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: 154054	Period: From 01/01/2011 To 12/31/2011	Worksheet S Parts I-III Date/Time Prepared: 5/29/2012 2:05 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2012 Time: 2:05 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HARSHA BEHAVIORAL CENTER 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	16,618	0	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	16,618	0	0	0	200.00

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

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FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 154054

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

Worksheet S
Parts I-III
Date/Time Prepared:
5/29/2012 2:05 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2012 Time: 2:05 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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

Encryption Information

ECR: Date: 5/29/2012 Time: 2:05 pm
NkUEYy1:mVqghkIjL7Uou0cj70M9E0
vKkr60jsM6XJkCG9jj7FeOAiU0GOg1
I.U60hkXht0HyQ23

PI: Date: 5/29/2012 Time: 2:05 pm
T75rcg9IZziHoN7iYFAYnnsmAWCxO0
2CZeA0Vbj6kAMAhinpSGse8ZcXInt6
FnY3pn8w4f0e4cAr

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

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital	0	16,618	0	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	16,618	0	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: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2012 2:04 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1420 EAST CROSSING BLVD	PO Box:			1.00
2.00	City: TERRE HAUTE	State: IN	Zip Code: 47802	County: VIGO	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	HARSHA BEHAVIORAL CENTER	154054	45460	4	09/30/2009	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.	3	N	23.00

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

		Urban/Rural S 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: 154054	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/29/2012 2:04 pm

		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.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME Average	Direct GME Average	
		1.00	2.00	3.00	
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	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: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2012 2:04 pm

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	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		0	71.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2012 2:04 pm

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

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

		V	XIX	
		1.00	2.00	
	Title V or XIX Inpatient Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		Y	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)	N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

		1.00	2.00	
	Miscellaneous Cost Reporting Information			
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.	N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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.	2		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 154054	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/29/2012 2:04 pm

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

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

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

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

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

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

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2012 2:04 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	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)		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		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: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2012 2:04 pm

		Description	Part A Y/N	Part A Date		
		0	1.00	2.00		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		Y			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.				N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?				N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				N	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: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2012 2:04 pm

		Part B			
		Y/N	Date		
		3.00	4.00		
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	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.	Y			21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2012 2:04 pm

	Cost Center Description	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours		
		1.00	2.00	3.00	4.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	44	16,060	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)		44	16,060	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)		44	16,060	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)		44				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: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2012 2:04 pm

	Cost Center Description	I/P Days / O/P Visits / Trips					
		Title V	Title XVIII	Title XIX	Total All Patients		
		5.00	6.00	7.00	8.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	1,421	7,126	10,247		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	1,421	7,126	10,247		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	1,421	7,126	10,247		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: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2012 2:04 pm

	Cost Center Description	Full Time Equivalents			Discharges		
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
		9.00	10.00	11.00	12.00	13.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	107	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	85.48	0.00	0	107	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	85.48	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: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2012 2:04 pm

	Cost Center Description	Discharges			
		Title XIX	Total All Patients		
		14.00	15.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	772	1,073		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)	772	1,073		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: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A | Date/Time Prepared: 5/29/2012 2:04 pm

	Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT		391,756	391,756	0	391,756	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		62,517	62,517	0	62,517	2.00
4.00	EMPLOYEE BENEFITS	0	364,342	364,342	0	364,342	4.00
5.00	ADMINISTRATIVE & GENERAL	0	445,962	445,962	487,622	933,584	5.00
6.00	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	OPERATION OF PLANT	0	27,913	27,913	36,757	64,670	7.00
8.00	LAUNDRY & LINEN SERVICE	0	110,647	110,647	0	110,647	8.00
9.00	HOUSEKEEPING	0	22,692	22,692	42,072	64,764	9.00
10.00	DIETARY	162,445	200,477	362,922	0	362,922	10.00
11.00	CAFETERIA	0	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	0	0	0	93,771	93,771	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	22,959	22,959	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,670,857	277,197	2,948,054	-691,710	2,256,344	30.00
	ANCILLARY SERVICE COST CENTERS						
60.00	LABORATORY	0	20,374	20,374	0	20,374	60.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	29,811	29,811	0	29,811	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	139,694	139,694	0	139,694	73.00
76.00	GROUP THERAPY	0	2,270	2,270	26,172	28,442	76.00
76.01	INDIVIDUAL THERAPY	0	0	0	23,746	23,746	76.01
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE		41,389	41,389	-41,389	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,833,302	2,137,041	4,970,343	0	4,970,343	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	NON-REIMBURSABLE MEALS	0	0	0	0	0	194.00
200.00	TOTAL (SUM OF LINES 118-199)	2,833,302	2,137,041	4,970,343	0	4,970,343	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A | Date/Time Prepared: 5/29/2012 2:04 pm

	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	-14,905	376,851		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	62,517		2.00
4.00	EMPLOYEE BENEFITS	0	364,342		4.00
5.00	ADMINISTRATIVE & GENERAL	-79,876	853,708		5.00
6.00	MAINTENANCE & REPAIRS	0	0		6.00
7.00	OPERATION OF PLANT	0	64,670		7.00
8.00	LAUNDRY & LINEN SERVICE	0	110,647		8.00
9.00	HOUSEKEEPING	0	64,764		9.00
10.00	DIETARY	-22,676	340,246		10.00
11.00	CAFETERIA	0	0		11.00
13.00	NURSING ADMINISTRATION	0	93,771		13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	PHARMACY	0	0		15.00
16.00	MEDICAL RECORDS & LIBRARY	0	22,959		16.00
17.00	SOCIAL SERVICE	0	0		17.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	2,256,344		30.00
	ANCILLARY SERVICE COST CENTERS				
60.00	LABORATORY	0	20,374		60.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	29,811		71.00
73.00	DRUGS CHARGED TO PATIENTS	0	139,694		73.00
76.00	GROUP THERAPY	0	28,442		76.00
76.01	INDIVIDUAL THERAPY	0	23,746		76.01
	SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	0	0		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-117,457	4,852,886		118.00
	NONREIMBURSABLE COST CENTERS				
194.00	NON-REIMBURSABLE MEALS	0	0		194.00
200.00	TOTAL (SUM OF LINES 118-199)	-117,457	4,852,886		200.00

RECLASSIFICATIONS | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-6 | Date/Time Prepared: 5/29/2012 2:04 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - SALARIES				
1.00	ADMINISTRATIVE & GENERAL	5.00	446,233	0	1.00
2.00	OPERATION OF PLANT	7.00	36,757	0	2.00
3.00	HOUSEKEEPING	9.00	42,072	0	3.00
4.00	NURSING ADMINISTRATION	13.00	93,771	0	4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	22,959	0	5.00
	TOTALS		641,792	0	
	B - THERAPY SALARIES				
1.00	GROUP THERAPY	76.00	26,172	0	1.00
2.00	INDIVIDUAL THERAPY	76.01	23,746	0	2.00
	TOTALS		49,918	0	
	C - INTEREST EXPENSE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	41,389	1.00
	TOTALS		0	41,389	
500.00	Grand Total: Increases		691,710	41,389	500.00

RECLASSIFICATIONS | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-6 | Date/Time Prepared: 5/29/2012 2:04 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - SALARIES						
1.00	ADULTS & PEDIATRICS	30.00	641,792	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	TOTALS		641,792	0			
	B - THERAPY SALARIES						
1.00	ADULTS & PEDIATRICS	30.00	49,918	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		49,918	0			
	C - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	41,389	0		1.00
	TOTALS		0	41,389			
500.00	Grand Total: Decreases		691,710	41,389			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 5/29/2012 2:04 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	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	43,660	1,983	0	1,983	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	124,302	142,317	0	142,317	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	167,962	144,300	0	144,300	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	167,962	144,300	0	144,300	0	10.00

		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	38,207	353,549	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	21,431	0	41,086	0	2.00
3.00	Total (sum of lines 1-2)	38,207	374,980	0	41,086	0	3.00

		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	45,643	0	45,643	0.146169	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	266,619	0	266,619	0.853831	0	2.00
3.00	Total (sum of lines 1-2)	312,262	0	312,262	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 5/29/2012 2:04 pm

		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	45,643	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	266,619	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	312,262	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	312,262	0				10.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	391,756				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	62,517				2.00
3.00	Total (sum of lines 1-2)	0	454,273				3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	38,207	338,644	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	21,431	2.00
3.00	Total (sum of lines 1-2)	0	0	0	38,207	360,075	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-7 Parts I-III | Date/Time Prepared: 5/29/2012 2:04 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	376,851	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	41,086	0	0	62,517	2.00
3.00	Total (sum of lines 1-2)	0	41,086	0	0	439,368	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8 | Date/Time Prepared: 5/29/2012 2:04 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	
		1.00	2.00	3.00	4.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)		0		0.00	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-14,905	NEW CAP REL COSTS-BLDG & FIXT	1.00	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	0			10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-24,869			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Cafeteria-employees and guests	B	-22,676	DIETARY	10.00	14.00
15.00	Rental of quarters to employee and others		0		0.00	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	16.00
17.00	Sale of drugs to other than patients		0		0.00	17.00
18.00	Sale of medical records and abstracts		0		0.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00	Vending machines	B	-425	ADMINISTRATIVE & GENERAL	5.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** 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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant		0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	0		0.00	32.00
33.00	MARKETING-NON SALARY	A	-29,402	ADMINISTRATIVE & GENERAL	5.00	33.00
33.01	MARKETING-SALARY AND BENEFITS	A	-25,180	ADMINISTRATIVE & GENERAL	5.00	33.01
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-117,457			50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8 | Date/Time Prepared: 5/29/2012 2:04 pm

	Cost Center Description	Wkst. A-7 Ref. 5.00		
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0		1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	0		2.00
3.00	Investment income - other (chapter 2)	0		3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0		4.00
5.00	Refunds and rebates of expenses (chapter 8)	0		5.00
6.00	Rental of provider space by suppliers (chapter 8)	10		6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0		7.00
8.00	Television and radio service (chapter 21)	0		8.00
9.00	Parking lot (chapter 21)	0		9.00
10.00	Provider-based physician adjustment	0		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0		11.00
12.00	Related organization transactions (chapter 10)	0		12.00
13.00	Laundry and linen service	0		13.00
14.00	Cafeteria-employees and guests	0		14.00
15.00	Rental of quarters to employee and others	0		15.00
16.00	Sale of medical and surgical supplies to other than patients	0		16.00
17.00	Sale of drugs to other than patients	0		17.00
18.00	Sale of medical records and abstracts	0		18.00
19.00	Nursing school (tuition, fees, books, etc.)	0		19.00
20.00	Vending machines	0		20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0		21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0		22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)			23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)			24.00
25.00	Utilization review - physicians' compensation (chapter 21)			25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0		26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0		27.00
28.00	Non-physician Anesthetist			28.00
29.00	Physicians' assistant	0		29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)			30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)			31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0		32.00
33.00	MARKETING-NON SALARY	0		33.00
33.01	MARKETING-SALARY AND BENEFITS	0		33.01
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: 154054	Period: From 01/01/2011 To 12/31/2011	Worksheet A-8-1 Date/Time Prepared: 5/29/2012 2:04 pm

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

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

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

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

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

6.00		G	NIRMALA JAIN MD	0.00		6.00
7.00				0.00		7.00
8.00				0.00		8.00
9.00				0.00		9.00
10.00				0.00		10.00
100.00	G. Other (financial or non-financial) specify:		FINANCIAL			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: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2012 2:04 pm

		Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
		4.00	5.00	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00		0	24,869	-24,869	0		1.00
2.00		0	0	0	0		2.00
3.00		0	0	0	0		3.00
4.00		0	0	0	0		4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	0	24,869	-24,869			5.00

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

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

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

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

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

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

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

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part I Date/Time Prepared: 5/29/2012 2:04 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	376,851	376,851				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	62,517		62,517			2.00
4.00	EMPLOYEE BENEFITS	364,342	0	0	364,342		4.00
5.00	ADMINISTRATIVE & GENERAL	853,708	73,964	12,270	57,382	997,324	5.00
6.00	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	OPERATION OF PLANT	64,670	0	0	4,727	69,397	7.00
8.00	LAUNDRY & LINEN SERVICE	110,647	0	0	0	110,647	8.00
9.00	HOUSEKEEPING	64,764	0	0	5,410	70,174	9.00
10.00	DIETARY	340,246	37,208	6,173	20,889	404,516	10.00
11.00	CAFETERIA	0	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	93,771	0	0	12,058	105,829	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	22,959	0	0	2,952	25,911	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,256,344	197,651	32,789	254,504	2,741,288	30.00
	ANCILLARY SERVICE COST CENTERS						
60.00	LABORATORY	20,374	0	0	0	20,374	60.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,811	0	0	0	29,811	71.00
73.00	DRUGS CHARGED TO PATIENTS	139,694	0	0	0	139,694	73.00
76.00	GROUP THERAPY	28,442	68,028	11,285	3,366	111,121	76.00
76.01	INDIVIDUAL THERAPY	23,746	0	0	3,054	26,800	76.01
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	4,852,886	376,851	62,517	364,342	4,852,886	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	NON-REIMBURSABLE MEALS	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	4,852,886	376,851	62,517	364,342	4,852,886	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part I Date/Time Prepared: 5/29/2012 2:04 pm

	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	997,324					5.00
6.00	MAINTENANCE & REPAIRS	0	0				6.00
7.00	OPERATION OF PLANT	17,951	0	87,348			7.00
8.00	LAUNDRY & LINEN SERVICE	28,621	0	0	139,268		8.00
9.00	HOUSEKEEPING	18,152	0	0	0	88,326	9.00
10.00	DIETARY	104,637	0	10,730	0	10,850	10.00
11.00	CAFETERIA	0	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	27,375	0	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	6,702	0	0	0	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	709,094	0	57,000	139,268	57,638	30.00
	ANCILLARY SERVICE COST CENTERS						
60.00	LABORATORY	5,270	0	0	0	0	60.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,711	0	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	36,135	0	0	0	0	73.00
76.00	GROUP THERAPY	28,744	0	19,618	0	19,838	76.00
76.01	INDIVIDUAL THERAPY	6,932	0	0	0	0	76.01
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	997,324	0	87,348	139,268	88,326	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	NON-REIMBURSABLE MEALS	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	997,324	0	87,348	139,268	88,326	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part I Date/Time Prepared: 5/29/2012 2:04 pm

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY	530,733					10.00
11.00	CAFETERIA	151,588	151,588				11.00
13.00	NURSING ADMINISTRATION	0	4,765	137,969			13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	1,859	0	0	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	369,174	143,693	137,969	0	0	30.00
	ANCILLARY SERVICE COST CENTERS						
60.00	LABORATORY	0	0	0	0	0	60.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	GROUP THERAPY	0	744	0	0	0	76.00
76.01	INDIVIDUAL THERAPY	0	527	0	0	0	76.01
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	520,762	151,588	137,969	0	0	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	NON-REIMBURSABLE MEALS	9,971	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	530,733	151,588	137,969	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part I Date/Time Prepared: 5/29/2012 2:04 pm

	Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION						13.00
14.00	CENTRAL SERVICES & SUPPLY						14.00
15.00	PHARMACY						15.00
16.00	MEDICAL RECORDS & LIBRARY	34,472					16.00
17.00	SOCIAL SERVICE	0	0				17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	31,591	0	4,386,715	0	4,386,715	30.00
	ANCILLARY SERVICE COST CENTERS						
60.00	LABORATORY	127	0	25,771	0	25,771	60.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	4	0	37,526	0	37,526	71.00
73.00	DRUGS CHARGED TO PATIENTS	883	0	176,712	0	176,712	73.00
76.00	GROUP THERAPY	1,709	0	181,774	0	181,774	76.00
76.01	INDIVIDUAL THERAPY	158	0	34,417	0	34,417	76.01
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	34,472	0	4,842,915	0	4,842,915	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	NON-REIMBURSABLE MEALS	0	0	9,971	0	9,971	194.00
200.00	Cross Foot Adjustments			0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	34,472	0	4,852,886	0	4,852,886	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part II Date/Time Prepared: 5/29/2012 2:04 pm

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS	0	0	0	0	0	4.00
5.00	ADMINISTRATIVE & GENERAL	0	73,964	12,270	86,234	0	5.00
6.00	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	DIETARY	0	37,208	6,173	43,381	0	10.00
11.00	CAFETERIA	0	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	197,651	32,789	230,440	0	30.00
	ANCILLARY SERVICE COST CENTERS						
60.00	LABORATORY	0	0	0	0	0	60.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	GROUP THERAPY	0	68,028	11,285	79,313	0	76.00
76.01	INDIVIDUAL THERAPY	0	0	0	0	0	76.01
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	376,851	62,517	439,368	0	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	NON-REIMBURSABLE MEALS	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	376,851	62,517	439,368	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part II | Date/Time Prepared: 5/29/2012 2:04 pm

	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	86,234					5.00
6.00	MAINTENANCE & REPAIRS	0	0				6.00
7.00	OPERATION OF PLANT	1,552	0	1,552			7.00
8.00	LAUNDRY & LINEN SERVICE	2,475	0	0	2,475		8.00
9.00	HOUSEKEEPING	1,570	0	0	0	1,570	9.00
10.00	DIETARY	9,047	0	191	0	193	10.00
11.00	CAFETERIA	0	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	2,367	0	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	580	0	0	0	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	61,312	0	1,012	2,475	1,024	30.00
	ANCILLARY SERVICE COST CENTERS						
60.00	LABORATORY	456	0	0	0	0	60.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	667	0	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	3,124	0	0	0	0	73.00
76.00	GROUP THERAPY	2,485	0	349	0	353	76.00
76.01	INDIVIDUAL THERAPY	599	0	0	0	0	76.01
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	86,234	0	1,552	2,475	1,570	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	NON-REIMBURSABLE MEALS	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	86,234	0	1,552	2,475	1,570	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part II Date/Time Prepared: 5/29/2012 2:04 pm

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY	52,812					10.00
11.00	CAFETERIA	15,084	15,084				11.00
13.00	NURSING ADMINISTRATION	0	474	2,841			13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	185	0	0	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	36,736	14,299	2,841	0	0	30.00
	ANCILLARY SERVICE COST CENTERS						
60.00	LABORATORY	0	0	0	0	0	60.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	GROUP THERAPY	0	74	0	0	0	76.00
76.01	INDIVIDUAL THERAPY	0	52	0	0	0	76.01
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	51,820	15,084	2,841	0	0	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	NON-REIMBURSABLE MEALS	992	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	52,812	15,084	2,841	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B Part II Date/Time Prepared: 5/29/2012 2:04 pm

	Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION						13.00
14.00	CENTRAL SERVICES & SUPPLY						14.00
15.00	PHARMACY						15.00
16.00	MEDICAL RECORDS & LIBRARY	765					16.00
17.00	SOCIAL SERVICE	0	0				17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	700	0	350,839	0	350,839	30.00
	ANCILLARY SERVICE COST CENTERS						
60.00	LABORATORY	3	0	459	0	459	60.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	667	0	667	71.00
73.00	DRUGS CHARGED TO PATIENTS	20	0	3,144	0	3,144	73.00
76.00	GROUP THERAPY	38	0	82,612	0	82,612	76.00
76.01	INDIVIDUAL THERAPY	4	0	655	0	655	76.01
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	765	0	438,376	0	438,376	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	NON-REIMBURSABLE MEALS	0	0	992	0	992	194.00
200.00	Cross Foot Adjustments			0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	765	0	439,368	0	439,368	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B-1 | Date/Time Prepared: 5/29/2012 2:04 pm

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	25,837					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		25,837				2.00
4.00	EMPLOYEE BENEFITS	0	0	2,833,302			4.00
5.00	ADMINISTRATIVE & GENERAL	5,071	5,071	446,233	-997,324	3,855,562	5.00
6.00	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	OPERATION OF PLANT	0	0	36,757	0	69,397	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	0	0	110,647	8.00
9.00	HOUSEKEEPING	0	0	42,072	0	70,174	9.00
10.00	DIETARY	2,551	2,551	162,445	0	404,516	10.00
11.00	CAFETERIA	0	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	0	0	93,771	0	105,829	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	22,959	0	25,911	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	13,551	13,551	1,979,147	0	2,741,288	30.00
	ANCILLARY SERVICE COST CENTERS						
60.00	LABORATORY	0	0	0	0	20,374	60.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	29,811	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	139,694	73.00
76.00	GROUP THERAPY	4,664	4,664	26,172	0	111,121	76.00
76.01	INDIVIDUAL THERAPY	0	0	23,746	0	26,800	76.01
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	25,837	25,837	2,833,302	-997,324	3,855,562	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	NON-REIMBURSABLE MEALS	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	376,851	62,517	364,342		997,324	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	14.585710	2.419669	0.128593		0.258671	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0		86,234	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.022366	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B-1 | Date/Time Prepared: 5/29/2012 2:04 pm

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS	0					6.00
7.00	OPERATION OF PLANT	0	20,766				7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	10,247			8.00
9.00	HOUSEKEEPING	0	0	0	20,766		9.00
10.00	DIETARY	0	2,551	0	2,551	44,020	10.00
11.00	CAFETERIA	0	0	0	0	12,573	11.00
13.00	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	13,551	10,247	13,551	30,620	30.00
	ANCILLARY SERVICE COST CENTERS						
60.00	LABORATORY	0	0	0	0	0	60.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	GROUP THERAPY	0	4,664	0	4,664	0	76.00
76.01	INDIVIDUAL THERAPY	0	0	0	0	0	76.01
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	20,766	10,247	20,766	43,193	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	NON-REIMBURSABLE MEALS	0	0	0	0	827	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	87,348	139,268	88,326	530,733	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	4.206299	13.591100	4.253395	12.056633	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	1,552	2,475	1,570	52,812	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.074738	0.241534	0.075604	1.199727	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B-1 | Date/Time Prepared: 5/29/2012 2:04 pm

	Cost Center Description	CAFETERIA (HOURS WORKED)	NURSING ADMINISTRATION (PATIENT DAYS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	132,353					11.00
13.00	NURSING ADMINISTRATION	4,160	10,247				13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0			14.00
15.00	PHARMACY	0	0	0	0		15.00
16.00	MEDICAL RECORDS & LIBRARY	1,623	0	0	0	11,160,686	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	125,460	10,247	0	0	10,227,964	30.00
	ANCILLARY SERVICE COST CENTERS						
60.00	LABORATORY	0	0	0	0	40,983	60.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,338	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	285,967	73.00
76.00	GROUP THERAPY	650	0	0	0	553,359	76.00
76.01	INDIVIDUAL THERAPY	460	0	0	0	51,075	76.01
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	132,353	10,247	0	0	11,160,686	118.00
	NONREIMBURSABLE COST CENTERS						
194.00	NON-REIMBURSABLE MEALS	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	151,588	137,969	0	0	34,472	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1.145331	13.464331	0.000000	0.000000	0.003089	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	15,084	2,841	0	0	765	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.113968	0.277252	0.000000	0.000000	0.000069	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet B-1 | Date/Time Prepared: 5/29/2012 2:04 pm

	Cost Center Description	SOCIAL SERVICE (PATIENT DAYS) 17.00		
	GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	EMPLOYEE BENEFITS			4.00
5.00	ADMINISTRATIVE & GENERAL			5.00
6.00	MAINTENANCE & REPAIRS			6.00
7.00	OPERATION OF PLANT			7.00
8.00	LAUNDRY & LINEN SERVICE			8.00
9.00	HOUSEKEEPING			9.00
10.00	DIETARY			10.00
11.00	CAFETERIA			11.00
13.00	NURSING ADMINISTRATION			13.00
14.00	CENTRAL SERVICES & SUPPLY			14.00
15.00	PHARMACY			15.00
16.00	MEDICAL RECORDS & LIBRARY			16.00
17.00	SOCIAL SERVICE	10,247		17.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	10,247		30.00
	ANCILLARY SERVICE COST CENTERS			
60.00	LABORATORY	0		60.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		71.00
73.00	DRUGS CHARGED TO PATIENTS	0		73.00
76.00	GROUP THERAPY	0		76.00
76.01	INDIVIDUAL THERAPY	0		76.01
	SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE			113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	10,247		118.00
	NONREIMBURSABLE COST CENTERS			
194.00	NON-REIMBURSABLE MEALS	0		194.00
200.00	Cross Foot Adjustments			200.00
201.00	Negative Cost Centers			201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/29/2012 2:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	4,386,715		4,386,715	0	4,386,715	30.00
	ANCILLARY SERVICE COST CENTERS						
60.00	LABORATORY	25,771		25,771	0	25,771	60.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	37,526		37,526	0	37,526	71.00
73.00	DRUGS CHARGED TO PATIENTS	176,712		176,712	0	176,712	73.00
76.00	GROUP THERAPY	181,774		181,774	0	181,774	76.00
76.01	INDIVIDUAL THERAPY	34,417		34,417	0	34,417	76.01
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	4,842,915	0	4,842,915	0	4,842,915	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	4,842,915	0	4,842,915	0	4,842,915	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/29/2012 2:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	10,227,964		10,227,964			30.00
	ANCILLARY SERVICE COST CENTERS						
60.00	LABORATORY	40,983	0	40,983	0.628822	0.000000	60.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,338	0	1,338	28.046338	0.000000	71.00
73.00	DRUGS CHARGED TO PATIENTS	285,967	0	285,967	0.617945	0.000000	73.00
76.00	GROUP THERAPY	553,359	0	553,359	0.328492	0.000000	76.00
76.01	INDIVIDUAL THERAPY	51,075	0	51,075	0.673852	0.000000	76.01
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	11,160,686	0	11,160,686			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	11,160,686	0	11,160,686			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/29/2012 2:04 pm

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			
60.00	LABORATORY	0.628822		60.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	28.046338		71.00
73.00	DRUGS CHARGED TO PATIENTS	0.617945		73.00
76.00	GROUP THERAPY	0.328492		76.00
76.01	INDIVIDUAL THERAPY	0.673852		76.01
	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: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/29/2012 2:04 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	4,386,715		4,386,715	0	0	30.00
	ANCILLARY SERVICE COST CENTERS						
60.00	LABORATORY	25,771		25,771	0	0	60.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	37,526		37,526	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	176,712		176,712	0	0	73.00
76.00	GROUP THERAPY	181,774		181,774	0	0	76.00
76.01	INDIVIDUAL THERAPY	34,417		34,417	0	0	76.01
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	4,842,915	0	4,842,915	0	0	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	4,842,915	0	4,842,915	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/29/2012 2:04 pm

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	10,227,964		10,227,964			30.00
	ANCILLARY SERVICE COST CENTERS						
60.00	LABORATORY	40,983	0	40,983	0.628822	0.000000	60.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,338	0	1,338	28.046338	0.000000	71.00
73.00	DRUGS CHARGED TO PATIENTS	285,967	0	285,967	0.617945	0.000000	73.00
76.00	GROUP THERAPY	553,359	0	553,359	0.328492	0.000000	76.00
76.01	INDIVIDUAL THERAPY	51,075	0	51,075	0.673852	0.000000	76.01
	SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	11,160,686	0	11,160,686			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	11,160,686	0	11,160,686			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet C Part I Date/Time Prepared: 5/29/2012 2:04 pm

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			
60.00	LABORATORY	0.000000		60.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	GROUP THERAPY	0.000000		76.00
76.01	INDIVIDUAL THERAPY	0.000000		76.01
	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: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part I Date/Time Prepared: 5/29/2012 2:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	350,839	0	350,839	10,247	34.24	30.00
200.00	Total (lines 30-199)	350,839		350,839	10,247		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part I Date/Time Prepared: 5/29/2012 2:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	1,421	48,655		30.00
200.00	Total (lines 30-199)	1,421	48,655		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part II Date/Time Prepared: 5/29/2012 2:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
60.00	LABORATORY	459	40,983	0.011200	40,983	459	60.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	667	1,338	0.498505	1,338	667	71.00
73.00	DRUGS CHARGED TO PATIENTS	3,144	285,967	0.010994	285,967	3,144	73.00
76.00	GROUP THERAPY	82,612	553,359	0.149292	553,359	82,612	76.00
76.01	INDIVIDUAL THERAPY	655	51,075	0.012824	51,075	655	76.01
200.00	Total (lines 50-199)	87,537	932,722		932,722	87,537	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part III Date/Time Prepared: 5/29/2012 2:04 pm

Title XVIII | Hospital | PPS

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part III Date/Time Prepared: 5/29/2012 2:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
		6.00	7.00	8.00	9.00	11.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	10,247	0.00	1,421	0	0	30.00
200.00	Total (lines 30-199)	10,247		1,421	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part III | Date/Time Prepared: 5/29/2012 2:04 pm

Title XVIII | Hospital | PPS

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/29/2012 2:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS						
60.00	LABORATORY	0	0	0	0	0	60.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	GROUP THERAPY	0	0	0	0	0	76.00
76.01	INDIVIDUAL THERAPY	0	0	0	0	0	76.01
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: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/29/2012 2:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS						
60.00	LABORATORY	0	40,983	0.000000	0.000000	40,983	60.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,338	0.000000	0.000000	1,338	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	285,967	0.000000	0.000000	285,967	73.00
76.00	GROUP THERAPY	0	553,359	0.000000	0.000000	553,359	76.00
76.01	INDIVIDUAL THERAPY	0	51,075	0.000000	0.000000	51,075	76.01
200.00	Total (lines 50-199)	0	932,722			932,722	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV | Date/Time Prepared: 5/29/2012 2:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
	ANCILLARY SERVICE COST CENTERS						
60.00	LABORATORY	0	0	0	0	0	60.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	GROUP THERAPY	0	0	0	0	0	76.00
76.01	INDIVIDUAL THERAPY	0	0	0	0	0	76.01
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: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D Part IV Date/Time Prepared: 5/29/2012 2:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
		23.00	24.00		
	ANCILLARY SERVICE COST CENTERS				
60.00	LABORATORY	0	0		60.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	GROUP THERAPY	0	0		76.00
76.01	INDIVIDUAL THERAPY	0	0		76.01
200.00	Total (lines 50-199)	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/29/2012 2:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	10,247	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,247	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)	10,247	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)	1,421	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)	4,386,715	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)	4,386,715	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	10,227,964	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	10,227,964	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.428894	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)	998.14	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,386,715	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)	428.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	608,330	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)	608,330	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/29/2012 2:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)	456,200	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,064,530	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)	48,655	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	87,537	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	136,192	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	928,338	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: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/29/2012 2:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	350,839	4,386,715	0.079978	0	0	90.00
91.00	Nursing School cost	0	4,386,715	0.000000	0	0	91.00
92.00	Allied health cost	0	4,386,715	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,386,715	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/29/2012 2:04 pm

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)	10,247	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	10,247	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)	10,247	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)	7,126	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)	4,386,715	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)	4,386,715	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	10,227,964	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	10,227,964	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.428894	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)	998.14	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,386,715	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)	428.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,050,641	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)	3,050,641	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/29/2012 2:04 pm

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)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,050,641	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: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-1 | Date/Time Prepared: 5/29/2012 2:04 pm

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: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-3 | Date/Time Prepared: 5/29/2012 2:04 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		2,760,451		30.00
	ANCILLARY SERVICE COST CENTERS				
60.00	LABORATORY	0.628822	40,983	25,771	60.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	28.046338	1,338	37,526	71.00
73.00	DRUGS CHARGED TO PATIENTS	0.617945	285,967	176,712	73.00
76.00	GROUP THERAPY	0.328492	553,359	181,774	76.00
76.01	INDIVIDUAL THERAPY	0.673852	51,075	34,417	76.01
200.00	Total (sum of lines 50-94 and 96-98)		932,722	456,200	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)		932,722		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet D-3 | Date/Time Prepared: 5/29/2012 2:04 pm

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		6,136,163		30.00
	ANCILLARY SERVICE COST CENTERS				
60.00	LABORATORY	0.628822	0	0	60.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	28.046338	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0.617945	0	0	73.00
76.00	GROUP THERAPY	0.328492	0	0	76.00
76.01	INDIVIDUAL THERAPY	0.673852	0	0	76.01
200.00	Total (sum of lines 50-94 and 96-98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 154054	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/29/2012 2:04 pm
	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)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	0	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	0	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	0	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	0	37.00
38.00	MSP-LCC reconciliation amount from PS&R	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)	0	40.00
41.00	Interim payments	0	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)	0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	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: 154054	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/29/2012 2:04 pm
	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: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2012 2:04 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,585,621		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,585,621		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		16,618		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,602,239		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 154054	Period: From 01/01/2011 To 12/31/2011	Worksheet E-1 Part II Date/Time Prepared: 5/29/2012 2:04 pm
	Title XVIII	Hospital	PPS

		1.00	
	DATA COLLECTION NEEDED FOR THE HIT CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	1,073	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	1,421	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	10,247	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	11,160,686	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	0	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment(s)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 minus line 30, plus or minus line 31)	0	32.00
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment	0	108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 154054	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part II Date/Time Prepared: 5/29/2012 2:04 pm
	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)	1,738,310	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)	28.073973	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)	1,738,310	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)	1,738,310	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	1,738,310	18.00
19.00	Deductibles	152,689	19.00
20.00	Subtotal (line 18 minus line 19)	1,585,621	20.00
21.00	Coinsurance	0	21.00
22.00	Subtotal (line 20 minus line 21)	1,585,621	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	23,740	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	16,618	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	23,740	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,602,239	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)	1,602,239	31.00
32.00	Interim payments	1,585,621	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)	16,618	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: 154054	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2012 2:04 pm
	Title XIX	Hospital	Cost

		1.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES		
1.00	Inpatient hospital/SNF/NF services	3,050,641	1.00
2.00	Medical and other services	0	2.00
3.00	Organ acquisition (certified transplant centers only)	0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	3,050,641	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)	3,050,641	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable Charges		
8.00	Routine service charges	0	8.00
9.00	Ancillary service charges	0	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)	0	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)	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	3,050,641	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)	0	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.	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30.00	Excess of reasonable cost (from line 18)	3,050,641	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	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)	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	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: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet G | Date/Time Prepared: 5/29/2012 2:04 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURENT ASSETS					
1.00	Cash on hand in banks	0	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	1,252,169	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	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	162	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	1,252,331	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	45,643	0	0	0	17.00
18.00	Accumulated depreciation	-23,044	0	0	0	18.00
19.00	Fixed equipment	61,554	0	0	0	19.00
20.00	Accumulated depreciation	-13,249	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	205,065	0	0	0	23.00
24.00	Accumulated depreciation	-48,721	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)	227,248	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	110,341	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	110,341	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	1,589,920	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	75,145	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,064	0	0	0	38.00
39.00	Payroll taxes payable	21,916	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	0	0	0	0	43.00
44.00	Other current liabilities	172,293	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	271,418	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	0	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	271,418	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	1,318,502				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)	1,318,502	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	1,589,920	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet G-1 | Date/Time Prepared: 5/29/2012 2:04 pm

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		119,218		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,615,079				2.00
3.00	Total (sum of line 1 and line 2)		1,734,297		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)		1,734,297		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0			12.00
13.00	OWNERS/PERSONAL EST TAXES DRAW	415,000		0			13.00
14.00	ADJUSTMENT TO BALANCE	795		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)		415,795		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		1,318,502		0		19.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet G-1 | Date/Time Prepared: 5/29/2012 2:04 pm

		Endowment Fund		Plant Fund			
		5.00	6.00	7.00	8.00		
1.00	Fund balances at beginning of period		0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)		0		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0			4.00
5.00		0		0			5.00
6.00		0		0			6.00
7.00		0		0			7.00
8.00		0		0			8.00
9.00		0		0			9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		0		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0			12.00
13.00	OWNERS/PERSONAL EST TAXES DRAW	0		0			13.00
14.00	ADJUSTMENT TO BALANCE	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: 154054 | Period: From 01/01/2011 To 12/31/2011 | Worksheet G-2 Parts | Date/Time Prepared: 5/29/2012 2:04 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	10,227,964		10,227,964	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)	10,227,964		10,227,964	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)	10,227,964		10,227,964	17.00
18.00	Ancillary services	960,121	0	960,121	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,188,085	0	11,188,085	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		4,970,343		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)		4,970,343		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 154054	Period: From 01/01/2011 To 12/31/2011	Worksheet G-3 Date/Time Prepared: 5/29/2012 2:04 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	11,188,085	1.00
2.00	Less contractual allowances and discounts on patients' accounts	4,642,332	2.00
3.00	Net patient revenues (line 1 minus line 2)	6,545,753	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	4,970,343	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,575,410	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	1,663	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	22,676	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	425	21.00
22.00	Rental of hospital space	14,905	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
25.00	Total other income (sum of lines 6-24)	39,669	25.00
26.00	Total (line 5 plus line 25)	1,615,079	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)	1,615,079	29.00