142		201,142		0	201.00
202.00	Total (see instructions)	18,908,125	0	18,908,125	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/15/2012 11:39 am

Title XIX | Hospital | Cost

	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	3,636,462		3,636,462			30.00
31.00	INTENSIVE CARE UNIT	352,782		352,782			31.00
44.00	SKILLED NURSING FACILITY	2,998,582		2,998,582			44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	39,572	1,739,763	1,779,335	0.520363	0.000000	50.00
53.00	ANESTHESIOLOGY	642	1,846	2,488	4.723473	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,018,924	9,941,660	10,960,584	0.182695	0.000000	54.00
55.00	RADIOLOGY-THERAPEUTIC	86,542	752,007	838,549	0.289543	0.000000	55.00
60.00	LABORATORY	2,060,266	8,381,307	10,441,573	0.177262	0.000000	60.00
65.00	RESPIRATORY THERAPY	1,234,332	1,329,829	2,564,161	0.258714	0.000000	65.00
66.00	PHYSICAL THERAPY	502,119	1,114,441	1,616,560	0.485470	0.000000	66.00
68.00	SPEECH PATHOLOGY	19,915	24,928	44,843	1.176594	0.000000	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,460,118	622,168	2,082,286	0.473215	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	124,681	60,756	185,437	0.631578	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	5,926,407	2,928,022	8,854,429	0.174662	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	1,514,983	1,514,983	0.586029	0.000000	90.00
91.00	EMERGENCY	135,795	6,315,636	6,451,431	0.324195	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	60,005	641,313	701,318	0.286806	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	1,284,311	1,284,311	0.226166	0.000000	95.00
200.00	Subtotal (see instructions)	19,657,144	36,652,970	56,310,114			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	19,657,144	36,652,970	56,310,114			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/15/2012 11:39 am

Title XIX | Hospital | Cost

	Cost Center Description	PPS Inpatient Ratio		
		11.00		
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS			30.00
31.00	INTENSIVE CARE UNIT			31.00
44.00	SKILLED NURSING FACILITY			44.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	0.000000		50.00
53.00	ANESTHESIOLOGY	0.000000		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	RADIOLOGY-THERAPEUTIC	0.000000		55.00
60.00	LABORATORY	0.000000		60.00
65.00	RESPIRATORY THERAPY	0.000000		65.00
66.00	PHYSICAL THERAPY	0.000000		66.00
68.00	SPEECH PATHOLOGY	0.000000		68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	0.000000		90.00
91.00	EMERGENCY	0.000000		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	AMBULANCE SERVICES	0.000000		95.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part II Date/Time Prepared: 5/15/2012 11:39 am

Title XVIII | Hospital | Cost

	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	80,716	1,779,335	0.045363	21,449	973	50.00
53.00	ANESTHESIOLOGY	212	2,488	0.085209	622	53	53.00
54.00	RADIOLOGY-DIAGNOSTIC	210,627	10,960,584	0.019217	401,171	7,709	54.00
55.00	RADIOLOGY-THERAPEUTIC	1,042	838,549	0.001243	51,731	64	55.00
60.00	LABORATORY	69,755	10,441,573	0.006681	1,135,451	7,586	60.00
65.00	RESPIRATORY THERAPY	35,656	2,564,161	0.013906	775,811	10,788	65.00
66.00	PHYSICAL THERAPY	19,226	1,616,560	0.011893	90,467	1,076	66.00
68.00	SPEECH PATHOLOGY	657	44,843	0.014651	8,546	125	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,211	2,082,286	0.002503	724,518	1,813	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	605	185,437	0.003263	55,871	182	72.00
73.00	DRUGS CHARGED TO PATIENTS	21,986	8,854,429	0.002483	2,476,392	6,149	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	15,723	1,514,983	0.010378	0	0	90.00
91.00	EMERGENCY	40,921	6,451,431	0.006343	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	701,318	0.000000	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	502,337	48,037,977		5,742,029	36,518	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/15/2012 11:39 am

Title XVIII | Hospital | Cost

	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
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	LABORATORY	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV Date/Time Prepared: 5/15/2012 11:39 am

Title XVIII | Hospital | Cost

	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	1,779,335	0.000000	0.000000	21,449	50.00
53.00	ANESTHESIOLOGY	0	2,488	0.000000	0.000000	622	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	10,960,584	0.000000	0.000000	401,171	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	838,549	0.000000	0.000000	51,731	55.00
60.00	LABORATORY	0	10,441,573	0.000000	0.000000	1,135,451	60.00
65.00	RESPIRATORY THERAPY	0	2,564,161	0.000000	0.000000	775,811	65.00
66.00	PHYSICAL THERAPY	0	1,616,560	0.000000	0.000000	90,467	66.00
68.00	SPEECH PATHOLOGY	0	44,843	0.000000	0.000000	8,546	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,082,286	0.000000	0.000000	724,518	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	185,437	0.000000	0.000000	55,871	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	8,854,429	0.000000	0.000000	2,476,392	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	1,514,983	0.000000	0.000000	0	90.00
91.00	EMERGENCY	0	6,451,431	0.000000	0.000000	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	701,318	0.000000	0.000000	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	48,037,977			5,742,029	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/15/2012 11:39 am

Title XVIII | Hospital | Cost

	Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0	0		50.00
53.00	ANESTHESIOLOGY	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
60.00	LABORATORY	0	0	0		60.00
65.00	RESPIRATORY THERAPY	0	0	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
68.00	SPEECH PATHOLOGY	0	0	0		68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0	0	0		90.00
91.00	EMERGENCY	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part V Date/Time Prepared: 5/15/2012 11:39 am

Title XVIII | Hospital | Cost

	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	0.520363	0	896,520	0		50.00
53.00	ANESTHESIOLOGY	4.723473	0	311	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.182695	0	4,238,947	0		54.00
55.00	RADIOLOGY-THERAPEUTIC	0.289543	0	560,180	0		55.00
60.00	LABORATORY	0.177262	0	4,757,284	0		60.00
65.00	RESPIRATORY THERAPY	0.258714	0	828,333	0		65.00
66.00	PHYSICAL THERAPY	0.485470	0	513,949	0		66.00
68.00	SPEECH PATHOLOGY	1.176594	0	12,119	0		68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.473215	0	376,620	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.631578	0	48,034	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.174662	0	2,087,093	0		73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0.586029	0	1,496,629	0		90.00
91.00	EMERGENCY	0.324195	0	1,670,946	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.286806	0	196,238	0		92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0.226166		0			95.00
200.00	Subtotal (see instructions)		0	17,683,203	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		0	17,683,203	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part V Date/Time Prepared: 5/15/2012 11:39 am

Title XVIII | Hospital | Cost

	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	0	466,516	0		50.00
53.00	ANESTHESIOLOGY	0	1,469	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	774,434	0		54.00
55.00	RADIOLOGY-THERAPEUTIC	0	162,196	0		55.00
60.00	LABORATORY	0	843,286	0		60.00
65.00	RESPIRATORY THERAPY	0	214,301	0		65.00
66.00	PHYSICAL THERAPY	0	249,507	0		66.00
68.00	SPEECH PATHOLOGY	0	14,259	0		68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	178,222	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	30,337	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	364,536	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0	877,068	0		90.00
91.00	EMERGENCY	0	541,712	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	56,282	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES		0			95.00
200.00	Subtotal (see instructions)	0	4,774,125	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	0	4,774,125	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141346 | Component CCN: 14Z346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part V | Date/Time Prepared: 5/15/2012 11:39 am

Title XVIII | Swing Beds - SNF | Cost

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	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	0.520363	0	0	0		50.00
53.00	ANESTHESIOLOGY	4.723473	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.182695	0	0	0		54.00
55.00	RADIOLOGY-THERAPEUTIC	0.289543	0	0	0		55.00
60.00	LABORATORY	0.177262	0	0	0		60.00
65.00	RESPIRATORY THERAPY	0.258714	0	0	0		65.00
66.00	PHYSICAL THERAPY	0.485470	0	0	0		66.00
68.00	SPEECH PATHOLOGY	1.176594	0	0	0		68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.473215	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.631578	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.174662	0	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0.586029	0	0	0		90.00
91.00	EMERGENCY	0.324195	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.286806	0	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0.226166		0			95.00
200.00	Subtotal (see instructions)		0	0	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141346 | Component CCN: 14Z346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part V | Date/Time Prepared: 5/15/2012 11:39 am

Title XVIII | Swing Beds - SNF | Cost

	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	0	0	0		50.00
53.00	ANESTHESIOLOGY	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
60.00	LABORATORY	0	0	0		60.00
65.00	RESPIRATORY THERAPY	0	0	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
68.00	SPEECH PATHOLOGY	0	0	0		68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0	0	0		90.00
91.00	EMERGENCY	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES		0			95.00
200.00	Subtotal (see instructions)	0	0	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141346 | Component CCN: 145499 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/15/2012 11:39 am

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
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	LABORATORY	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141346 Component CCN: 145499 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV Date/Time Prepared: 5/15/2012 11:39 am

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	1,779,335	0.000000	0.000000	0	50.00
53.00	ANESTHESIOLOGY	0	2,488	0.000000	0.000000	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	10,960,584	0.000000	0.000000	14,207	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	838,549	0.000000	0.000000	1,602	55.00
60.00	LABORATORY	0	10,441,573	0.000000	0.000000	64,192	60.00
65.00	RESPIRATORY THERAPY	0	2,564,161	0.000000	0.000000	2,507	65.00
66.00	PHYSICAL THERAPY	0	1,616,560	0.000000	0.000000	123,983	66.00
68.00	SPEECH PATHOLOGY	0	44,843	0.000000	0.000000	3,465	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,082,286	0.000000	0.000000	106,915	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	185,437	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	8,854,429	0.000000	0.000000	446,538	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	1,514,983	0.000000	0.000000	0	90.00
91.00	EMERGENCY	0	6,451,431	0.000000	0.000000	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	701,318	0.000000	0.000000	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	48,037,977			763,409	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141346 | Component CCN: 145499 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/15/2012 11:39 am

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)		
		11.00	12.00	13.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0	0		50.00
53.00	ANESTHESIOLOGY	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
60.00	LABORATORY	0	0	0		60.00
65.00	RESPIRATORY THERAPY	0	0	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
68.00	SPEECH PATHOLOGY	0	0	0		68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0	0	0		90.00
91.00	EMERGENCY	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part V Date/Time Prepared: 5/15/2012 11:39 am

Title XIX | Hospital | Cost

	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	0.520363	0	178,104	0		50.00
53.00	ANESTHESIOLOGY	4.723473	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.182695	0	2,354,220	0		54.00
55.00	RADIOLOGY-THERAPEUTIC	0.289543	0	66,628	0		55.00
60.00	LABORATORY	0.177262	0	1,376,402	0		60.00
65.00	RESPIRATORY THERAPY	0.258714	0	139,837	0		65.00
66.00	PHYSICAL THERAPY	0.485470	0	161,923	0		66.00
68.00	SPEECH PATHOLOGY	1.176594	0	1,410	0		68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.473215	0	103,675	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.631578	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.174662	0	482,546	0		73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0.586029	0	0	0		90.00
91.00	EMERGENCY	0.324195	0	2,112,721	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.286806	0	94,294	0		92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0.226166	0	0			95.00
200.00	Subtotal (see instructions)		0	7,071,760	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		0	7,071,760	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part V Date/Time Prepared: 5/15/2012 11:39 am

Title XIX | Hospital | Cost

	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	0	92,679	0		50.00
53.00	ANESTHESIOLOGY	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	430,104	0		54.00
55.00	RADIOLOGY-THERAPEUTIC	0	19,292	0		55.00
60.00	LABORATORY	0	243,984	0		60.00
65.00	RESPIRATORY THERAPY	0	36,178	0		65.00
66.00	PHYSICAL THERAPY	0	78,609	0		66.00
68.00	SPEECH PATHOLOGY	0	1,659	0		68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	49,061	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	84,282	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0	0	0		90.00
91.00	EMERGENCY	0	684,934	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	27,044	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES		0			95.00
200.00	Subtotal (see instructions)	0	1,747,826	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	0	1,747,826	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/15/2012 11:39 am

Title XVIII | Hospital | Cost

	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)	5,720	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,209	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)	3,209	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	2,410	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	101	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)	2,153	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)	2,410	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	163.05	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	166.80	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,907,044	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)	16,468	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	1,256,244	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,650,800	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	3,636,462	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	3,636,462	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.453958	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,133.21	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)	1,650,800	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)	514.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,107,568	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,107,568	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/15/2012 11:39 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	533,849	264	2,022.16	210	424,654	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,369,000	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,901,222	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	1,239,776	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,239,776	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)	391	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	514.43	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	201,142	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/15/2012 11:39 am

Title XVIII | Hospital | Cost

	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: 141346 Component CCN: 145499	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/15/2012 11:39 am
	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)	19,299	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,299	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)	19,299	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)	786	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	163.05	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	166.80	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,013,688	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,013,688	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	207,363	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	207,363	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	14.533393	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)	10.74	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,013,688	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: 141346 | Period: From 01/01/2011 | Worksheet D-1
Component CCN: 145499 | To 12/31/2011 | Date/Time Prepared: 5/15/2012 11:39 am
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)	3,013,688	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	156.16	71.00
72.00	Program routine service cost (line 9 x line 71)	122,742	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)	122,742	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)	122,742	83.00
84.00	Program inpatient ancillary services (see instructions)	207,942	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)	330,684	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: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1

Component CCN: 145499 | Date/Time Prepared: 5/15/2012 11:39 am

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: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/15/2012 11:39 am

Title XIX | Hospital | Cost

	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)	5,720	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,209	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)	3,209	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	2,410	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	101	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)	313	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)	101	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	163.05	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	166.80	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,907,044	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)	16,468	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	1,256,244	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,650,800	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	3,636,462	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	3,636,462	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.453958	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,133.21	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)	1,650,800	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)	514.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	161,017	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)	161,017	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/15/2012 11:39 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	533,849	264	2,022.16	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	231,251	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	392,268	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	51,957	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)	51,957	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)	391	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	514.43	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	201,142	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/15/2012 11:39 am

Title XIX | Hospital | Cost

	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: 141346 Component CCN: 145499	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/15/2012 11:39 am
	Title XIX	Skilled Nursing Facility	

	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)	19,299	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,299	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)	19,299	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)	9,345	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	163.05	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	166.80	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,013,688	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,013,688	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	207,363	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	207,363	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	14.533393	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)	10.74	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,013,688	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: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1

Component CCN: 145499 | Date/Time Prepared: 5/15/2012 11:39 am

Title XIX | Skilled Nursing Facility

	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)	3,013,688	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	156.16	71.00
72.00	Program routine service cost (line 9 x line 71)	1,459,315	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)	1,459,315	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	69,236	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	3.59	76.00
77.00	Program capital-related costs (line 9 x line 76)	33,549	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	1,425,766	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)	1,425,766	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)	33,549	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)	33,549	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: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1

Component CCN: 145499 | Date/Time Prepared: 5/15/2012 11:39 am

Title XIX | Skilled Nursing Facility

	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: 141346	Period: From 01/01/2011	Worksheet D-1
Component CCN:	To 12/31/2011	Date/Time Prepared: 5/15/2012 11:39 am
Title XIX	Nursing Facility	

	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)	0	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	0	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)	0	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)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	163.05	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	166.80	20.00
21.00	Total general inpatient routine service cost (see instructions)	0	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)	0	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	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)	0.00	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)	0	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: 141346 | Component CCN: | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/15/2012 11:39 am

Title XIX | Nursing Facility

	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)	0	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	0.00	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)	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)	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: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1

Component CCN: | Date/Time Prepared: 5/15/2012 11:39 am

Title XIX | Nursing Facility

	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: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-3 | Date/Time Prepared: 5/15/2012 11:39 am

Title XVIII | Hospital | Cost

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		1,806,072		30.00
31.00	INTENSIVE CARE UNIT		283,500		31.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.520363	21,449	11,161	50.00
53.00	ANESTHESIOLOGY	4.723473	622	2,938	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.182695	401,171	73,292	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.289543	51,731	14,978	55.00
60.00	LABORATORY	0.177262	1,135,451	201,272	60.00
65.00	RESPIRATORY THERAPY	0.258714	775,811	200,713	65.00
66.00	PHYSICAL THERAPY	0.485470	90,467	43,919	66.00
68.00	SPEECH PATHOLOGY	1.176594	8,546	10,055	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.473215	724,518	342,853	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.631578	55,871	35,287	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.174662	2,476,392	432,532	73.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0.586029	0	0	90.00
91.00	EMERGENCY	0.324195	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.286806	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		5,742,029	1,369,000	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)		5,742,029		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-3

Component CCN: 14Z346 | Date/Time Prepared: 5/15/2012 11:39 am

Title XVIII | Swing Beds - SNF | Cost

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.520363	792	412	50.00
53.00	ANESTHESIOLOGY	4.723473	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.182695	122,788	22,433	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.289543	11,759	3,405	55.00
60.00	LABORATORY	0.177262	445,215	78,920	60.00
65.00	RESPIRATORY THERAPY	0.258714	418,735	108,333	65.00
66.00	PHYSICAL THERAPY	0.485470	253,840	123,232	66.00
68.00	SPEECH PATHOLOGY	1.176594	7,904	9,300	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.473215	432,217	204,532	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.631578	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.174662	2,116,811	369,726	73.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0.586029	0	0	90.00
91.00	EMERGENCY	0.324195	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.286806	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		3,810,061	920,293	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)		3,810,061		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141346 | Component CCN: 145499 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-3 | Date/Time Prepared: 5/15/2012 11:39 am

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
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.520363	0	0	50.00
53.00	ANESTHESIOLOGY	4.723473	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.182695	14,207	2,596	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.289543	1,602	464	55.00
60.00	LABORATORY	0.177262	64,192	11,379	60.00
65.00	RESPIRATORY THERAPY	0.258714	2,507	649	65.00
66.00	PHYSICAL THERAPY	0.485470	123,983	60,190	66.00
68.00	SPEECH PATHOLOGY	1.176594	3,465	4,077	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.473215	106,915	50,594	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.631578	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.174662	446,538	77,993	73.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0.586029	0	0	90.00
91.00	EMERGENCY	0.324195	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.286806	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		763,409	207,942	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)		763,409		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-3 | Date/Time Prepared: 5/15/2012 11:39 am

Title XIX | Hospital | Cost

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		238,903		30.00
31.00	INTENSIVE CARE UNIT		40,500		31.00
	ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.520363	12,834	6,678	50.00
53.00	ANESTHESIOLOGY	4.723473	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.182695	147,458	26,940	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.289543	10,513	3,044	55.00
60.00	LABORATORY	0.177262	188,611	33,434	60.00
65.00	RESPIRATORY THERAPY	0.258714	37,003	9,573	65.00
66.00	PHYSICAL THERAPY	0.485470	4,637	2,251	66.00
68.00	SPEECH PATHOLOGY	1.176594	0	0	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.473215	119,807	56,694	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.631578	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.174662	356,409	62,251	73.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0.586029	0	0	90.00
91.00	EMERGENCY	0.324195	70,686	22,916	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.286806	26,044	7,470	92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		974,002	231,251	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)		974,002		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141346	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/15/2012 11:39 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,774,125	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,774,125	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)	4,821,866	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)	38,286	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,594,532	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	2,189,048	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,189,048	30.00
31.00	Primary payer payments	470	31.00
32.00	Subtotal (line 30 minus line 31)	2,188,578	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)	851,678	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	851,678	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)	3,040,256	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)	3,040,256	40.00
41.00	Interim payments	3,235,953	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)	-195,697	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: 141346 Component CCN: 145499	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/15/2012 11:39 am
	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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet E-1 Part I | Date/Time Prepared: 5/15/2012 11:39 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,501,740		3,068,353	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	04/03/2012	13,700	07/01/2011	167,600	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)		13,700		167,600	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)		2,515,440		3,235,953	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		69,712		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		195,697	6.02
7.00	Total Medicare program liability (see instructions)		2,585,152		3,040,256	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: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet E-1 Part I | Date/Time Prepared: 5/15/2012 11:39 am

Component CCN: 14Z346 | Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,954,210		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	06/30/2011	80,900		0	3.01
3.02		08/01/2011	149,800		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)		230,700		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)		2,184,910		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		67,481		0	6.02
7.00	Total Medicare program liability (see instructions)		2,117,429		0	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: 141346 Component CCN: 145499	Period: From 01/01/2011 To 12/31/2011	Worksheet E-1 Part I Date/Time Prepared: 5/15/2012 11:39 am
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		226,252		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)		226,252		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)		226,252		0	7.00

			Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 141346 | Component CCN: 14Z346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet E-2 | Date/Time Prepared: 5/15/2012 11:39 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,252,174	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	929,496	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	2,410	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	2,181,670	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,181,670	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	2,181,670	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	64,241	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	2,117,429	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	2,117,429	0	19.00
20.00	Interim payments	2,184,910	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	-67,481	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141346	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part V Date/Time Prepared: 5/15/2012 11:39 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	2,901,222	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	2,901,222	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5) . For CAH (see instructions)	2,930,234	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,930,234	19.00
20.00	Deductibles (exclude professional component)	468,892	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	2,461,342	22.00
23.00	Coinsurance	566	23.00
24.00	Subtotal (line 22 minus line 23)	2,460,776	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	124,376	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	124,376	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26)	2,585,152	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	2,585,152	30.00
31.00	Interim payments	2,515,440	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)	69,712	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141346 Component CCN: 145499	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part VI Date/Time Prepared: 5/15/2012 11:39 am
	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)	267,004	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)	267,004	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	40,752	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)	226,252	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	226,252	15.00
16.00	Interim payments	226,252	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141346	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part VII Date/Time Prepared: 5/15/2012 11:39 am
	Title XIX	Hospital	Cost

		1.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES		
1.00	Inpatient hospital/SNF/NF services	392,268	1.00
2.00	Medical and other services	1,747,826	2.00
3.00	Organ acquisition (certified transplant centers only)	0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	2,140,094	4.00
5.00	Inpatient primary payer payments	0	5.00
6.00	Outpatient primary payer payments	0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	2,140,094	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable Charges		
8.00	Routine service charges	0	8.00
9.00	Ancillary service charges	8,045,762	9.00
10.00	Organ acquisition charges, net of revenue	0	10.00
11.00	Incentive from target amount computation	0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	8,045,762	12.00
	CUSTOMARY CHRGES		
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	15.00
16.00	Total customary charges (see instructions)	8,045,762	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	5,905,668	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	18.00
19.00	Interns and Residents (see instructions)	0	19.00
20.00	Cost of Teaching Physicians (see instructions)	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	2,140,094	21.00
	PROSPECTIVE PAYMENT AMOUNT		
22.00	Other than outlier payments	0	22.00
23.00	Outlier payments	0	23.00
24.00	Program capital payments	0	24.00
25.00	Capital exception payments (see instructions)	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	28.00
29.00	Titles V or XIX enter the sum of lines 27 and 21.	2,140,094	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30.00	Excess of reasonable cost (from line 18)	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	2,140,094	31.00
32.00	Deductibles	0	32.00
33.00	Coinsurance	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Utilization review	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	2,140,094	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	37.00
38.00	Subtotal (line 36 ± line 37)	2,140,094	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	2,140,094	40.00
41.00	Interim payments	0	41.00
42.00	Balance due provider/program (line 40 minus 41)	2,140,094	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet G | Date/Time Prepared: 5/15/2012 11:39 am

		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	-81,379	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	8,088,800	0	0	0	4.00
5.00	Other receivable	101,540	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,553,614	0	0	0	6.00
7.00	Inventory	164,446	0	0	0	7.00
8.00	Prepaid expenses	527,085	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	16,667	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,263,545	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	0	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	4,754,458	0	0	0	19.00
20.00	Accumulated depreciation	-3,211,719	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)	1,542,739	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	4,935	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,935	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	5,811,219	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	336,999	0	0	0	37.00
38.00	Salaries, wages, and fees payable	639,747	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	142,321	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,731,717	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,850,784	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	0	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	2,850,784	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	2,960,435				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)	2,960,435	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	5,811,219	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet G-1 | Date/Time Prepared: 5/15/2012 11:39 am

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		2,389,328		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,548,818				2.00
3.00	Total (sum of line 1 and line 2)		3,938,146		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0			4.00
5.00		0		0			5.00
6.00		0		0			6.00
7.00		0		0			7.00
8.00		0		0			8.00
9.00		0		0			9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		3,938,146		0		11.00
12.00	Deductions (debit adjustments) (specify)	977,711		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)		977,711		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		2,960,435		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet G-1 | Date/Time Prepared: 5/15/2012 11:39 am

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet G-2 Parts | Date/Time Prepared: 5/15/2012 11:39 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,636,462		3,636,462	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	2,791,219		2,791,219	6.00
7.00	SKILLED NURSING FACILITY	207,363		207,363	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)	6,635,044		6,635,044	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	352,782		352,782	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)	352,782		352,782	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,987,826		6,987,826	17.00
18.00	Ancillary services	12,710,997	36,075,154	48,786,151	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	1,284,311	1,284,311	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	161,859	2,752,211	2,914,070	27.00
27.01	TIE OUT	0	-568,935	-568,935	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	19,860,682	39,542,741	59,403,423	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		21,927,484		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	MEDICIAID TAX ASSESSMENT	47,112			37.00
38.00	PHYSICIAN EXPENSE	618,225			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)		665,337		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		21,262,147		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141346 | Period: From 01/01/2011 To 12/31/2011 | Worksheet G-3 | Date/Time Prepared: 5/15/2012 11:39 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	59,403,423	1.00
2.00	Less contractual allowances and discounts on patients' accounts	37,045,130	2.00
3.00	Net patient revenues (line 1 minus line 2)	22,358,293	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	21,262,147	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,096,146	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	622,253	24.00
25.00	Total other income (sum of lines 6-24)	622,253	25.00
26.00	Total (line 5 plus line 25)	1,718,399	26.00
27.00	NON OPERATING REVENUE	169,581	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	169,581	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,548,818	29.00