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: 144005

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

Worksheet S
Parts I-III
Date/Time Prepared:
5/11/2012 9:43 am

PART I - COST REPORT STATUS

Provider use only

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

Contractor use only

5. [0] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 05
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 AURORA CHICAGO LAKESHORE 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	-362,159	-3,608	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	-362,159	-3,608	0	0	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: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part I | Date/Time Prepared: 5/11/2012 9:43 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 4840 N MARINE DRIVE	PO Box:			1.00
2.00	City: CHICAGO	State: IL	Zip Code: 60640-7860	County: COOK	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	AURORA CHICAGO LAKESHORE	144005	16974	4	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF						N	N	N	7.00
8.00	Swing Beds - NF						N		N	8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									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: 1.00	To: 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)	4		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.	0		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 1.00	Date of Geogr 2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.	1		26.00
27.00	For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification (in column 2).	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning: 1.00	Ending: 2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 144005	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/11/2012 9:43 am

		Beginning:	Ending:	
		1.00	2.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				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: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part I Date/Time Prepared: 5/11/2012 9:43 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.	Y			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N	N	0	71.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part I Date/Time Prepared: 5/11/2012 9:43 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	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)			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.					109.00

		1.00	2.00	
	Miscellaneous Cost Reporting Information			
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.	N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.	1,000,000	3,000,000	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00

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		1.00	2.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0230	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: SIGNATURE HEALTHCARE	Contractor's Name: WPS	Contractor's Number: 05401	141.00
142.00	Street: 29433 SOUTHFIELD ROAD	PO Box:		142.00
143.00	City: SOUTHFIELD	State: MI	Zip Code: 48076	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.	Y	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: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part II | Date/Time Prepared: 5/11/2012 9:43 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)	Y			3.00

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

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

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

			Part A		
		Description	Y/N	Date	
		0	1.00	2.00	
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	03/14/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part II Date/Time Prepared: 5/11/2012 9:43 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	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part II Date/Time Prepared: 5/11/2012 9:43 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	03/14/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part I | Date/Time Prepared: 5/11/2012 9:43 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	113	41,245	0.00		1.00
2.00	HMO						2.00
3.00	HMO IPF						3.00
4.00	HMO IRF						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		113	41,245	0.00		7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		113	41,245	0.00		14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		113				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: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part I | Date/Time Prepared: 5/11/2012 9:43 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	7,305	7,942	27,589		1.00
2.00	HMO		0	0			2.00
3.00	HMO IPF		0	0			3.00
4.00	HMO IRF		0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	0	7,305	7,942	27,589		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	7,305	7,942	27,589		14.00
15.00	CAH visits	0	0	0	0		15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
25.00	CMHC - CMHC						25.00
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	0		28.00
29.00	Ambulance Trips		0				29.00
30.00	Employee discount days (see instruction)				0		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)			0	0		32.00
33.00	LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part I | Date/Time Prepared: 5/11/2012 9:43 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	671	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	169.95	0.00	0	671	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)	0.00	169.95	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: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part I | Date/Time Prepared: 5/11/2012 9:43 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)	903	3,125		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)	903	3,125		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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A | Date/Time Prepared: 5/11/2012 9:43 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	CAP REL COSTS-BLDG & FIXT		0	0	2,554,469	2,554,469	1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0	0	171,475	171,475	2.00
3.00	OTHER CAP REL COSTS		302,680	302,680	-302,680	0	3.00
4.00	EMPLOYEE BENEFITS	104,024	905,014	1,009,038	0	1,009,038	4.00
5.00	ADMINISTRATIVE & GENERAL	2,678,762	5,400,883	8,079,645	-3,558,414	4,521,231	5.00
7.00	OPERATION OF PLANT	141,359	393,411	534,770	-26,724	508,046	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	0	101,820	101,820	8.00
9.00	HOUSEKEEPING	141,101	176,050	317,151	-101,820	215,331	9.00
10.00	DIETARY	370,580	533,822	904,402	-110,804	793,598	10.00
11.00	CAFETERIA	0	0	0	107,432	107,432	11.00
13.00	NURSING ADMINISTRATION	759,377	75,038	834,415	0	834,415	13.00
16.00	MEDICAL RECORDS & LIBRARY	509,784	172,334	682,118	0	682,118	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	4,836,940	903,612	5,740,552	581,467	6,322,019	30.00
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	186,989	186,989	0	186,989	60.00
69.00	ELECTROCARDIOLOGY	0	17,660	17,660	-17,660	0	69.00
73.00	DRUGS CHARGED TO PATIENTS	0	803,136	803,136	0	803,136	73.00
	OUTPATIENT SERVICE COST CENTERS						
93.00	PARTIAL HOSPITAL	358,587	74,582	433,169	0	433,169	93.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE		0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	9,900,514	9,945,211	19,845,725	-601,439	19,244,286	118.00
	NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	PATIENT SCHOOL	49,247	3,975	53,222	-39,916	13,306	194.00
194.01	NON REIMBURSABLE MEALS	0	0	0	0	0	194.01
194.02	BUSINESS DEVELOPMENT	0	0	0	582,673	582,673	194.02
194.03	PATIENT TRANSPORTATION	0	0	0	58,682	58,682	194.03
200.00	TOTAL (SUM OF LINES 118-199)	9,949,761	9,949,186	19,898,947	0	19,898,947	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A | Date/Time Prepared: 5/11/2012 9:43 am

	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	-836,870	1,717,599		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	171,475		2.00
3.00	OTHER CAP REL COSTS	0	0		3.00
4.00	EMPLOYEE BENEFITS	0	1,009,038		4.00
5.00	ADMINISTRATIVE & GENERAL	-123,361	4,397,870		5.00
7.00	OPERATION OF PLANT	0	508,046		7.00
8.00	LAUNDRY & LINEN SERVICE	0	101,820		8.00
9.00	HOUSEKEEPING	0	215,331		9.00
10.00	DIETARY	0	793,598		10.00
11.00	CAFETERIA	-16,417	91,015		11.00
13.00	NURSING ADMINISTRATION	-13	834,402		13.00
16.00	MEDICAL RECORDS & LIBRARY	-5,340	676,778		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-364,281	5,957,738		30.00
	ANCILLARY SERVICE COST CENTERS				
54.00	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	LABORATORY	0	186,989		60.00
69.00	ELECTROCARDIOLOGY	0	0		69.00
73.00	DRUGS CHARGED TO PATIENTS	0	803,136		73.00
	OUTPATIENT SERVICE COST CENTERS				
93.00	PARTIAL HOSPITAL	-15,089	418,080		93.00
	SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	0	0		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-1,361,371	17,882,915		118.00
	NONREIMBURSABLE COST CENTERS				
192.00	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	PATIENT SCHOOL	0	13,306		194.00
194.01	NON REIMBURSABLE MEALS	0	0		194.01
194.02	BUSINESS DEVELOPMENT	0	582,673		194.02
194.03	PATIENT TRANSPORTATION	0	58,682		194.03
200.00	TOTAL (SUM OF LINES 118-199)	-1,361,371	18,537,576		200.00

RECLASSIFICATIONS | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-6 | Date/Time Prepared: 5/11/2012 9:43 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RENT AND LEASE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,803,173		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	81,134		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	TOTALS		0	1,884,307		
	B - INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,093		1.00
	TOTALS		0	2,093		
	C - MEDICAL PROFESSIONAL FEES					
1.00	ADULTS & PEDIATRICS	30.00	159,198	425,800		1.00
	TOTALS		159,198	425,800		
	D - PATIENT TRANSPORTATION					
1.00	PATIENT TRANSPORTATION	194.03	53,983	4,699		1.00
	TOTALS		53,983	4,699		
	E - CONTRACT LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	101,820		1.00
	TOTALS		0	101,820		
	F - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	485,010		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	51,854		2.00
	TOTALS		0	536,864		
	G - PATIENT SCHOOL					
1.00	ADULTS & PEDIATRICS	30.00	36,935	2,981		1.00
	TOTALS		36,935	2,981		
	H - CAFETERIA COSTS					
1.00	CAFETERIA	11.00	44,020	63,412		1.00
	TOTALS		44,020	63,412		
	I - BUSINESS DEVELOPMENT COSTS					
1.00	BUSINESS DEVELOPMENT	194.02	431,274	151,399		1.00
	TOTALS		431,274	151,399		
	J - EKG COSTS					
1.00	ADULTS & PEDIATRICS	30.00	0	17,660		1.00
	TOTALS		0	17,660		
500.00	Grand Total: Increases		725,410	3,191,035		500.00

RECLASSIFICATIONS | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-6 | Date/Time Prepared: 5/11/2012 9:43 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RENT AND LEASE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,851,786	10		1.00
2.00	OPERATION OF PLANT	7.00	0	26,724	10		2.00
3.00	DIETARY	10.00	0	3,372	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	2,425	0		4.00
	TOTALS		0	1,884,307			
	B - INTEREST						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,093	11		1.00
	TOTALS		0	2,093			
	C - MEDICAL PROFESSIONAL FEES						
1.00	ADMINISTRATIVE & GENERAL	5.00	159,198	425,800	0		1.00
	TOTALS		159,198	425,800			
	D - PATIENT TRANSPORTATION						
1.00	ADULTS & PEDIATRICS	30.00	53,983	4,699	0		1.00
	TOTALS		53,983	4,699			
	E - CONTRACT LAUNDRY						
1.00	HOUSEKEEPING	9.00	0	101,820	0		1.00
	TOTALS		0	101,820			
	F - DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	536,864	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	536,864			
	G - PATIENT SCHOOL						
1.00	PATIENT SCHOOL	194.00	36,935	2,981	0		1.00
	TOTALS		36,935	2,981			
	H - CAFETERIA COSTS						
1.00	DIETARY	10.00	44,020	63,412	0		1.00
	TOTALS		44,020	63,412			
	I - BUSINESS DEVELOPMENT COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	431,274	151,399	0		1.00
	TOTALS		431,274	151,399			
	J - EKG COSTS						
1.00	ELECTROCARDIOLOGY	69.00	0	17,660	0		1.00
	TOTALS		0	17,660			
500.00	Grand Total: Decreases		725,410	3,191,035			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 5/11/2012 9:43 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	2,606,070	143,818	0	143,818	0	4.00
5.00	Fixed Equipment	253,197	1,400	0	1,400	0	5.00
6.00	Movable Equipment	400,825	36,859	0	36,859	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	3,260,092	182,077	0	182,077	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	3,260,092	182,077	0	182,077	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	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	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	CAP REL COSTS-BLDG & FIXT	3,004,485	0	3,004,485	0.872846	40,222	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	437,684	0	437,684	0.127154	5,860	2.00
3.00	Total (sum of lines 1-2)	3,442,169	0	3,442,169	1.000000	46,082	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 5/11/2012 9:43 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	2,749,888	0	4.00
5.00	Fixed Equipment	254,597	0	5.00
6.00	Movable Equipment	437,684	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	3,442,169	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	3,442,169	0	10.00

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

		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
	Cost Center Description	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	CAP REL COSTS-BLDG & FIXT	223,971	0	264,193	485,010	966,303	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	32,627	0	38,487	51,854	81,134	2.00
3.00	Total (sum of lines 1-2)	256,598	0	302,680	536,864	1,047,437	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 5/11/2012 9:43 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	CAP REL COSTS-BLDG & FIXT	2,093	40,222	223,971	0	1,717,599	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,860	32,627	0	171,475	2.00
3.00	Total (sum of lines 1-2)	2,093	46,082	256,598	0	1,889,074	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8 | Date/Time Prepared: 5/11/2012 9:43 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 - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)	B	-4,229	ADMINISTRATIVE & GENERAL	5.00	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-8,311	ADMINISTRATIVE & GENERAL	5.00	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	7.00
8.00	Television and radio service (chapter 21)		0		0.00	8.00
9.00	Parking lot (chapter 21)		0		0.00	9.00
10.00	Provider-based physician adjustment	A-8-2	-351,537			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	-708,824			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Cafeteria-employees and guests	B	-16,417	CAFETERIA	11.00	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	-5,190	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	-1,136	ADMINISTRATIVE & GENERAL	5.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	B	-7,131	ADMINISTRATIVE & GENERAL	5.00	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	*** Cost Center Deleted ***	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant		0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	32.00
33.00	RENTAL INCOME/COMMISSION	B	-25,070	ADMINISTRATIVE & GENERAL	5.00	33.00
33.01	OTHER OPERATING REVENUE	B	-26,676	ADMINISTRATIVE & GENERAL	5.00	33.01
34.00	PHYSICIAN COSTS	A	-59,184	ADMINISTRATIVE & GENERAL	5.00	34.00
35.00	CONTRIBUTIONS	A	-4,300	ADMINISTRATIVE & GENERAL	5.00	35.00
36.00	LOBBYING COSTS	A	-563	ADMINISTRATIVE & GENERAL	5.00	36.00
37.00	PATIENT TRANSPORTATION	A	-24,761	ADMINISTRATIVE & GENERAL	5.00	37.00
37.01	PATIENT TRANSPORTATION	A	-13	NURSING ADMINISTRATION	13.00	37.01
37.02	PATIENT TRANSPORTATION	A	-25,433	ADULTS & PEDIATRICS	30.00	37.02
37.03	PATIENT TRANSPORTATION	A	-2,400	PARTIAL HOSPITAL	93.00	37.03
38.00	PENALTIES	A	-100	ADMINISTRATIVE & GENERAL	5.00	38.00
39.00	OTHER NON ALLOWABLE	A	-1,323	ADMINISTRATIVE & GENERAL	5.00	39.00
39.01	OTHER NON ALLOWABLE	A	-150	MEDICAL RECORDS & LIBRARY	16.00	39.01
40.00	LEGAL FEES	A	-88,623	ADMINISTRATIVE & GENERAL	5.00	40.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,361,371			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8 | Date/Time Prepared: 5/11/2012 9:43 am

	Cost Center Description	Wkst. A-7 Ref. 5.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	0		1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	0		2.00
3.00	Investment income - other (chapter 2)	0		3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0		4.00
5.00	Refunds and rebates of expenses (chapter 8)	0		5.00
6.00	Rental of provider space by suppliers (chapter 8)	0		6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0		7.00
8.00	Television and radio service (chapter 21)	0		8.00
9.00	Parking lot (chapter 21)	0		9.00
10.00	Provider-based physician adjustment	0		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0		11.00
12.00	Related organization transactions (chapter 10)	0		12.00
13.00	Laundry and linen service	0		13.00
14.00	Cafeteria-employees and guests	0		14.00
15.00	Rental of quarters to employee and others	0		15.00
16.00	Sale of medical and surgical supplies to other than patients	0		16.00
17.00	Sale of drugs to other than patients	0		17.00
18.00	Sale of medical records and abstracts	0		18.00
19.00	Nursing school (tuition, fees, books, etc.)	0		19.00
20.00	Vending machines	0		20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0		21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0		22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)			23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)			24.00
25.00	Utilization review - physicians' compensation (chapter 21)			25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	0		26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	0		27.00
28.00	Non-physician Anesthetist			28.00
29.00	Physicians' assistant	0		29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)			30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)			31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0		32.00
33.00	RENTAL INCOME/COMMISSION	0		33.00
33.01	OTHER OPERATING REVENUE	0		33.01
34.00	PHYSICIAN COSTS	0		34.00
35.00	CONTRIBUTIONS	0		35.00
36.00	LOBBYING COSTS	0		36.00
37.00	PATIENT TRANSPORTATION	0		37.00
37.01	PATIENT TRANSPORTATION	0		37.01
37.02	PATIENT TRANSPORTATION	0		37.02
37.03	PATIENT TRANSPORTATION	0		37.03
38.00	PENALTIES	0		38.00
39.00	OTHER NON ALLOWABLE	0		39.00
39.01	OTHER NON ALLOWABLE	0		39.01
40.00	LEGAL FEES	0		40.00
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: 144005	Period: From 01/01/2011 To 12/31/2011	Worksheet A-8-1 Date/Time Prepared: 5/11/2012 9:43 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	HOME OFFICE COSTS	1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY COSTS	2.00
3.00		1.00	CAP REL COSTS-BLDG & FIXT	OWNERSHIP COSTS	3.00
4.00		0.00			4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 144005	Period: From 01/01/2011 To 12/31/2011	Worksheet A-8-1 Date/Time Prepared: 5/11/2012 9:43 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		1,030,364	840,000	190,364	0		1.00
2.00		139,684	202,002	-62,318	0		2.00
3.00		903,130	1,740,000	-836,870	10		3.00
4.00		0	0	0	0		4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	2,073,178	2,782,002	-708,824			5.00

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

		Related Organization(s) and/or Home Office			
		Name	Percentage of Ownership	Type of Business	
		4.00	5.00	6.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				
6.00		SIGNATURE HLTHC	100.00	HOSPITAL MGMT	6.00
7.00		KEBOK	0.00	COMPUTER SVCS	7.00
8.00		IL MENTAL HLTH	0.00	REIT	8.00
9.00			0.00		9.00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 5/11/2012 9:43 am

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		30.00	ADULTS & PEDIATRICS	804,926	149,318	1.00
2.00		93.00	PARTIAL HOSPITAL	35,804	800	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				840,730	150,118	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 5/11/2012 9:43 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		655,608	154,100	6,291	466,078	23,304	1.00
2.00		35,004	154,100	312	23,115	1,156	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		690,612		6,603	489,193	24,460	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 5/11/2012 9:43 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	466,078	1.00
2.00		0	0	0	0	23,115	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	489,193	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8-2 | Date/Time Prepared: 5/11/2012 9:43 am

		RCE Disallowance	Adjustment		
		17.00	18.00		
1.00		189,530	338,848		1.00
2.00		11,889	12,689		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		201,419	351,537		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part I Date/Time Prepared: 5/11/2012 9:43 am

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
		0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,717,599	1,717,599				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	171,475		171,475			2.00
4.00	EMPLOYEE BENEFITS	1,009,038	7,010	700	1,016,748		4.00
5.00	ADMINISTRATIVE & GENERAL	4,397,870	186,651	18,634	215,654	4,818,809	5.00
7.00	OPERATION OF PLANT	508,046	115,521	11,533	14,598	649,698	7.00
8.00	LAUNDRY & LINEN SERVICE	101,820	0	0	0	101,820	8.00
9.00	HOUSEKEEPING	215,331	9,754	974	14,571	240,630	9.00
10.00	DIETARY	793,598	50,985	5,090	33,723	883,396	10.00
11.00	CAFETERIA	91,015	40,788	4,072	4,546	140,421	11.00
13.00	NURSING ADMINISTRATION	834,402	23,165	2,313	78,419	938,299	13.00
16.00	MEDICAL RECORDS & LIBRARY	676,778	10,640	1,062	52,644	741,124	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	5,957,738	1,121,071	111,921	514,179	7,704,909	30.00
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	186,989	0	0	0	186,989	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
73.00	DRUGS CHARGED TO PATIENTS	803,136	8,867	885	0	812,888	73.00
	OUTPATIENT SERVICE COST CENTERS						
93.00	PARTIAL HOSPITAL	418,080	120,952	12,075	37,031	588,138	93.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	17,882,915	1,695,404	169,259	965,365	17,807,121	118.00
	NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	0	9,449	943	0	10,392	192.00
194.00	PATIENT SCHOOL	13,306	12,746	1,273	1,271	28,596	194.00
194.01	NON REIMBURSABLE MEALS	0	0	0	0	0	194.01
194.02	BUSINESS DEVELOPMENT	582,673	0	0	44,537	627,210	194.02
194.03	PATIENT TRANSPORTATION	58,682	0	0	5,575	64,257	194.03
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)	18,537,576	1,717,599	171,475	1,016,748	18,537,576	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part I Date/Time Prepared: 5/11/2012 9:43 am

	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	4,818,809					5.00
7.00	OPERATION OF PLANT	228,211	877,909				7.00
8.00	LAUNDRY & LINEN SERVICE	35,765	0	137,585			8.00
9.00	HOUSEKEEPING	84,523	6,080	0	331,233		9.00
10.00	DIETARY	310,299	31,781	0	12,074	1,237,550	10.00
11.00	CAFETERIA	49,324	25,425	0	9,660	63,575	11.00
13.00	NURSING ADMINISTRATION	329,584	14,440	0	5,486	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	260,325	6,633	0	2,520	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,706,398	698,795	137,585	265,492	1,090,544	30.00
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	65,681	0	0	0	0	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
73.00	DRUGS CHARGED TO PATIENTS	285,533	5,527	0	2,100	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
93.00	PARTIAL HOSPITAL	206,588	75,393	0	28,644	0	93.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	4,562,231	864,074	137,585	325,976	1,154,119	118.00
	NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	3,650	5,890	0	2,238	0	192.00
194.00	PATIENT SCHOOL	10,045	7,945	0	3,019	0	194.00
194.01	NON REIMBURSABLE MEALS	0	0	0	0	83,431	194.01
194.02	BUSINESS DEVELOPMENT	220,312	0	0	0	0	194.02
194.03	PATIENT TRANSPORTATION	22,571	0	0	0	0	194.03
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)	4,818,809	877,909	137,585	331,233	1,237,550	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part I Date/Time Prepared: 5/11/2012 9:43 am

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		11.00	13.00	16.00	24.00	25.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	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
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	288,405					11.00
13.00	NURSING ADMINISTRATION	17,863	1,305,672				13.00
16.00	MEDICAL RECORDS & LIBRARY	24,313	126,188	1,161,103			16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	207,775	1,082,540	987,920	14,881,958	0	30.00
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	38,409	291,079	0	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	43,187	1,149,235	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
93.00	PARTIAL HOSPITAL	18,607	96,944	91,587	1,105,901	0	93.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	268,558	1,305,672	1,161,103	17,428,173	0	118.00
	NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	22,170	0	192.00
194.00	PATIENT SCHOOL	2,481	0	0	52,086	0	194.00
194.01	NON REIMBURSABLE MEALS	0	0	0	83,431	0	194.01
194.02	BUSINESS DEVELOPMENT	17,366	0	0	864,888	0	194.02
194.03	PATIENT TRANSPORTATION	0	0	0	86,828	0	194.03
200.00	Cross Foot Adjustments				0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	288,405	1,305,672	1,161,103	18,537,576	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part I Date/Time Prepared: 5/11/2012 9:43 am

	Cost Center Description	Total		
		26.00		
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT			1.00
2.00	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
8.00	LAUNDRY & LINEN SERVICE			8.00
9.00	HOUSEKEEPING			9.00
10.00	DIETARY			10.00
11.00	CAFETERIA			11.00
13.00	NURSING ADMINISTRATION			13.00
16.00	MEDICAL RECORDS & LIBRARY			16.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	14,881,958		30.00
	ANCILLARY SERVICE COST CENTERS			
54.00	RADIOLOGY-DIAGNOSTIC	0		54.00
60.00	LABORATORY	291,079		60.00
69.00	ELECTROCARDIOLOGY	0		69.00
73.00	DRUGS CHARGED TO PATIENTS	1,149,235		73.00
	OUTPATIENT SERVICE COST CENTERS			
93.00	PARTIAL HOSPITAL	1,105,901		93.00
	SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE			113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	17,428,173		118.00
	NONREIMBURSABLE COST CENTERS			
192.00	PHYSICIANS' PRIVATE OFFICES	22,170		192.00
194.00	PATIENT SCHOOL	52,086		194.00
194.01	NON REIMBURSABLE MEALS	83,431		194.01
194.02	BUSINESS DEVELOPMENT	864,888		194.02
194.03	PATIENT TRANSPORTATION	86,828		194.03
200.00	Cross Foot Adjustments	0		200.00
201.00	Negative Cost Centers	0		201.00
202.00	TOTAL (sum lines 118-201)	18,537,576		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part II Date/Time Prepared: 5/11/2012 9:43 am

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS	0	7,010	700	7,710	7,710	4.00
5.00	ADMINISTRATIVE & GENERAL	0	186,651	18,634	205,285	1,635	5.00
7.00	OPERATION OF PLANT	0	115,521	11,533	127,054	111	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	HOUSEKEEPING	0	9,754	974	10,728	110	9.00
10.00	DIETARY	0	50,985	5,090	56,075	256	10.00
11.00	CAFETERIA	0	40,788	4,072	44,860	34	11.00
13.00	NURSING ADMINISTRATION	0	23,165	2,313	25,478	595	13.00
16.00	MEDICAL RECORDS & LIBRARY	0	10,640	1,062	11,702	399	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	1,121,071	111,921	1,232,992	3,899	30.00
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
73.00	DRUGS CHARGED TO PATIENTS	0	8,867	885	9,752	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
93.00	PARTIAL HOSPITAL	0	120,952	12,075	133,027	281	93.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,695,404	169,259	1,864,663	7,320	118.00
	NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	0	9,449	943	10,392	0	192.00
194.00	PATIENT SCHOOL	0	12,746	1,273	14,019	10	194.00
194.01	NON REIMBURSABLE MEALS	0	0	0	0	0	194.01
194.02	BUSINESS DEVELOPMENT	0	0	0	0	338	194.02
194.03	PATIENT TRANSPORTATION	0	0	0	0	42	194.03
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	1,717,599	171,475	1,889,074	7,710	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part II Date/Time Prepared: 5/11/2012 9:43 am

	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	206,920					5.00
7.00	OPERATION OF PLANT	9,799	136,964				7.00
8.00	LAUNDRY & LINEN SERVICE	1,536	0	1,536			8.00
9.00	HOUSEKEEPING	3,629	949	0	15,416		9.00
10.00	DIETARY	13,324	4,958	0	562	75,175	10.00
11.00	CAFETERIA	2,118	3,967	0	450	3,862	11.00
13.00	NURSING ADMINISTRATION	14,152	2,253	0	255	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	11,178	1,035	0	117	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	116,215	109,019	1,536	12,357	66,245	30.00
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	2,820	0	0	0	0	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
73.00	DRUGS CHARGED TO PATIENTS	12,261	862	0	98	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
93.00	PARTIAL HOSPITAL	8,871	11,762	0	1,333	0	93.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	195,903	134,805	1,536	15,172	70,107	118.00
	NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	157	919	0	104	0	192.00
194.00	PATIENT SCHOOL	431	1,240	0	140	0	194.00
194.01	NON REIMBURSABLE MEALS	0	0	0	0	5,068	194.01
194.02	BUSINESS DEVELOPMENT	9,460	0	0	0	0	194.02
194.03	PATIENT TRANSPORTATION	969	0	0	0	0	194.03
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)	206,920	136,964	1,536	15,416	75,175	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part II | Date/Time Prepared: 5/11/2012 9:43 am

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		11.00	13.00	16.00	24.00	25.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	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
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	55,291					11.00
13.00	NURSING ADMINISTRATION	3,424	46,157				13.00
16.00	MEDICAL RECORDS & LIBRARY	4,661	4,461	33,553			16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	39,834	38,269	28,548	1,648,914	0	30.00
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	1,110	3,930	0	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	1,248	24,221	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
93.00	PARTIAL HOSPITAL	3,567	3,427	2,647	164,915	0	93.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	51,486	46,157	33,553	1,841,980	0	118.00
	NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	11,572	0	192.00
194.00	PATIENT SCHOOL	476	0	0	16,316	0	194.00
194.01	NON REIMBURSABLE MEALS	0	0	0	5,068	0	194.01
194.02	BUSINESS DEVELOPMENT	3,329	0	0	13,127	0	194.02
194.03	PATIENT TRANSPORTATION	0	0	0	1,011	0	194.03
200.00	Cross Foot Adjustments				0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	55,291	46,157	33,553	1,889,074	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part II | Date/Time Prepared: 5/11/2012 9:43 am

	Cost Center Description	Total		
		26.00		
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT			1.00
2.00	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
8.00	LAUNDRY & LINEN SERVICE			8.00
9.00	HOUSEKEEPING			9.00
10.00	DIETARY			10.00
11.00	CAFETERIA			11.00
13.00	NURSING ADMINISTRATION			13.00
16.00	MEDICAL RECORDS & LIBRARY			16.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	1,648,914		30.00
	ANCILLARY SERVICE COST CENTERS			
54.00	RADIOLOGY-DIAGNOSTIC	0		54.00
60.00	LABORATORY	3,930		60.00
69.00	ELECTROCARDIOLOGY	0		69.00
73.00	DRUGS CHARGED TO PATIENTS	24,221		73.00
	OUTPATIENT SERVICE COST CENTERS			
93.00	PARTIAL HOSPITAL	164,915		93.00
	SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE			113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,841,980		118.00
	NONREIMBURSABLE COST CENTERS			
192.00	PHYSICIANS' PRIVATE OFFICES	11,572		192.00
194.00	PATIENT SCHOOL	16,316		194.00
194.01	NON REIMBURSABLE MEALS	5,068		194.01
194.02	BUSINESS DEVELOPMENT	13,127		194.02
194.03	PATIENT TRANSPORTATION	1,011		194.03
200.00	Cross Foot Adjustments	0		200.00
201.00	Negative Cost Centers	0		201.00
202.00	TOTAL (sum lines 118-201)	1,889,074		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B-1 | Date/Time Prepared: 5/11/2012 9:43 am

	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	61,986					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		61,986				2.00
4.00	EMPLOYEE BENEFITS	253	253	9,845,737			4.00
5.00	ADMINISTRATIVE & GENERAL	6,736	6,736	2,088,290	-4,818,809	13,718,767	5.00
7.00	OPERATION OF PLANT	4,169	4,169	141,359	0	649,698	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	0	0	101,820	8.00
9.00	HOUSEKEEPING	352	352	141,101	0	240,630	9.00
10.00	DIETARY	1,840	1,840	326,560	0	883,396	10.00
11.00	CAFETERIA	1,472	1,472	44,020	0	140,421	11.00
13.00	NURSING ADMINISTRATION	836	836	759,377	0	938,299	13.00
16.00	MEDICAL RECORDS & LIBRARY	384	384	509,784	0	741,124	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	40,458	40,458	4,979,090	0	7,704,909	30.00
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	186,989	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
73.00	DRUGS CHARGED TO PATIENTS	320	320	0	0	812,888	73.00
	OUTPATIENT SERVICE COST CENTERS						
93.00	PARTIAL HOSPITAL	4,365	4,365	358,587	0	588,138	93.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	61,185	61,185	9,348,168	-4,818,809	12,988,312	118.00
	NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	341	341	0	0	10,392	192.00
194.00	PATIENT SCHOOL	460	460	12,312	0	28,596	194.00
194.01	NON REIMBURSABLE MEALS	0	0	0	0	0	194.01
194.02	BUSINESS DEVELOPMENT	0	0	431,274	0	627,210	194.02
194.03	PATIENT TRANSPORTATION	0	0	53,983	0	64,257	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,717,599	171,475	1,016,748		4,818,809	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	27.709467	2.766350	0.103268		0.351257	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			7,710		206,920	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000783		0.015083	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B-1 | Date/Time Prepared: 5/11/2012 9:43 am

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S SERVED)	
		7.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT	50,828					7.00
8.00	LAUNDRY & LINEN SERVICE	0	27,589				8.00
9.00	HOUSEKEEPING	352	0	50,476			9.00
10.00	DIETARY	1,840	0	1,840	94,799		10.00
11.00	CAFETERIA	1,472	0	1,472	4,870	11,625	11.00
13.00	NURSING ADMINISTRATION	836	0	836	0	720	13.00
16.00	MEDICAL RECORDS & LIBRARY	384	0	384	0	980	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	40,458	27,589	40,458	83,538	8,375	30.00
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
73.00	DRUGS CHARGED TO PATIENTS	320	0	320	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
93.00	PARTIAL HOSPITAL	4,365	0	4,365	0	750	93.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	50,027	27,589	49,675	88,408	10,825	118.00
	NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	341	0	341	0	0	192.00
194.00	PATIENT SCHOOL	460	0	460	0	100	194.00
194.01	NON REIMBURSABLE MEALS	0	0	0	6,391	0	194.01
194.02	BUSINESS DEVELOPMENT	0	0	0	0	700	194.02
194.03	PATIENT TRANSPORTATION	0	0	0	0	0	194.03
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)	877,909	137,585	331,233	1,237,550	288,405	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	17.272153	4.986951	6.562188	13.054463	24.809032	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	136,964	1,536	15,416	75,175	55,291	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2.694656	0.055674	0.305412	0.792994	4.756215	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B-1 | Date/Time Prepared: 5/11/2012 9:43 am

	Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
		13.00	16.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT				1.00
2.00	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
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	210,914			13.00
16.00	MEDICAL RECORDS & LIBRARY	20,384	43,127,211		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	174,870	36,694,695		30.00
	ANCILLARY SERVICE COST CENTERS				
54.00	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	LABORATORY	0	1,426,615		60.00
69.00	ELECTROCARDIOLOGY	0	0		69.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,604,096		73.00
	OUTPATIENT SERVICE COST CENTERS				
93.00	PARTIAL HOSPITAL	15,660	3,401,805		93.00
	SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE				113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	210,914	43,127,211		118.00
	NONREIMBURSABLE COST CENTERS				
192.00	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	PATIENT SCHOOL	0	0		194.00
194.01	NON REIMBURSABLE MEALS	0	0		194.01
194.02	BUSINESS DEVELOPMENT	0	0		194.02
194.03	PATIENT TRANSPORTATION	0	0		194.03
200.00	Cross Foot Adjustments				200.00
201.00	Negative Cost Centers				201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,305,672	1,161,103		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	6.190542	0.026923		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	46,157	33,553		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.218843	0.000778		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/11/2012 9:43 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	14,881,958		14,881,958	189,530	15,071,488	30.00
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0		0	0	0	54.00
60.00	LABORATORY	291,079		291,079	0	291,079	60.00
69.00	ELECTROCARDIOLOGY	0		0	0	0	69.00
73.00	DRUGS CHARGED TO PATIENTS	1,149,235		1,149,235	0	1,149,235	73.00
	OUTPATIENT SERVICE COST CENTERS						
93.00	PARTIAL HOSPITAL	1,105,901		1,105,901	11,889	1,117,790	93.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	17,428,173	0	17,428,173	201,419	17,629,592	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	17,428,173	0	17,428,173	201,419	17,629,592	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/11/2012 9:43 am

Title XVIII | Hospital | PPS

	Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	36,694,695		36,694,695			30.00
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
60.00	LABORATORY	1,371,896	54,719	1,426,615	0.204035	0.000000	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
73.00	DRUGS CHARGED TO PATIENTS	1,604,096	0	1,604,096	0.716438	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS						
93.00	PARTIAL HOSPITAL	0	3,401,805	3,401,805	0.325092	0.000000	93.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	39,670,687	3,456,524	43,127,211			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	39,670,687	3,456,524	43,127,211			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/11/2012 9:43 am

Title XVIII | Hospital | PPS

	Cost Center Description	PPS Inpatient Ratio	
		11.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	ADULTS & PEDIATRICS		30.00
	ANCILLARY SERVICE COST CENTERS		
54.00	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	LABORATORY	0.204035	60.00
69.00	ELECTROCARDIOLOGY	0.000000	69.00
73.00	DRUGS CHARGED TO PATIENTS	0.716438	73.00
	OUTPATIENT SERVICE COST CENTERS		
93.00	PARTIAL HOSPITAL	0.328587	93.00
	SPECIAL PURPOSE COST CENTERS		
113.00	INTEREST EXPENSE		113.00
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/11/2012 9:43 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	14,881,958		14,881,958	0	0	30.00
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0		0	0	0	54.00
60.00	LABORATORY	291,079		291,079	0	0	60.00
69.00	ELECTROCARDIOLOGY	0		0	0	0	69.00
73.00	DRUGS CHARGED TO PATIENTS	1,149,235		1,149,235	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
93.00	PARTIAL HOSPITAL	1,105,901		1,105,901	0	0	93.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	17,428,173	0	17,428,173	0	0	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	17,428,173	0	17,428,173	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/11/2012 9:43 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	36,694,695		36,694,695			30.00
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
60.00	LABORATORY	1,371,896	54,719	1,426,615	0.204035	0.000000	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
73.00	DRUGS CHARGED TO PATIENTS	1,604,096	0	1,604,096	0.716438	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS						
93.00	PARTIAL HOSPITAL	0	3,401,805	3,401,805	0.325092	0.000000	93.00
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	39,670,687	3,456,524	43,127,211			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	39,670,687	3,456,524	43,127,211			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/11/2012 9:43 am

Title XIX | Hospital | Cost

	Cost Center Description	PPS Inpatient Ratio		
		11.00		
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS			30.00
	ANCILLARY SERVICE COST CENTERS			
54.00	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	LABORATORY	0.000000		60.00
69.00	ELECTROCARDIOLOGY	0.000000		69.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
	OUTPATIENT SERVICE COST CENTERS			
93.00	PARTIAL HOSPITAL	0.000000		93.00
	SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part I Date/Time Prepared: 5/11/2012 9:43 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,648,914	0	1,648,914	27,589	59.77	30.00
200.00	Total (lines 30-199)	1,648,914		1,648,914	27,589		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part I Date/Time Prepared: 5/11/2012 9:43 am

Title XVIII | Hospital | PPS

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	7,305	436,620		30.00
200.00	Total (lines 30-199)	7,305	436,620		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part II Date/Time Prepared: 5/11/2012 9:43 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0	0	54.00
60.00	LABORATORY	3,930	1,426,615	0.002755	332,256	915	60.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
73.00	DRUGS CHARGED TO PATIENTS	24,221	1,604,096	0.015099	607,555	9,173	73.00
	OUTPATIENT SERVICE COST CENTERS						
93.00	PARTIAL HOSPITAL	164,915	3,401,805	0.048479	0	0	93.00
200.00	Total (lines 50-199)	193,066	6,432,516		939,811	10,088	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part III Date/Time Prepared: 5/11/2012 9:43 am

Title XVIII | Hospital | PPS

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part III Date/Time Prepared: 5/11/2012 9:43 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
		6.00	7.00	8.00	9.00	11.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	27,589	0.00	7,305	0	0	30.00
200.00	Total (lines 30-199)	27,589		7,305	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part III Date/Time Prepared: 5/11/2012 9:43 am

Title XVIII | Hospital | PPS

	Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost		
		12.00	13.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	0		30.00
200.00	Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/11/2012 9:43 am

Title XVIII | Hospital | PPS

	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
93.00	PARTIAL HOSPITAL	0	0	0	0	0	93.00
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: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/11/2012 9:43 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0.000000	0	54.00
60.00	LABORATORY	0	1,426,615	0.000000	0.000000	332,256	60.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,604,096	0.000000	0.000000	607,555	73.00
	OUTPATIENT SERVICE COST CENTERS						
93.00	PARTIAL HOSPITAL	0	3,401,805	0.000000	0.000000	0	93.00
200.00	Total (lines 50-199)	0	6,432,516			939,811	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/11/2012 9:43 am

Title XVIII | Hospital | PPS

	Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
93.00	PARTIAL HOSPITAL	0	529,070	0	0	0	93.00
200.00	Total (lines 50-199)	0	529,070	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV Date/Time Prepared: 5/11/2012 9:43 am

Title XVIII | Hospital | PPS

	Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
		23.00	24.00		
	ANCILLARY SERVICE COST CENTERS				
54.00	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	LABORATORY	0	0		60.00
69.00	ELECTROCARDIOLOGY	0	0		69.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS				
93.00	PARTIAL HOSPITAL	0	0		93.00
200.00	Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part V Date/Time Prepared: 5/11/2012 9:43 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see instructions)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
		1.00	2.00	3.00	4.00		
	ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0		54.00
60.00	LABORATORY	0.204035	0	0	0		60.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	0		69.00
73.00	DRUGS CHARGED TO PATIENTS	0.716438	0	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS						
93.00	PARTIAL HOSPITAL	0.325092	529,070	0	0		93.00
200.00	Subtotal (see instructions)		529,070	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)		529,070	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part V Date/Time Prepared: 5/11/2012 9:43 am

Title XVIII | Hospital | PPS

	Cost Center Description	Costs: PPS Services (see instructions)	Costs: Cost Services Subject To Ded. & Coins. (see instructions)	Costs: Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	LABORATORY	0	0	0		60.00
69.00	ELECTROCARDIOLOGY	0	0	0		69.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
93.00	PARTIAL HOSPITAL	171,996	0	0		93.00
200.00	Subtotal (see instructions)	171,996	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)	171,996	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part V Date/Time Prepared: 5/11/2012 9:43 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						
54.00	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0		54.00
60.00	LABORATORY	0.204035	0	0	3,418		60.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	0		69.00
73.00	DRUGS CHARGED TO PATIENTS	0.716438	0	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS						
93.00	PARTIAL HOSPITAL	0.325092	0	0	219,085		93.00
200.00	Subtotal (see instructions)		0	0	222,503		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	222,503		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part V Date/Time Prepared: 5/11/2012 9:43 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					
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	LABORATORY	0	0	697		60.00
69.00	ELECTROCARDIOLOGY	0	0	0		69.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
93.00	PARTIAL HOSPITAL	0	0	71,223		93.00
200.00	Subtotal (see instructions)	0	0	71,920		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	71,920		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/11/2012 9:43 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	27,589	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	27,589	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)	27,589	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)	7,305	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	15,071,488	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	15,071,488	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	36,694,695	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	36,694,695	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.410727	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)	1,330.05	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	15,071,488	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)	546.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,990,648	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,990,648	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/11/2012 9:43 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)	503,067	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,493,715	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)	436,620	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	10,088	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	446,708	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,047,007	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/11/2012 9:43 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,648,914	15,071,488	0.109406	0	0	90.00
91.00	Nursing School cost	0	15,071,488	0.000000	0	0	91.00
92.00	Allied health cost	0	15,071,488	0.000000	0	0	92.00
93.00	All other Medical Education	0	15,071,488	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/11/2012 9:43 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)	27,589	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	27,589	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)	27,589	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)	7,942	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	14,881,958	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)	14,881,958	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	36,694,695	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	36,694,695	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.405562	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)	1,330.05	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)	14,881,958	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)	539.42	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,284,074	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)	4,284,074	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/11/2012 9:43 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						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)	299,646	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,583,720	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	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: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/11/2012 9:43 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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-3 | Date/Time Prepared: 5/11/2012 9:43 am

Title XVIII | Hospital | PPS

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		9,682,095		30.00
	ANCILLARY SERVICE COST CENTERS				
54.00	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
60.00	LABORATORY	0.204035	332,256	67,792	60.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	69.00
73.00	DRUGS CHARGED TO PATIENTS	0.716438	607,555	435,275	73.00
	OUTPATIENT SERVICE COST CENTERS				
93.00	PARTIAL HOSPITAL	0.328587	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		939,811	503,067	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)		939,811		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-3 | Date/Time Prepared: 5/11/2012 9:43 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		10,523,916		30.00
	ANCILLARY SERVICE COST CENTERS				
54.00	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
60.00	LABORATORY	0.204035	274,835	56,076	60.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	69.00
73.00	DRUGS CHARGED TO PATIENTS	0.716438	339,973	243,570	73.00
	OUTPATIENT SERVICE COST CENTERS				
93.00	PARTIAL HOSPITAL	0.325092	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		614,808	299,646	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)		614,808		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet E Part B Date/Time Prepared: 5/11/2012 9:43 am

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	171,996	2.00
3.00	PPS payments	215,471	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a 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)	215,471	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)	48,148	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)	167,323	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)	167,323	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	167,323	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)	41,561	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	29,093	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	30,987	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	196,416	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)	196,416	40.00
41.00	Interim payments	200,024	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)	-3,608	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: 144005	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/11/2012 9:43 am
	Title XVIII	Hospital	PPS

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet E-1 Part I Date/Time Prepared: 5/11/2012 9:43 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,879,020		200,024	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	223,400		0	3.01
3.02		12/20/2011	319,200		0	3.02
3.03		12/20/2011	700		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)		543,300		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)		5,422,320		200,024	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		362,159		3,608	6.02
7.00	Total Medicare program liability (see instructions)		5,060,161		196,416	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 144005	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part II Date/Time Prepared: 5/11/2012 9:43 am
	Title XVIII	Hospital	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	5,426,873	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	75.586301	9.00
10.00	Medical Education Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Medical Education Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	5,426,873	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition	0	14.00
15.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	15.00
16.00	Subtotal (see instructions)	5,426,873	16.00
17.00	Primary payer payments	4,302	17.00
18.00	Subtotal (line 16 less line 17).	5,422,571	18.00
19.00	Deductibles	444,373	19.00
20.00	Subtotal (line 18 minus line 19)	4,978,198	20.00
21.00	Coinsurance	92,258	21.00
22.00	Subtotal (line 20 minus line 21)	4,885,940	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	248,887	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	174,221	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	136,165	25.00
26.00	Subtotal (sum of lines 22 and 24)	5,060,161	26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	5,060,161	31.00
32.00	Interim payments	5,422,320	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus the sum lines 32 and 33)	-362,159	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 144005	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part VII Date/Time Prepared: 5/11/2012 9:43 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	4,583,720	1.00
2.00	Medical and other services	71,920	2.00
3.00	Organ acquisition (certified transplant centers only)	0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	4,655,640	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)	4,655,640	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable Charges		
8.00	Routine service charges	10,523,916	8.00
9.00	Ancillary service charges	837,311	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)	11,361,227	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)	11,361,227	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	6,705,587	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)	4,655,640	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.	4,655,640	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)	4,655,640	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)	4,655,640	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	-4,655,640	37.00
38.00	Subtotal (line 36 ± line 37)	0	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)	0	40.00
41.00	Interim payments	0	41.00
42.00	Balance due provider/program (line 40 minus 41)	0	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: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet G | Date/Time Prepared: 5/11/2012 9:43 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	1,479,302	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,722,077	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	110,562	0	0	0	7.00
8.00	Prepaid expenses	140,189	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,452,130	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	1,408,172	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	1,408,172	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	488,180	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	488,180	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	8,348,482	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,153,901	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	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	23,154	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,177,055	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	440,088	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	440,088	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	1,617,143	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	6,731,339				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)	6,731,339	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	8,348,482	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet G-1 | Date/Time Prepared: 5/11/2012 9:43 am

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		6,880,204		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,051,135				2.00
3.00	Total (sum of line 1 and line 2)		9,931,339		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)		9,931,339		0		11.00
12.00	DISTRIBUTION OF EARNINGS	3,200,000		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)		3,200,000		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		6,731,339		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet G-1 | Date/Time Prepared: 5/11/2012 9:43 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	DISTRIBUTION OF EARNINGS	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: 144005 | Period: From 01/01/2011 To 12/31/2011 | Worksheet G-2 Parts | Date/Time Prepared: 5/11/2012 9:43 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	36,694,695		36,694,695	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				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)	36,694,695		36,694,695	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	36,694,695		36,694,695	17.00
18.00	Ancillary services	2,975,992	54,719	3,030,711	18.00
19.00	Outpatient services	0	3,408,282	3,408,282	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				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN REVENUE	1,308,958	0	1,308,958	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	40,979,645	3,463,001	44,442,646	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		19,898,947		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		19,898,947		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 144005	Period: From 01/01/2011 To 12/31/2011	Worksheet G-3 Date/Time Prepared: 5/11/2012 9:43 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	44,442,646	1.00
2.00	Less contractual allowances and discounts on patients' accounts	23,383,053	2.00
3.00	Net patient revenues (line 1 minus line 2)	21,059,593	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	19,898,947	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,160,646	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	4,231	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	OTEHR REVENUES	1,886,258	24.00
25.00	Total other income (sum of lines 6-24)	1,890,489	25.00
26.00	Total (line 5 plus line 25)	3,051,135	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,051,135	29.00