

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

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

Provider CCN: 144009
 Period: From 01/01/2011 To 12/31/2011
 Date/Time Prepared: 5/15/2012 12:49 pm
 Worksheet 5
 Parts I-III

PART I - COST REPORT STATUS

Provider use only
 1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only
 5. 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. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN
 10. NPR Date:
 11. Contractor's Vendor Code: 04
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 5/15/2012 Time: 12:49 pm

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 RIVEREDGE HOSPITAL for the cost reporting period beginning 01/01/2011 and ending 12/31/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 5/15/2012 Time: 12:49 pm
 WQGi.bAgjIDE1Hm7CYTCORGpOF8Lg0
 .bkW0Gy5Ddvp62DAjs7gzwfVBdcws
 k2ev0hyodf0VU7BE
 PI: Date: 5/15/2012 Time: 12:49 pm
 Ux2mVTtheZW3A5pLHeg4GMj3YnAad0
 l19WP0RRVZbeV1q9FJXEhqZKSH14pN
 dADUBCUJVE0VZOR:

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

 Title

 Date

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-27,683	0	0	-4,395,984	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	-27,683	0	0	-4,395,984	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 144009

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

Worksheet S-2
Part I
Date/Time Prepared:
5/15/2012 10:58 am

		1.00	2.00	3.00	4.00						
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 8311 WEST ROOSEVELT RD	PO Box:		Zip Code: 60130		County: COOK					1.00
2.00	City: FOREST PARK	State: IL									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	RIVEREDGE HOSPITAL	144009	16974	4	07/01/1967	N	P	O	3.00	
4.00	Subprovider - IPF	RIVEREDGE HOSPITAL RTC	144009	16974	4	07/01/1967	N	N	O	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:	To:			
20.00	Cost Reporting Period (mm/dd/yyyy)	1.00		2.00		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	Date of Geogr			
							1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.							1		26.00	
27.00	For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification (in column 2).							1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							0		35.00	
							Beginning:	Ending:			
							1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.									36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.							0		37.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 144009	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/15/2012 10:58 am		
		Beginning:	Ending:			
		1.00	2.00			
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete worksheet L, Part III and L-1, Parts I through III 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.	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.				58.00	
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital 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	
		1.00	2.00	3.00	4.00	
				Ratio (col. 3/ (col. 3 + col. 4))	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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

Worksheet S-2
Part I
Date/Time Prepared:
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		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: 144009

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

Worksheet S-2
Part I
Date/Time Prepared:
5/15/2012 10:58 am

		1.00	2.00	3.00	
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N		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)(i)? Enter "Y" for yes and "N" for no.		N		86.00
		V		XIX	
		1.00		2.00	
Title V or XIX Inpatient Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		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		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		97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				109.00
				1.00	2.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.	N			115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1	118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.		200,000,000		119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with ≤ 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N			121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00

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		1.00	2.00				
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00		
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00		
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00		
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00		
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00		
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00		
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00		
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00		
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00		
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	399001		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: HIGHMARK HEALTH SERVICES	Contractor's Name: HIGHMARK HEALTH SERVICES		Contractor's Number: 12901	141.00		
142.00	Street: 120 FIFTH AVENUE	PO Box:			142.00		
143.00	City: PITTSBURGH	State: PA		Zip Code: 15222-3099	143.00		
			1.00				
144.00	Are provider based physicians' costs included in worksheet A?		Y		144.00		
145.00	If costs for renal services are claimed on worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		Y		145.00		
		1.00	2.00				
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N			146.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N			147.00		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N			148.00		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N			149.00		
		Part A	Part B				
		1.00	2.00				
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N		155.00		
156.00	Subprovider - IPF	N	N		156.00		
157.00	Subprovider - IRF	N	N		157.00		
158.00	SUBPROVIDER	N	N		158.00		
159.00	SNF	N	N		159.00		
160.00	HOME HEALTH AGENCY	N	N		160.00		
161.00	CMHC		N		161.00		
			1.00				
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.		N		165.00		
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
							1.00
Health Information Technology (HIT) Incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.		N				167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00169.00

		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions)	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N	
			1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		
Description		Y/N	Date	
0		1.00	2.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	02/29/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00

		Part A		
Description		Y/N	Date	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	2.00	21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N		33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N		35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 144009

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

Worksheet S-2
Part II
Date/Time Prepared:
5/15/2012 10:58 am

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	02/29/2012	16.00
17.00	was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 144009

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

Worksheet S-3
Part I
Date/Time Prepared:
5/15/2012 10:58 am

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	
	Line Number				
	1.00	2.00	3.00	4.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	196	71,540	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)		196	71,540	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)		196	71,540	0.00	14.00
15.00 CAH visits					15.00
16.00 SUBPROVIDER - IPF	40.00	14	5,110		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)		210			27.00
28.00 Observation Bed Days					28.00
28.01 SUBPROVIDER - IPF	40.00				28.01
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: 144009

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

Worksheet S-3
Part I
Date/Time Prepared:
5/15/2012 10:58 am

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	12,542	17,515	36,480		1.00
2.00 HMO		0	0			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	12,542	17,515	36,480		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	12,542	17,515	36,480		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF	0	0	0	4,803		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
28.01 SUBPROVIDER - IPF				0		28.01
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: 144009

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

worksheet S-3
Part I
Date/Time Prepared:
5/15/2012 10:58 am

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	944	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	227.47	0.00	0	944	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	16.34	0.00	0	0	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	243.81	0.00			27.00
28.00 Observation Bed Days						28.00
28.01 SUBPROVIDER - IPF						28.01
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

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)	1,541	3,030		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)	1,541	3,030		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF	0	5		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
28.01 SUBPROVIDER - IPF				28.01
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 UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 144009

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

Worksheet S-10

Date/Time Prepared:
5/15/2012 10:58 am

		1.00		
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)	0.397366		1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	0		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0		5.00
6.00	Medicaid charges	0		6.00
7.00	Medicaid cost (line 1 times line 6)	0		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0		8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone SCHIP	0		9.00
10.00	Stand-alone SCHIP charges	0		10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0		11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	0	0	0
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	0	0	0
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	0	0	0
				1.00
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	0		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	72,131		27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	-72,131		28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	-28,662		29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	-28,662		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	-28,662		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 144009

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

Worksheet A

Date/Time Prepared:
5/15/2012 10:58 am

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification	Reclassified	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00		1,042,069	1,042,069	0	1,042,069	1.00
2.00		-39,438	-39,438	36,135	-3,303	2.00
4.00	108,685	2,294,528	2,403,213	0	2,403,213	4.00
5.00	2,023,698	11,007,493	13,031,191	-1,348,580	11,682,611	5.00
7.00	48,023	769,416	817,439	-16,850	800,589	7.00
8.00	0	172,146	172,146	0	172,146	8.00
9.00	0	558,472	558,472	0	558,472	9.00
10.00	269,599	556,908	826,507	-188	826,319	10.00
13.00	1,006,719	61,831	1,068,550	-3,052	1,065,498	13.00
16.00	214,124	201,511	415,635	0	415,635	16.00
17.00	926,306	115,020	1,041,326	0	1,041,326	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	6,328,051	220,770	6,548,821	814,096	7,362,917	30.00
40.00	750,204	50,401	800,605	-62,183	738,422	40.00
ANCILLARY SERVICE COST CENTERS						
60.00	0	182,420	182,420	0	182,420	60.00
69.00	0	0	0	0	0	69.00
70.00	0	17,335	17,335	0	17,335	70.00
73.00	0	1,004,154	1,004,154	0	1,004,154	73.00
76.00	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	375,589	5,197	380,786	48,295	429,081	90.00
91.00	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
98.00	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
113.00		0	0	0	0	113.00
118.00	12,050,998	18,220,233	30,271,231	-532,327	29,738,904	118.00
NONREIMBURSABLE COST CENTERS						
192.00	0	0	0	0	0	192.00
194.00	0	0	0	0	0	194.00
194.01	0	0	0	0	0	194.01
194.02	0	0	0	336,596	336,596	194.02
194.03	0	0	0	195,731	195,731	194.03
200.00	12,050,998	18,220,233	30,271,231	0	30,271,231	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 144009

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

Worksheet A
Date/Time Prepared:
5/15/2012 10:58 am

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	2,391,067	3,433,136	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	310,498	307,195	2.00
4.00	EMPLOYEE BENEFITS	-250,870	2,152,343	4.00
5.00	ADMINISTRATIVE & GENERAL	-7,302,151	4,380,460	5.00
7.00	OPERATION OF PLANT	0	800,589	7.00
8.00	LAUNDRY & LINEN SERVICE	0	172,146	8.00
9.00	HOUSEKEEPING	0	558,472	9.00
10.00	DIETARY	-29,275	797,044	10.00
13.00	NURSING ADMINISTRATION	0	1,065,498	13.00
16.00	MEDICAL RECORDS & LIBRARY	-2,218	413,417	16.00
17.00	SOCIAL SERVICE	0	1,041,326	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-789,119	6,573,798	30.00
40.00	SUBPROVIDER - IPF	-5,749	732,673	40.00
ANCILLARY SERVICE COST CENTERS				
60.00	LABORATORY	0	182,420	60.00
69.00	ELECTROCARDIOLOGY	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	17,335	70.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,004,154	73.00
76.00	RECREATION THERAPY	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	-22,809	406,272	90.00
91.00	EMERGENCY	0	0	91.00
OTHER REIMBURSABLE COST CENTERS				
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-5,700,626	24,038,278	118.00
NONREIMBURSABLE COST CENTERS				
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	PATIENT TRANSPORTATION	0	0	194.01
194.02	COMMUNITY RELATIONS	0	336,596	194.02
194.03	EDUCATION	0	195,731	194.03
200.00	TOTAL (SUM OF LINES 118-199)	-5,700,626	24,570,605	200.00

RECLASSIFICATIONS

Provider CCN: 144009

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

Worksheet A-6

Date/Time Prepared:
5/15/2012 10:58 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - RENT LEASE					
1.00		0.00	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	36,135	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		0	36,135	
B - PHYSICIAN FEES					
1.00	ADULTS & PEDIATRICS	30.00	0	935,044	1.00
2.00	SUBPROVIDER - IPF	40.00	0	12,600	2.00
3.00	CLINIC	90.00	0	48,295	3.00
	TOTALS		0	995,939	
C - COMMUNITY RELATIONS					
1.00	COMMUNITY RELATIONS	194.02	295,123	41,473	1.00
	TOTALS		295,123	41,473	
D - EDUCATION					
1.00	EDUCATION	194.03	172,981	22,750	1.00
2.00		0.00	0	0	2.00
	TOTALS		172,981	22,750	
500.00	Grand Total: Increases		468,104	1,096,297	500.00

Provider CCN: 144009

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

Worksheet A-6

Date/Time Prepared:
5/15/2012 10:58 am

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7	Ref.	
6.00	7.00	8.00	9.00	10.00		
A - RENT LEASE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	16,045	10	1.00
2.00	OPERATION OF PLANT	7.00	0	16,850	10	2.00
3.00	DIETARY	10.00	0	188	10	3.00
4.00	NURSING ADMINISTRATION	13.00	0	3,052	10	4.00
	TOTALS		0	36,135		
B - PHYSICIAN FEES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	995,939	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		0	995,939		
C - COMMUNITY RELATIONS						
1.00	ADMINISTRATIVE & GENERAL	5.00	295,123	41,473	0	1.00
	TOTALS		295,123	41,473		
D - EDUCATION						
1.00	ADULTS & PEDIATRICS	30.00	114,842	6,106	0	1.00
2.00	SUBPROVIDER - IPF	40.00	58,139	16,644	0	2.00
	TOTALS		172,981	22,750		
500.00	Grand Total: Decreases		468,104	1,096,297		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144009

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/15/2012 10:58 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	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	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	3,597,655	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	1,283,211	0	0	0	6.00
7.00	HIT designated Assets	15,775	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	4,896,641	0	0	0	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	4,896,641	0	0	0	10.00
SUMMARY OF CAPITAL						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	525,089	0	0	36,980	480,000
2.00	CAP REL COSTS-MVBLE EQUIP	-53,758	0	7,298	7,022	0
3.00	Total (sum of lines 1-2)	471,331	0	7,298	44,002	480,000
COMPUTATION OF RATIOS						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144009

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/15/2012 10:58 am

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0		1.00	
2.00	Land Improvements	0	0		2.00	
3.00	Buildings and Fixtures	3,597,655	0		3.00	
4.00	Building Improvements	0	0		4.00	
5.00	Fixed Equipment	0	0		5.00	
6.00	Movable Equipment	1,283,211	0		6.00	
7.00	HIT designated Assets	15,775	0		7.00	
8.00	Subtotal (sum of lines 1-7)	4,896,641	0		8.00	
9.00	Reconciling Items	0	0		9.00	
10.00	Total (line 8 minus line 9)	4,896,641	0		10.00	
SUMMARY OF CAPITAL						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,042,069		1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	-39,438		2.00	
3.00	Total (sum of lines 1-2)	0	1,002,631		3.00	
ALLOCATION OF OTHER CAPITAL						
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,916,156	0
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	256,740	36,135
3.00	Total (sum of lines 1-2)	0	0	0	3,172,896	36,135

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 144009

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/15/2012 10:58 am

Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	36,980	480,000	0	3,433,136	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,298	7,022	0	0	307,195	2.00
3.00	Total (sum of lines 1-2)	7,298	44,002	480,000	0	3,740,331	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 144009

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

Worksheet A-8

Date/Time Prepared:
5/15/2012 10:58 am

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted	
				Cost Center	Line #
		1.00	2.00	3.00	4.00
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00 2.00
3.00	Investment income - other (chapter 2)		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)	B	-44,608	ADMINISTRATIVE & GENERAL	5.00 5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00 6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00 7.00
8.00	Television and radio service (chapter 21)		0		0.00 8.00
9.00	Parking lot (chapter 21)		0		0.00 9.00
10.00	Provider-based physician adjustment	A-8-2	-817,677		10.00 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	-5,414,339		12.00 12.00
13.00	Laundry and linen service		0		0.00 13.00
14.00	Cafeteria-employees and guests	B	-28,026	DIETARY	10.00 14.00
15.00	Rental of quarters to employee and others		0		0.00 15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00 16.00
17.00	Sale of drugs to other than patients		0		0.00 17.00
18.00	Sale of medical records and abstracts	B	-2,218	MEDICAL RECORDS & LIBRARY	16.00 18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00 19.00
20.00	Vending machines	B	-1,249	DIETARY	10.00 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 - CAP REL COSTS-BLDG & FIXT	A	156,578	CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	310,498	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	ADMIN NON ALLOWABLE MISC	A	-536	ADMINISTRATIVE & GENERAL	5.00 33.00
33.01	MISC ADMIN REVENUE	B	-18,636	ADMINISTRATIVE & GENERAL	5.00 33.01
33.02	LOBBYING	A	-5,185	ADMINISTRATIVE & GENERAL	5.00 33.02
33.03	DONATIONS	A	-21,097	ADMINISTRATIVE & GENERAL	5.00 33.03
33.04	BAD DEBT	A	-213,463	ADMINISTRATIVE & GENERAL	5.00 33.04
33.05	MARKETING	A	-36,244	ADMINISTRATIVE & GENERAL	5.00 33.05
33.06	PATIENT TRANSPORTATION	A	-98,914	ADMINISTRATIVE & GENERAL	5.00 33.06
33.07	REBATES	B	44,608	ADMINISTRATIVE & GENERAL	5.00 33.07
33.08	RELATED PARTY CAPITAL COST	A	2,234,489	CAP REL COSTS-BLDG & FIXT	1.00 33.08
33.09	RELATED PARTY RENT EXP	A	-1,711,525	ADMINISTRATIVE & GENERAL	5.00 33.09
33.10	PHYSICIAN BILLING COST	A	-33,082	ADMINISTRATIVE & GENERAL	5.00 33.10
33.11			0		0.00 33.11
33.12			0		0.00 33.12
33.13			0		0.00 33.13
33.14			0		0.00 33.14
33.15			0		0.00 33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,700,626		50.00 50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 144009

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

Worksheet A-8

Date/Time Prepared:
5/15/2012 10:58 am

Cost Center Description	wkst. A-7 Ref.	
	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00 Investment income - other (chapter 2)	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00 Television and radio service (chapter 21)	0	8.00
9.00 Parking lot (chapter 21)	0	9.00
10.00 Provider-based physician adjustment	0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00 Related organization transactions (chapter 10)	0	12.00
13.00 Laundry and linen service	0	13.00
14.00 Cafeteria-employees and guests	0	14.00
15.00 Rental of quarters to employee and others	0	15.00
16.00 Sale of medical and surgical supplies to other than patients	0	16.00
17.00 Sale of drugs to other than patients	0	17.00
18.00 Sale of medical records and abstracts	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)	0	19.00
20.00 Vending machines	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	9	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 ADMIN NON ALLOWABLE MISC	0	33.00
33.01 MISC ADMIN REVENUE	0	33.01
33.02 LOBBYING	0	33.02
33.03 DONATIONS	0	33.03
33.04 BAD DEBT	0	33.04
33.05 MARKETING	0	33.05
33.06 PATIENT TRANSPORTATION	0	33.06
33.07 REBATES	0	33.07
33.08 RELATED PARTY CAPITAL COST	9	33.08
33.09 RELATED PARTY RENT EXP	0	33.09
33.10 PHYSICIAN BILLING COST	0	33.10
33.11	0	33.11
33.12	0	33.12
33.13	0	33.13
33.14	0	33.14
33.15	0	33.15
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: 144009

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

worksheet A-8-1

Date/Time Prepared:
5/15/2012 10:58 am

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

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

		Symbol (1)	Name	Percentage of Ownership	
		1.00	2.00	3.00	

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

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

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

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

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

Provider CCN: 144009

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

Worksheet A-8-1

Date/Time Prepared:
5/15/2012 10:58 am

		Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
		4.00	5.00	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00		0	6,116,004	-6,116,004	0	1.00
2.00		842,217	562,368	279,849	0	2.00
3.00		49,221	300,091	-250,870	0	3.00
4.00		931,390	258,704	672,686	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.	1,822,828	7,237,167	-5,414,339		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		UNIVERSAL HEALT	100.00	HEALTHCARE	6.00
7.00			0.00		7.00
8.00			0.00		8.00
9.00			0.00		9.00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 144009

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

Worksheet A-8-2
Date/Time Prepared:
5/15/2012 10:58 am

	wkst. A Line #		Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00				
1.00	30.00	ADULTS & PEDIATRICS		935,044	638,918	1.00
2.00	40.00	SUBPROVIDER - IPF		12,600	0	2.00
3.00	90.00	CLINIC		48,295	0	3.00
4.00	0.00			0	0	4.00
5.00	0.00			0	0	5.00
6.00	0.00			0	0	6.00
7.00	0.00			0	0	7.00
8.00	0.00			0	0	8.00
9.00	0.00			0	0	9.00
10.00	0.00			0	0	10.00
200.00				995,939	638,918	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 144009

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

Worksheet A-8-2

Date/Time Prepared:
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	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	296,125	142,500	2,130	145,925	7,296	1.00
2.00	12,600	142,500	100	6,851	343	2.00
3.00	48,295	142,500	372	25,486	1,274	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	357,020		2,602	178,262	8,913	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 144009

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

Worksheet A-8-2

Date/Time Prepared:
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	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	
	12.00	13.00	14.00	15.00	16.00	
1.00	0	0	0	0	145,925	1.00
2.00	0	0	0	0	6,851	2.00
3.00	0	0	0	0	25,486	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	0	0	0	0	178,262	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 144009

Period:
From 01/01/2011
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	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	150,200	789,119	1.00
2.00	5,749	5,749	2.00
3.00	22,809	22,809	3.00
4.00	0	0	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	178,758	817,677	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144009

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col: 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	3,433,136	3,433,136			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	307,195		307,195		2.00
4.00	EMPLOYEE BENEFITS	2,152,343	20,758	1,935	2,175,036	4.00
5.00	ADMINISTRATIVE & GENERAL	4,380,460	576,114	53,715	314,824	5.00
7.00	OPERATION OF PLANT	800,589	203,729	18,995	8,746	7.00
8.00	LAUNDRY & LINEN SERVICE	172,146	39,492	3,682	0	8.00
9.00	HOUSEKEEPING	558,472	42,281	3,942	0	9.00
10.00	DIETARY	797,044	201,212	18,760	49,102	10.00
13.00	NURSING ADMINISTRATION	1,065,498	193,017	17,996	183,353	13.00
16.00	MEDICAL RECORDS & LIBRARY	413,417	37,764	3,521	38,998	16.00
17.00	SOCIAL SERVICE	1,041,326	0	0	168,707	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	6,573,798	1,714,520	159,859	1,131,600	30.00
40.00	SUBPROVIDER - IPF	732,673	165,101	15,394	126,045	40.00
ANCILLARY SERVICE COST CENTERS						
60.00	LABORATORY	182,420	10,342	964	0	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	17,335	0	0	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	1,004,154	29,471	2,748	0	73.00
76.00	RECREATION THERAPY	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	406,272	21,202	1,977	68,406	90.00
91.00	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	24,038,278	3,255,003	303,488	2,089,781	118.00
NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	0	138,370	0	0	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	PATIENT TRANSPORTATION	0	0	0	0	194.01
194.02	COMMUNITY RELATIONS	336,596	24,682	2,301	53,750	194.02
194.03	EDUCATION	195,731	15,081	1,406	31,505	194.03
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	24,570,605	3,433,136	307,195	2,175,036	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144009

Period:
From 01/01/2011
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	5,325,113					5.00
7.00	OPERATION OF PLANT	285,565	1,317,624				7.00
8.00	LAUNDRY & LINEN SERVICE	59,578	19,766	294,664			8.00
9.00	HOUSEKEEPING	167,315	21,162	0	793,172		9.00
10.00	DIETARY	294,988	100,709	0	62,568	1,524,383	10.00
13.00	NURSING ADMINISTRATION	403,936	96,608	0	60,020	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	136,604	18,902	0	11,743	0	16.00
17.00	SOCIAL SERVICE	334,809	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,650,668	858,144	260,382	533,137	1,256,751	30.00
40.00	SUBPROVIDER - IPF	287,544	82,636	34,282	51,339	161,914	40.00
ANCILLARY SERVICE COST CENTERS							
60.00	LABORATORY	53,603	5,176	0	3,216	0	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	4,796	0	0	0	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	286,758	14,751	0	9,164	0	73.00
76.00	RECREATION THERAPY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	137,754	10,612	0	6,593	105,718	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	5,103,918	1,228,466	294,664	737,780	1,524,383	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	38,286	69,256	0	43,027	0	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	PATIENT TRANSPORTATION	0	0	0	0	0	194.01
194.02	COMMUNITY RELATIONS	115,472	12,354	0	7,675	0	194.02
194.03	EDUCATION	67,437	7,548	0	4,690	0	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	5,325,113	1,317,624	294,664	793,172	1,524,383	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144009

Period:
From 01/01/2011
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Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	13.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
13.00 NURSING ADMINISTRATION	2,020,428					13.00
16.00 MEDICAL RECORDS & LIBRARY	0	660,949				16.00
17.00 SOCIAL SERVICE	0	0	1,544,842			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1,673,715	537,889	1,365,110	18,715,573	0	30.00
40.00 SUBPROVIDER - IPF	225,349	17,457	179,732	2,079,466	0	40.00
ANCILLARY SERVICE COST CENTERS						
60.00 LABORATORY	0	14,560	0	270,281	0	60.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	1,410	0	23,541	0	70.00
73.00 DRUGS CHARGED TO PATIENTS	0	46,188	0	1,393,234	0	73.00
76.00 RECREATION THERAPY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	121,364	43,445	0	923,343	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	2,020,428	660,949	1,544,842	23,405,438	0	118.00
NONREIMBURSABLE COST CENTERS						
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	288,939	0	192.00
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 PATIENT TRANSPORTATION	0	0	0	0	0	194.01
194.02 COMMUNITY RELATIONS	0	0	0	552,830	0	194.02
194.03 EDUCATION	0	0	0	323,398	0	194.03
200.00 Cross Foot Adjustments				0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	2,020,428	660,949	1,544,842	24,570,605	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 144009

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

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT		1.00
2.00	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	EMPLOYEE BENEFITS		4.00
5.00	ADMINISTRATIVE & GENERAL		5.00
7.00	OPERATION OF PLANT		7.00
8.00	LAUNDRY & LINEN SERVICE		8.00
9.00	HOUSEKEEPING		9.00
10.00	DIETARY		10.00
13.00	NURSING ADMINISTRATION		13.00
16.00	MEDICAL RECORDS & LIBRARY		16.00
17.00	SOCIAL SERVICE		17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	18,715,573	30.00
40.00	SUBPROVIDER - IPF	2,079,466	40.00
ANCILLARY SERVICE COST CENTERS			
60.00	LABORATORY	270,281	60.00
69.00	ELECTROCARDIOLOGY	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	23,541	70.00
73.00	DRUGS CHARGED TO PATIENTS	1,393,234	73.00
76.00	RECREATION THERAPY	0	76.00
OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	923,343	90.00
91.00	EMERGENCY	0	91.00
OTHER REIMBURSABLE COST CENTERS			
98.00	OTHER REIMBURSABLE COST CENTERS	0	98.00
SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	23,405,438	118.00
NONREIMBURSABLE COST CENTERS			
192.00	PHYSICIANS' PRIVATE OFFICES	288,939	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	194.00
194.01	PATIENT TRANSPORTATION	0	194.01
194.02	COMMUNITY RELATIONS	552,830	194.02
194.03	EDUCATION	323,398	194.03
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	24,570,605	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144009

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	0	20,758	1,935	22,693	4.00
5.00	ADMINISTRATIVE & GENERAL	42,070	576,114	53,715	671,899	5.00
7.00	OPERATION OF PLANT	0	203,729	18,995	222,724	7.00
8.00	LAUNDRY & LINEN SERVICE	0	39,492	3,682	43,174	8.00
9.00	HOUSEKEEPING	0	42,281	3,942	46,223	9.00
10.00	DIETARY	0	201,212	18,760	219,972	10.00
13.00	NURSING ADMINISTRATION	0	193,017	17,996	211,013	13.00
16.00	MEDICAL RECORDS & LIBRARY	0	37,764	3,521	41,285	16.00
17.00	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	1,714,520	159,859	1,874,379	30.00
40.00	SUBPROVIDER - IPF	0	165,101	15,394	180,495	40.00
ANCILLARY SERVICE COST CENTERS						
60.00	LABORATORY	0	10,342	964	11,306	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	0	29,471	2,748	32,219	73.00
76.00	RECREATION THERAPY	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	21,202	1,977	23,179	90.00
91.00	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	42,070	3,255,003	303,488	3,600,561	118.00
NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	0	138,370	0	138,370	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	PATIENT TRANSPORTATION	0	0	0	0	194.01
194.02	COMMUNITY RELATIONS	0	24,682	2,301	26,983	194.02
194.03	EDUCATION	0	15,081	1,406	16,487	194.03
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	42,070	3,433,136	307,195	3,782,401	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144009

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	675,183					5.00
7.00	OPERATION OF PLANT	36,208	259,023				7.00
8.00	LAUNDRY & LINEN SERVICE	7,554	3,886	54,614			8.00
9.00	HOUSEKEEPING	21,215	4,160	0	71,598		9.00
10.00	DIETARY	37,403	19,798	0	5,648	283,333	10.00
13.00	NURSING ADMINISTRATION	51,216	18,992	0	5,418	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	17,320	3,716	0	1,060	0	16.00
17.00	SOCIAL SERVICE	42,452	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	336,081	168,694	48,260	48,126	233,588	30.00
40.00	SUBPROVIDER - IPF	36,459	16,245	6,354	4,634	30,095	40.00
ANCILLARY SERVICE COST CENTERS							
60.00	LABORATORY	6,796	1,018	0	290	0	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	608	0	0	0	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	36,359	2,900	0	827	0	73.00
76.00	RECREATION THERAPY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	17,466	2,086	0	595	19,650	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	647,137	241,495	54,614	66,598	283,333	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	4,854	13,615	0	3,884	0	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	PATIENT TRANSPORTATION	0	0	0	0	0	194.01
194.02	COMMUNITY RELATIONS	14,641	2,429	0	693	0	194.02
194.03	EDUCATION	8,551	1,484	0	423	0	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	675,183	259,023	54,614	71,598	283,333	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144009

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

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Part II
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Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
13.00	NURSING ADMINISTRATION	288,552					13.00
16.00	MEDICAL RECORDS & LIBRARY	0	63,788				16.00
17.00	SOCIAL SERVICE	0	0	44,212			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	239,035	51,911	39,068	3,050,949	0	30.00
40.00	SUBPROVIDER - IPF	32,184	1,685	5,144	314,610	0	40.00
ANCILLARY SERVICE COST CENTERS							
60.00	LABORATORY	0	1,405	0	20,815	0	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	136	0	744	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	0	4,458	0	76,763	0	73.00
76.00	RECREATION THERAPY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	17,333	4,193	0	85,216	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	288,552	63,788	44,212	3,549,097	0	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	160,723	0	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	PATIENT TRANSPORTATION	0	0	0	0	0	194.01
194.02	COMMUNITY RELATIONS	0	0	0	45,307	0	194.02
194.03	EDUCATION	0	0	0	27,274	0	194.03
200.00	Cross Foot Adjustments				0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	288,552	63,788	44,212	3,782,401	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 144009

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

Worksheet B
Part II
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT		1.00
2.00	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	EMPLOYEE BENEFITS		4.00
5.00	ADMINISTRATIVE & GENERAL		5.00
7.00	OPERATION OF PLANT		7.00
8.00	LAUNDRY & LINEN SERVICE		8.00
9.00	HOUSEKEEPING		9.00
10.00	DIETARY		10.00
13.00	NURSING ADMINISTRATION		13.00
16.00	MEDICAL RECORDS & LIBRARY		16.00
17.00	SOCIAL SERVICE		17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	3,050,949	30.00
40.00	SUBPROVIDER - IPF	314,610	40.00
ANCILLARY SERVICE COST CENTERS			
60.00	LABORATORY	20,815	60.00
69.00	ELECTROCARDIOLOGY	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	744	70.00
73.00	DRUGS CHARGED TO PATIENTS	76,763	73.00
76.00	RECREATION THERAPY	0	76.00
OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	85,216	90.00
91.00	EMERGENCY	0	91.00
OTHER REIMBURSABLE COST CENTERS			
98.00	OTHER REIMBURSABLE COST CENTERS	0	98.00
SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,549,097	118.00
NONREIMBURSABLE COST CENTERS			
192.00	PHYSICIANS' PRIVATE OFFICES	160,723	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	194.00
194.01	PATIENT TRANSPORTATION	0	194.01
194.02	COMMUNITY RELATIONS	45,307	194.02
194.03	EDUCATION	27,274	194.03
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	3,782,401	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144009

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

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Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (PHYS SQ FT)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	139,092					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		133,486				2.00
4.00	EMPLOYEE BENEFITS	841	841	11,942,313			4.00
5.00	ADMINISTRATIVE & GENERAL	23,341	23,341	1,728,575	-5,325,113	19,245,492	5.00
7.00	OPERATION OF PLANT	8,254	8,254	48,023	0	1,032,059	7.00
8.00	LAUNDRY & LINEN SERVICE	1,600	1,600	0	0	215,320	8.00
9.00	HOUSEKEEPING	1,713	1,713	0	0	604,695	9.00
10.00	DIETARY	8,152	8,152	269,599	0	1,066,118	10.00
13.00	NURSING ADMINISTRATION	7,820	7,820	1,006,719	0	1,459,864	13.00
16.00	MEDICAL RECORDS & LIBRARY	1,530	1,530	214,124	0	493,700	16.00
17.00	SOCIAL SERVICE	0	0	926,306	0	1,210,033	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	69,463	69,463	6,213,209	0	9,579,777	30.00
40.00	SUBPROVIDER - IPF	6,689	6,689	692,065	0	1,039,213	40.00
ANCILLARY SERVICE COST CENTERS							
60.00	LABORATORY	419	419	0	0	193,726	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	17,335	70.00
73.00	DRUGS CHARGED TO PATIENTS	1,194	1,194	0	0	1,036,373	73.00
76.00	RECREATION THERAPY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	859	859	375,589	0	497,857	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	131,875	131,875	11,474,209	-5,325,113	18,446,070	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	5,606	0	0	0	138,370	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	PATIENT TRANSPORTATION	0	0	0	0	0	194.01
194.02	COMMUNITY RELATIONS	1,000	1,000	295,123	0	417,329	194.02
194.03	EDUCATION	611	611	172,981	0	243,723	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per wkst. B, Part I)	3,433,136	307,195	2,175,036		5,325,113	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	24.682484	2.301327	0.182129		0.276694	203.00
204.00	Cost to be allocated (per wkst. B, Part II)			22,693		675,183	204.00
205.00	Unit cost multiplier (wkst. B, Part II)			0.001900		0.035083	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 144009

Period:
From 01/01/2011
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Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (NURSING MANHOURS)	
	7.00	8.00	9.00	10.00	13.00	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
7.00	OPERATION OF PLANT	106,656				7.00
8.00	LAUNDRY & LINEN SERVICE	1,600	41,283			8.00
9.00	HOUSEKEEPING	1,713	0	103,343		9.00
10.00	DIETARY	8,152	0	8,152	135,657	10.00
13.00	NURSING ADMINISTRATION	7,820	0	7,820	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	1,530	0	1,530	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	69,463	36,480	69,463	111,840	30.00
40.00	SUBPROVIDER - IPF	6,689	4,803	6,689	14,409	40.00
ANCILLARY SERVICE COST CENTERS						
60.00	LABORATORY	419	0	419	0	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	1,194	0	1,194	0	73.00
76.00	RECREATION THERAPY	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	859	0	859	9,408	90.00
91.00	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	99,439	41,283	96,126	135,657	118.00
NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	5,606	0	5,606	0	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	PATIENT TRANSPORTATION	0	0	0	0	194.01
194.02	COMMUNITY RELATIONS	1,000	0	1,000	0	194.02
194.03	EDUCATION	611	0	611	0	194.03
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,317,624	294,664	793,172	1,524,383	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	12.353960	7.137660	7.675140	11.237039	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	259,023	54,614	71,598	283,333	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2.428583	1.322917	0.692819	2.088598	205.00

COST ALLOCATION - STATISTICAL BASIS

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Period:
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Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	
		16.00	17.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT			1.00
2.00	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	EMPLOYEE BENEFITS			4.00
5.00	ADMINISTRATIVE & GENERAL			5.00
7.00	OPERATION OF PLANT			7.00
8.00	LAUNDRY & LINEN SERVICE			8.00
9.00	HOUSEKEEPING			9.00
10.00	DIETARY			10.00
13.00	NURSING ADMINISTRATION			13.00
16.00	MEDICAL RECORDS & LIBRARY	58,901,440		16.00
17.00	SOCIAL SERVICE	0	41,283	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	47,934,380	36,480	30.00
40.00	SUBPROVIDER - IPF	1,555,788	4,803	40.00
ANCILLARY SERVICE COST CENTERS				
60.00	LABORATORY	1,297,593	0	60.00
69.00	ELECTROCARDIOLOGY	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	125,664	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	4,116,250	0	73.00
76.00	RECREATION THERAPY	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	3,871,765	0	90.00
91.00	EMERGENCY	0	0	91.00
OTHER REIMBURSABLE COST CENTERS				
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE			113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	58,901,440	41,283	118.00
NONREIMBURSABLE COST CENTERS				
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	PATIENT TRANSPORTATION	0	0	194.01
194.02	COMMUNITY RELATIONS	0	0	194.02
194.03	EDUCATION	0	0	194.03
200.00	Cross Foot Adjustments			200.00
201.00	Negative Cost Centers			201.00
202.00	Cost to be allocated (per wkst. B, Part I)	660,949	1,544,842	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	0.011221	37.420779	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	63,788	44,212	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	0.001083	1.070949	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144009

Period:
From 01/01/2011
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		Title XVIII		Hospital		PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs		
				RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS		18,715,573	150,200	18,865,773	30.00
40.00	SUBPROVIDER - IPF		2,079,466	5,749	2,085,215	40.00
ANCILLARY SERVICE COST CENTERS						
60.00	LABORATORY		270,281	0	270,281	60.00
69.00	ELECTROCARDIOLOGY		0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY		23,541	0	23,541	70.00
73.00	DRUGS CHARGED TO PATIENTS		1,393,234	0	1,393,234	73.00
76.00	RECREATION THERAPY		0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC		923,343	22,809	946,152	90.00
91.00	EMERGENCY		0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
98.00	OTHER REIMBURSABLE COST CENTERS		0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	0	23,405,438	178,758	23,584,196	200.00
201.00	Less Observation Beds	0	0	0	0	201.00
202.00	Total (see instructions)	0	23,405,438	178,758	23,584,196	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144009

Period:
From 01/01/2011
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Cost Center Description	Title XVIII			Hospital	PPS	
	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	47,934,380		47,934,380		30.00
40.00	SUBPROVIDER - IPF	1,555,788		1,555,788		40.00
ANCILLARY SERVICE COST CENTERS						
60.00	LABORATORY	1,297,593	0	1,297,593	0.208294	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
70.00	ELECTROENCEPHALOGRAPHY	125,664	0	125,664	0.187333	70.00
73.00	DRUGS CHARGED TO PATIENTS	4,116,250	0	4,116,250	0.338472	73.00
76.00	RECREATION THERAPY	0	0	0	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	3,871,765	3,871,765	0.238481	90.00
91.00	EMERGENCY	0	0	0	0.000000	91.00
OTHER REIMBURSABLE COST CENTERS						
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	55,029,675	3,871,765	58,901,440		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	55,029,675	3,871,765	58,901,440		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144009

Period:
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
40.00	SUBPROVIDER - IPF				40.00
ANCILLARY SERVICE COST CENTERS					
60.00	LABORATORY	0.208294			60.00
69.00	ELECTROCARDIOLOGY	0.000000			69.00
70.00	ELECTROENCEPHALOGRAPHY	0.187333			70.00
73.00	DRUGS CHARGED TO PATIENTS	0.338472			73.00
76.00	RECREATION THERAPY	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0.244372			90.00
91.00	EMERGENCY	0.000000			91.00
OTHER REIMBURSABLE COST CENTERS					
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000			98.00
SPECIAL PURPOSE COST CENTERS					
113.00	INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144009

Period:
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		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Total 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	18,715,573		18,715,573	0	0	30.00
40.00	SUBPROVIDER - IPF	2,079,466		2,079,466	0	0	40.00
ANCILLARY SERVICE COST CENTERS							
60.00	LABORATORY	270,281		270,281	0	0	60.00
69.00	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	23,541		23,541	0	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	1,393,234		1,393,234	0	0	73.00
76.00	RECREATION THERAPY	0		0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	923,343		923,343	0	0	90.00
91.00	EMERGENCY	0		0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
98.00	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	23,405,438	0	23,405,438	0	0	200.00
201.00	Less Observation Beds	0		0			201.00
202.00	Total (see instructions)	23,405,438	0	23,405,438	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144009

Period:
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Cost Center Description	Title XIX			Hospital	Cost	TEFRA Inpatient Ratio	
	Charges			Cost or Other Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
6.00	7.00	8.00	9.00	10.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	47,934,380		47,934,380			30.00
40.00	SUBPROVIDER - IPF	1,555,788		1,555,788			40.00
ANCILLARY SERVICE COST CENTERS							
60.00	LABORATORY	1,297,593	0	1,297,593	0.208294	0.000000	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	ELECTROENCEPHALOGRAPHY	125,664	0	125,664	0.187333	0.000000	70.00
73.00	DRUGS CHARGED TO PATIENTS	4,116,250	0	4,116,250	0.338472	0.000000	73.00
76.00	RECREATION THERAPY	0	0	0	0.000000	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	0	3,871,765	3,871,765	0.238481	0.000000	90.00
91.00	EMERGENCY	0	0	0	0.000000	0.000000	91.00
OTHER REIMBURSABLE COST CENTERS							
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	55,029,675	3,871,765	58,901,440			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	55,029,675	3,871,765	58,901,440			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 144009

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

Worksheet C
Part I
Date/Time Prepared:
5/15/2012 10:58 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
40.00	SUBPROVIDER - IPF				40.00
ANCILLARY SERVICE COST CENTERS					
60.00	LABORATORY	0.000000			60.00
69.00	ELECTROCARDIOLOGY	0.000000			69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000			70.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	RECREATION THERAPY	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0.000000			90.00
91.00	EMERGENCY	0.000000			91.00
OTHER REIMBURSABLE COST CENTERS					
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000			98.00
SPECIAL PURPOSE COST CENTERS					
113.00	INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

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

Provider CCN: 144009

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

Worksheet C
Part II
Date/Time Prepared:
5/15/2012 10:58 am

Cost Center Description	Title XIX			Hospital Cost		
	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
60.00 LABORATORY	270,281	20,815	249,466	0	0	60.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	23,541	744	22,797	0	0	70.00
73.00 DRUGS CHARGED TO PATIENTS	1,393,234	76,763	1,316,471	0	0	73.00
76.00 RECREATION THERAPY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	923,343	85,216	838,127	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
200.00 Subtotal (sum of lines 50 thru 199)	2,610,399	183,538	2,426,861	0	0	200.00
201.00 Less Observation Beds	0	0	0	0	0	201.00
202.00 Total (line 200 minus line 201)	2,610,399	183,538	2,426,861	0	0	202.00

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

Provider CCN: 144009

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

Worksheet C
Part II
Date/Time Prepared:
5/15/2012 10:58 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital Cost
		6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS					
60.00	LABORATORY	270,281	1,297,593	0.208294	60.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	69.00
70.00	ELECTROENCEPHALOGRAPHY	23,541	125,664	0.187333	70.00
73.00	DRUGS CHARGED TO PATIENTS	1,393,234	4,116,250	0.338472	73.00
76.00	RECREATION THERAPY	0	0	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	923,343	3,871,765	0.238481	90.00
91.00	EMERGENCY	0	0	0.000000	91.00
OTHER REIMBURSABLE COST CENTERS					
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	98.00
SPECIAL PURPOSE COST CENTERS					
113.00	INTEREST EXPENSE				113.00
200.00	Subtotal (sum of lines 50 thru 199)	2,610,399	0		200.00
201.00	Less Observation Beds	0	0		201.00
202.00	Total (line 200 minus line 201)	2,610,399	9,411,272		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 144009

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

Worksheet D
Part I
Date/Time Prepared:
5/15/2012 10:58 am

Cost Center Description	Title XVIII			Hospital	PPS	
	Capital Related Cost (from wkst. 8, 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	3,050,949	0	3,050,949	36,480	83.63 30.00
40.00	SUBPROVIDER - IPF	314,610	0	314,610	4,803	65.50 40.00
200.00	Total (lines 30-199)	3,365,559		3,365,559	41,283	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 144009		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part I Date/Time Prepared: 5/15/2012 10:58 am	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Title XVIII		Hospital PPS	
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	12,542	1,048,887			30.00	
40.00	SUBPROVIDER - IPF	0	0			40.00	
200.00	Total (lines 30-199)	12,542	1,048,887			200.00	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 144009

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

Worksheet D
Part II
Date/Time Prepared:
5/15/2012 10:58 am

Cost Center Description		Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Hospital Inpatient Program Charges	PPS Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
60.00	LABORATORY	20,815	1,297,593	0.016041	290,458	4,659	60.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	744	125,664	0.005921	20,328	120	70.00
73.00	DRUGS CHARGED TO PATIENTS	76,763	4,116,250	0.018649	2,107,591	39,304	73.00
76.00	RECREATION THERAPY	0	0	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	85,216	3,871,765	0.022010	0	0	90.00
91.00	EMERGENCY	0	0	0.000000	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (lines 50-199)	183,538	9,411,272		2,418,377	44,083	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 144009			Period: From 01/01/2011 To 12/31/2011		Worksheet D Part III Date/Time Prepared: 5/15/2012 10:58 am	
Cost Center Description		Title XVIII			Hospital		PPS	
		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	0	30.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00
200.00	Total (lines 30-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 144009		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part III Date/Time Prepared: 5/15/2012 10:58 am	
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)	PPS PSA Adj. Nursing School
			6.00	7.00	8.00	9.00	11.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	36,480	0.00	12,542	0	0	30.00
40.00	SUBPROVIDER - IPF	4,803	0.00	0	0	0	40.00
200.00	Total (lines 30-199)	41,283		12,542	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 144009		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part III Date/Time Prepared: 5/15/2012 10:58 am	
Cost Center Description		PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost	Title XVIII	Hospital	PPS	
INPATIENT ROUTINE SERVICE COST CENTERS		12.00	13.00				
30.00	ADULTS & PEDIATRICS	0	0				30.00
40.00	SUBPROVIDER - IPF	0	0				40.00
200.00	Total (lines 30-199)	0	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144009

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

Worksheet D
Part IV
Date/Time Prepared:
5/15/2012 10:58 am

Cost Center Description	Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS								
60.00	LABORATORY	0	0	0	0	0	0	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00	RECREATION THERAPY	0	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	CLINIC	0	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS								
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	0	98.00
200.00	Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144009

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

Worksheet D
Part IV
Date/Time Prepared:
5/15/2012 10:58 am

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)	Hospital Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
60.00	LABORATORY	0	1,297,593	0.000000	0.000000	290,458	60.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	125,664	0.000000	0.000000	20,328	70.00
73.00	DRUGS CHARGED TO PATIENTS	0	4,116,250	0.000000	0.000000	2,107,591	73.00
76.00	RECREATION THERAPY	0	0	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	0	3,871,765	0.000000	0.000000	0	90.00
91.00	EMERGENCY	0	0	0.000000	0.000000	0	91.00
OTHER REIMBURSABLE COST CENTERS							
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00	Total (lines 50-199)	0	9,411,272			2,418,377	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144009

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

Worksheet D
Part IV
Date/Time Prepared:
5/15/2012 10:58 am

Cost Center Description	Title XVIII			Hospital	PPS	
	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
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 RECREATION THERAPY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 144009	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/15/2012 10:58 am
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Cost Center Description	Title XVIII		Hospital	PPS
	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
69.00 ELECTROCARDIOLOGY	0	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0		70.00
73.00 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00 RECREATION THERAPY	0	0		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00 CLINIC	0	0		90.00
91.00 EMERGENCY	0	0		91.00
OTHER REIMBURSABLE COST CENTERS				
98.00 OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00 Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 144009	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/15/2012 10:58 am		
		Title XVIII	Hospital	PPS		
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see instructions)	Charges			
			Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
	1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS						
60.00	LABORATORY	0.208294	0	0	0	60.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.187333	0	0	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	0.338472	0	0	0	73.00
76.00	RECREATION THERAPY	0.000000	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0.238481	0	0	0	90.00
91.00	EMERGENCY	0.000000	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	98.00
200.00	Subtotal (see instructions)		0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 144009	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/15/2012 10:58 am
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Cost Center Description	Costs			Hospital	PPS
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5:00	6:00	7:00		
ANCILLARY SERVICE COST CENTERS					
60.00 LABORATORY	0	0	0		60.00
69.00 ELECTROCARDIOLOGY	0	0	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00 RECREATION THERAPY	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	0	0	0		90.00
91.00 EMERGENCY	0	0	0		91.00
OTHER REIMBURSABLE COST CENTERS					
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
200.00 Subtotal (see instructions)	0	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 144009 Component CCN:144009		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part II Date/Time Prepared: 5/15/2012 10:58 am	
Title XVIII				Subprovider - IPF			
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	20,815	1,297,593	0.016041	0	0	60.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	744	125,664	0.005921	0	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	76,763	4,116,250	0.018649	0	0	73.00
76.00	RECREATION THERAPY	0	0	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	85,216	3,871,765	0.022010	0	0	90.00
91.00	EMERGENCY	0	0	0.000000	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (lines 50-199)	183,538	9,411,272		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144009
Component CCN: 144009

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

Worksheet D
Part IV
Date/Time Prepared:
5/15/2012 10:58 am

Title XVIII

Subprovider -
IPF

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
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 RECREATION THERAPY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144009
Component CCN: 144009

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

Worksheet D
Part IV
Date/Time Prepared:
5/15/2012 10:58 am

Title XVIII

Subprovider -
IPF

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	1,297,593	0.000000	0.000000	0	60.00
69.00 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	125,664	0.000000	0.000000	0	70.00
73.00 DRUGS CHARGED TO PATIENTS	0	4,116,250	0.000000	0.000000	0	73.00
76.00 RECREATION THERAPY	0	0	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	3,871,765	0.000000	0.000000	0	90.00
91.00 EMERGENCY	0	0	0.000000	0.000000	0	91.00
OTHER REIMBURSABLE COST CENTERS						
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00 Total (lines 50-199)	0	9,411,272			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144009
Component CCN: 144009

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

Worksheet D
Part IV
Date/Time Prepared:
5/15/2012 10:58 am

Title XVIII

Subprovider -
IPF

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
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 RECREATION THERAPY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 144009 Component CCN:144009	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/15/2012 10:58 am
Title XVIII		Subprovider - IPF	

Cost Center Description	PSA Adj.	PSA Adj. All		
	Allied Health	Other Medical Education Cost		
	23.00	24.00		
ANCILLARY SERVICE COST CENTERS				
60.00 LABORATORY	0	0		60.00
69.00 ELECTROCARDIOLOGY	0	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0		70.00
73.00 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00 RECREATION THERAPY	0	0		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00 CLINIC	0	0		90.00
91.00 EMERGENCY	0	0		91.00
OTHER REIMBURSABLE COST CENTERS				
98.00 OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00 Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 144009

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

Worksheet D
Part II
Date/Time Prepared:
5/15/2012 10:58 am

Component CCN:

Title XVIII

Subprovider -
IRF

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	20,815	1,297,593	0.016041	0	0	60.00
69.00 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	744	125,664	0.005921	0	0	70.00
73.00 DRUGS CHARGED TO PATIENTS	76,763	4,116,250	0.018649	0	0	73.00
76.00 RECREATION THERAPY	0	0	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	85,216	3,871,765	0.022010	0	0	90.00
91.00 EMERGENCY	0	0	0.000000	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00 Total (lines 50-199)	183,538	9,411,272		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144009

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

Worksheet D
Part IV
Date/Time Prepared:
5/15/2012 10:58 am

Title XVIII

Subprovider -
IRF

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	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	RECREATION THERAPY	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
200.00	Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144009

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

Worksheet D
Part IV
Date/Time Prepared:
5/15/2012 10:58 am

Component CCN:

Title XVIII

Subprovider -
IRF

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient
	Outpatient Cost (sum of col. 2, 3 and 4)	(from wkst. C, Part I, col. 8)	to Charges (col. 5 ÷ col. 7)	Ratio of Cost to Charges (col. 6 ÷ col. 7)	Program Charges
	6.00	7.00	8.00	9.00	10.00
ANCILLARY SERVICE COST CENTERS					
60.00 LABORATORY	0	1,297,593	0.000000	0.000000	0 60.00
69.00 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0 69.00
70.00 ELECTROENCEPHALOGRAPHY	0	125,664	0.000000	0.000000	0 70.00
73.00 DRUGS CHARGED TO PATIENTS	0	4,116,250	0.000000	0.000000	0 73.00
76.00 RECREATION THERAPY	0	0	0.000000	0.000000	0 76.00
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	0	3,871,765	0.000000	0.000000	0 90.00
91.00 EMERGENCY	0	0	0.000000	0.000000	0 91.00
OTHER REIMBURSABLE COST CENTERS					
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0 98.00
200.00 Total (lines 50-199)	0	9,411,272			0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144009

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

Worksheet D
Part IV
Date/Time Prepared:
5/15/2012 10:58 am

Component CCN:

Title XVIII

Subprovider -
IRF

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
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 RECREATION THERAPY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144009

Period:

Worksheet D

Component CCN:

From 01/01/2011

Part IV

To 12/31/2011

Date/Time Prepared:

5/15/2012 10:58 am

Title XVIII

Subprovider - IRF

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
69.00 ELECTROCARDIOLOGY	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	70.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00 RECREATION THERAPY	0	0	76.00
OUTPATIENT SERVICE COST CENTERS			
90.00 CLINIC	0	0	90.00
91.00 EMERGENCY	0	0	91.00
OTHER REIMBURSABLE COST CENTERS			
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	98.00
200.00 Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 144009

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

Worksheet D
Part I
Date/Time Prepared:
5/15/2012 10:58 am

Cost Center Description	Title XIX			Hospital	Cost	
	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	3,050,949	0	3,050,949	36,480	83.63 30.00
40.00	SUBPROVIDER - IPF	314,610	0	314,610	4,803	65.50 40.00
200.00	Total (lines 30-199)	3,365,559		3,365,559	41,283	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 144009		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part I Date/Time Prepared: 5/15/2012 10:58 am	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Title XIX Hospital		Cost	
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	17,515	1,464,779			30.00	
40.00	SUBPROVIDER - IPF	0	0			40.00	
200.00	Total (lines 30-199)	17,515	1,464,779			200.00	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 144009

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

Worksheet D
Part II
Date/Time Prepared:
5/15/2012 10:58 am

Cost Center Description		Capital Related Cost (from wkst. 8, 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	20,815	1,297,593	0.016041	665,250	10,671	60.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	744	125,664	0.005921	68,376	405	70.00
73.00	DRUGS CHARGED TO PATIENTS	76,763	4,116,250	0.018649	1,250,582	23,322	73.00
76.00	RECREATION THERAPY	0	0	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	85,216	3,871,765	0.022010	0	0	90.00
91.00	EMERGENCY	0	0	0.000000	0	0	91.00
OTHER REIMBURSABLE COST CENTERS							
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (lines 50-199)	183,538	9,411,272		1,984,208	34,398	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 144009		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part III Date/Time Prepared: 5/15/2012 10:58 am	
Cost-Center Description		Title XIX			Hospital		Cost
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 5, 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
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
200.00	Total (Lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 144009		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part III Date/Time Prepared: 5/15/2012 10:58 am	
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	Cost
		6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	36,480	0.00	17,515	0	0	30.00
40.00	SUBPROVIDER - IPF	4,803	0.00	0	0	0	40.00
200.00	Total (lines 30-199)	41,283		17,515	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144009

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

Worksheet D
Part III
Date/Time Prepared:
5/15/2012 10:58 am

Cost Center Description	Title XIX		Hospital	Cost
	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
40.00 SUBPROVIDER - IPF	0	0		40.00
200.00 Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144009

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

Worksheet D
Part IV
Date/Time Prepared:
5/15/2012 10:58 am

Cost Center Description	Title XIX				Hospital	Cost
	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
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 RECREATION THERAPY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144009

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

Worksheet D
Part IV
Date/Time Prepared:
5/15/2012 10:58 am

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	Cost
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
60.00	LABORATORY	0	1,297,593	0.000000	0.000000	665,250	60.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	125,664	0.000000	0.000000	68,376	70.00
73.00	DRUGS CHARGED TO PATIENTS	0	4,116,250	0.000000	0.000000	1,250,582	73.00
76.00	RECREATION THERAPY	0	0	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	0	3,871,765	0.000000	0.000000	0	90.00
91.00	EMERGENCY	0	0	0.000000	0.000000	0	91.00
OTHER REIMBURSABLE COST CENTERS							
98.00	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00	Total (lines 50-199)	0	9,411,272			1,984,208	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144009

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

Worksheet D
Part IV
Date/Time Prepared:
5/15/2012 10:58 am

Cost Center Description	Title XIX			Hospital	Cost	
	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
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 RECREATION THERAPY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
OTHER REIMBURSABLE COST CENTERS						
98.00 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 144009

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

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XIX	Hospital	Cost
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
60.00	LABORATORY	0	0			60.00
69.00	ELECTROCARDIOLOGY	0	0			69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0			70.00
73.00	DRUGS CHARGED TO PATIENTS	0	0			73.00
76.00	RECREATION THERAPY	0	0			76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0			90.00
91.00	EMERGENCY	0	0			91.00
OTHER REIMBURSABLE COST CENTERS						
98.00	OTHER REIMBURSABLE COST CENTERS	0	0			98.00
200.00	Total (lines 50-199)	0	0			200.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 144009	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/15/2012 10:58 am
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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)	36,480	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	36,480	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)	36,480	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	12,542	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)	18,865,773	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)	18,865,773	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed charges)	47,934,380	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	47,934,380	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.393575	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,313.99	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)	18,865,773	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)	517.15	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	6,486,095	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)	6,486,095	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 144009

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

Worksheet D-1

Date/Time Prepared:
5/15/2012 10:58 am

Cost Center Description	Title XVIII			Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	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)					777,670	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					7,263,765	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					1,048,887	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					44,083	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,092,970	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					6,170,795	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: 144009

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

Worksheet D-1

Date/Time Prepared:
5/15/2012 10:58 am

Cost Center Description	Cost	Title XVIII		Hospital	PPS
		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	3,050,949	18,865,773	0.161719	0	0 90.00
91.00 Nursing School cost	0	18,865,773	0.000000	0	0 91.00
92.00 Allied health cost	0	18,865,773	0.000000	0	0 92.00
93.00 All other Medical Education	0	18,865,773	0.000000	0	0 93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 144009

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

Worksheet D-1

Component CCN: 144009

Date/Time Prepared: 5/15/2012 10:58 am

Title XVIII

Subprovider - IPF

Cost Center Description		1.00	
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,803	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,803	2.00
3.00	Private room days (excluding swing-bed and observation bed days)	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,803	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING-BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,079,466	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,079,466	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,555,788	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,555,788	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.336600	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)	323.92	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,079,466	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)	432.95	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	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)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 144009		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1	
		Component CCN: 144009				Date/Time Prepared: 5/15/2012 10:58 am	
				Title XVIII		Subprovider - IPF	
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)						0 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: 144009	Period: From 01/01/2011 To 12/31/2011	worksheet D-1		
		Component CCN:144009		Date/Time Prepared: 5/15/2012 10:58 am		
		Title XVIII	Subprovider - IPF			
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	314,610	2,079,466	0.151294	0	90.00
91.00	Nursing School cost	0	2,079,466	0.000000	0	91.00
92.00	Allied health cost	0	2,079,466	0.000000	0	92.00
93.00	All other Medical Education	0	2,079,466	0.000000	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 144009

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

Worksheet D-1

Component CCN:

Date/Time Prepared:
5/15/2012 10:58 am

Title XVIII

Subprovider -
IRF

Cost Center Description			
		1.00	
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	0	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	0	2.00
3.00	Private room days (excluding swing-bed and observation bed days)	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	0	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	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)	0	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	0	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	0	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	0.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	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)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 144009		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1		
		Component CCN:				Date/Time Prepared: 5/15/2012 10:58 am		
		Title XVIII		Subprovider - IRF				
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)					0	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)						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: 144009

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

Worksheet D-1

Component CCN:

Date/Time Prepared:
5/15/2012 10:58 am

Title XVIII

Subprovider -
IRF

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

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 144009

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

worksheet D-1

Date/Time Prepared:
5/15/2012 10:58 am

		Title XIX	Hospital	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			36,480 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			36,480 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)			36,480 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)			17,515 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)			18,715,573 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)			18,715,573 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			47,934,380 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			47,934,380 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.390442 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			1,313.99 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)			18,715,573 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)			513.04 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			8,985,896 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)			8,985,896 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 144009

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

Worksheet D-1

Date/Time Prepared:
5/15/2012 10:58 am

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	Cost
		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							
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					574,664	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					9,560,560	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: 144009	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/15/2012 10:58 am
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Cost Center Description	Cost	Title XIX		Hospital	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: 144009

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

Worksheet D-3

Date/Time Prepared:
5/15/2012 10:58 am

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		16,492,730		30.00
40.00	SUBPROVIDER - IPF		0		40.00
ANCILLARY SERVICE COST CENTERS					
60.00	LABORATORY	0.208294	290,458	60,501	60.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.187333	20,328	3,808	70.00
73.00	DRUGS CHARGED TO PATIENTS	0.338472	2,107,591	713,361	73.00
76.00	RECREATION THERAPY	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0.244372	0	0	90.00
91.00	EMERGENCY	0.000000	0	0	91.00
OTHER REIMBURSABLE COST CENTERS					
98.00	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50-94 and 96-98)		2,418,377	777,670	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)		2,418,377		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 144009

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

Worksheet D-3

Date/Time Prepared:
5/15/2012 10:58 am

Cost Center Description	Title XIX		Hospital		Cost
	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		22,563,966			30.00
40.00 SUBPROVIDER - IPF		0			40.00
ANCILLARY SERVICE COST CENTERS					
60.00 LABORATORY	0.208294	665,250	138,568		60.00
69.00 ELECTROCARDIOLOGY	0.000000	0	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0.187333	68,376	12,809		70.00
73.00 DRUGS CHARGED TO PATIENTS	0.338472	1,250,582	423,287		73.00
76.00 RECREATION THERAPY	0.000000	0	0		76.00
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	0.238481	0	0		90.00
91.00 EMERGENCY	0.000000	0	0		91.00
OTHER REIMBURSABLE COST CENTERS					
98.00 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0		98.00
200.00 Total (sum of lines 50-94 and 96-98)		1,984,208	574,664		200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0		201.00
202.00 Net Charges (line 200 minus line 201)		1,984,208			202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 144009

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

Worksheet E
Part A
Date/Time Prepared:
5/15/2012 10:58 am

		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments			0 1.00
2.00	Outlier payments for discharges. (see instructions)			0 2.00
3.00	Managed Care Simulated Payments			0 3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			196.00 4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			0.00 5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00 6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00 7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00 7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.			0.00 8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00 8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)			0.00 8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			0.00 9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			0.00 10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00 11.00
12.00	Current year allowable FTE (see instructions)			0.00 12.00
13.00	Total allowable FTE count for the prior year.			0.00 13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			0.00 14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00 15.00
16.00	Adjustment for residents in initial years of the program			0.00 16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00 17.00
18.00	Adjusted rolling average FTE count			0.00 18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000 19.00
20.00	Prior year resident to bed ratio (see instructions)			0.000000 20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000 21.00
22.00	IME payment adjustment (see instructions)			0 22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 sec. 412.105 (f)(1)(iv)(C).			0.00 23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00 24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			0.00 25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000 26.00
27.00	IME payments adjustment. (see instructions)			0.000000 27.00
28.00	IME Adjustment (see instructions)			0 28.00
29.00	Total IME payment (sum of lines 22 and 28)			0 29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			0.00 30.00
31.00	Percentage of Medicaid patient days to total days reported on worksheet S-2, Part I, line 24. (see instructions)			0.00 31.00
32.00	Sum of lines 30 and 31			0.00 32.00
33.00	Allowable disproportionate share percentage (see instructions)			0.00 33.00
34.00	Disproportionate share adjustment (see instructions)			0 34.00
Additional payment for high percentage of ESRD beneficiary discharges				
40.00	Total Medicare discharges on worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)			0 40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0 41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)			0.00 42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0 43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)			0.000000 44.00
45.00	Average weekly cost for dialysis treatments (see instructions)			0.00 45.00
46.00	Total additional payment (line 45 times line 44 times line 41)			0 46.00
47.00	Subtotal (see instructions)			0 47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)			0 48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)			0 49.00
50.00	Payment for inpatient program capital (from worksheet L, Parts I, II, as applicable)			0 50.00
51.00	Exception payment for inpatient program capital (worksheet L, Part III, see instructions)			0 51.00
52.00	Direct graduate medical education payment (from worksheet E-4, line 49 see instructions).			0 52.00
53.00	Nursing and Allied Health Managed Care payment			0 53.00
54.00	Special add-on payments for new technologies			0 54.00
55.00	Net organ acquisition cost (worksheet D-4 Part III, col. 1, line 69)			0 55.00
56.00	Cost of teaching physicians (worksheet D-5, Part II, col. 3, line 20)			0 56.00
57.00	Routine service other pass through costs			0 57.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 144009	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part A Date/Time Prepared: 5/15/2012 10:58 am
	Title XVIII	Hospital	PPS

		1.00	
58.00	Ancillary service other pass through costs worksheet D, Part IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	0	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	0	61.00
62.00	Deductibles billed to program beneficiaries	0	62.00
63.00	Coinsurance billed to program beneficiaries	0	63.00
64.00	Allowable bad debts (see instructions)	0	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	0	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	0	67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)	0	68.00
69.00	Outlier payments reconciliation	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.95	Recovery of Accelerated Depreciation	0	70.95
70.96	Low Volume Payment-1	0	70.96
70.97	Low Volume Payment-2	0	70.97
70.98	Low Volume Payment-3	0	70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)	0	71.00
72.00	Interim payments	8,442,173	72.00
73.00	Tentative settlement (for contractor use only)	0	73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)	-8,442,173	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	75.00
TO BE COMPLETED BY CONTRACTOR			
90.00	Operating outlier amount from worksheet E, Part A line 2	0	90.00
91.00	Capital outlier from worksheet L, Part I, line 2	0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)	0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)	0	93.00
94.00	The rate used to calculate the Time Value of Money	0.00	94.00
95.00	Time Value of Money for operating expenses(see instructions)	0	95.00
96.00	Time Value of Money for capital related expenses (see instructions)	0	96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 144009	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/15/2012 10:58 am
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		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 charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			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: 144009	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/15/2012 10:58 am	
	Title XVIII	Hospital	PPS	
WORKSHEET OVERRIDE VALUES			Overrides	
			1.00	
112.00	override of Ancillary service charges (line 12)		0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 144009

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

Worksheet E-1
Part I
Date/Time Prepared:
5/15/2012 10:58 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1:00	2:00	3:00	4:00		
1.00	Total interim payments paid to provider		8,422,213		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	08/29/2011	19,960		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)		19,960		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)		8,442,173		0	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		27,683		0	6.02	
7.00	Total Medicare program liability (see instructions)		8,414,490		0	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1:00	2:00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 144009	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part II Date/Time Prepared: 5/15/2012 10:58 am
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	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)		9,329,395 1.00
2.00	Net IPF PPS Outlier Payments		1,495 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)		99.945205 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)		9,330,890 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)		9,330,890 16.00
17.00	Primary payer payments		3,941 17.00
18.00	Subtotal (line 16 less line 17).		9,326,949 18.00
19.00	Deductibles		532,756 19.00
20.00	Subtotal (line 18 minus line 19)		8,794,193 20.00
21.00	Coinsurance		451,834 21.00
22.00	Subtotal (line 20 minus line 21)		8,342,359 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		103,044 23.00
24.00	Adjusted reimbursable bad debts (see instructions)		72,131 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		8,928 25.00
26.00	Subtotal (sum of lines 22 and 24)		8,414,490 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)		8,414,490 31.00
32.00	Interim payments		8,442,173 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)		-27,683 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		96,245 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: 144009	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part II Date/Time Prepared: 5/15/2012 10:58 am
		Component CCN:144009		
		Title XVIII	Subprovider - IPF	
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			1.00
2.00	Net IPF PPS Outlier Payments			2.00
3.00	Net IPF PPS ECT Payments			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)	13.158904		9.00
10.00	Medical Education Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$.	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)	0		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)	0		16.00
17.00	Primary payer payments	0		17.00
18.00	Subtotal (line 16 less line 17).	0		18.00
19.00	Deductibles	0		19.00
20.00	Subtotal (line 18 minus line 19)	0		20.00
21.00	Coinsurance	0		21.00
22.00	Subtotal (line 20 minus line 21)	0		22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0		23.00
24.00	Adjusted reimbursable bad debts (see instructions)	0		24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		25.00
26.00	Subtotal (sum of lines 22 and 24)	0		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)	0		31.00
32.00	Interim payments	0		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)	0		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			50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			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)			53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 144009	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part VII Date/Time Prepared: 5/15/2012 10:58 am
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	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	9,560,560	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)	9,560,560	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)	9,560,560	7.00
COMPUTATION OF LESSER OF COST OR CHARGES			
Reasonable Charges			
8.00	Routine service charges	22,563,966	8.00
9.00	Ancillary service charges	1,984,208	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)	24,548,174	12.00
CUSTOMARY CHARGES			
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)	24,548,174	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	14,987,614	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	18.00
19.00	Interns and Residents (see instructions)	0	19.00
20.00	Cost of Teaching Physicians (see instructions)	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	9,560,560	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.	9,560,560	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	9,560,560	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)	9,560,560	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	37.00
38.00	Subtotal (line 36 ± line 37)	9,560,560	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)	9,560,560	40.00
41.00	Interim payments	13,956,544	41.00
42.00	Balance due provider/program (line 40 minus 41)	-4,395,984	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 144009	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part VII Date/Time Prepared: 5/15/2012 10:58 am
		Component CCN:144009		
		Title XIX	Subprovider - IPF	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		0	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)		0	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)		0	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)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		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)		0	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 144009	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part VII Date/Time Prepared: 5/15/2012 10:58 am
		Component CCN:	Title XIX	Subprovider - IRF

			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		0	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)		0	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)		0	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)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		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)		0	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: 144009

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

Worksheet G

Date/Time Prepared:
5/15/2012 10:58 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-164,547	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	8,754,158	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	162,429	0	0	0	7.00
8.00	Prepaid expenses	12,469	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	8,764,509	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	3,597,655	0	0	0	15.00
16.00	Accumulated depreciation	-325,620	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	1,283,211	0	0	0	23.00
24.00	Accumulated depreciation	-245,632	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)	4,309,614	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	53,645,321	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	53,645,321	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	66,719,444	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	336,182	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,108,165	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	59,187,758	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	3,860,866	0	0	0	43.00
44.00	Other current liabilities	57,307	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	64,550,278	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 liabilities (sum of lines 45 and 50)	64,550,278	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	2,169,166	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	2,169,166	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	66,719,444	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 144009

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

Worksheet G-1

Date/Time Prepared:
5/15/2012 10:58 am

	General Fund		Special Purpose Fund		
	1.00	2.00	3.00	4.00	
1.00 Fund balances at beginning of period		40,605,725		0	1.00
2.00 Net income (loss) (from wkst. G-3, line 29)		2,149,752			2.00
3.00 Total (sum of line 1 and line 2)		42,755,477		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)		42,755,477		0	11.00
12.00 ACQUISITION ENTRIES	40,586,314		0		12.00
13.00	0		0		13.00
14.00	0		0		14.00
15.00	0		0		15.00
16.00	0		0		16.00
17.00	0		0		17.00
18.00 Total deductions (sum of lines 12-17)		40,586,314		0	18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		2,169,163		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 144009

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

Worksheet G-1

Date/Time Prepared:
5/15/2012 10:58 am

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 144009

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

Worksheet G-2 Parts

Date/Time Prepared:
5/15/2012 10:58 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	47,934,380		47,934,380	1.00
2.00	SUBPROVIDER - IPF	1,555,788		1,555,788	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)	49,490,168		49,490,168	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)	49,490,168		49,490,168	17.00
18.00	Ancillary services	5,539,507	0	5,539,507	18.00
19.00	Outpatient services	0	3,871,765	3,871,765	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)	55,029,675	3,871,765	58,901,440	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		30,271,231		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	PHYSICIAN REVENUE	1,364,200			37.00
38.00	EDUCATION REVENUE	165,672			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)		1,529,872		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		28,741,359		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 144009

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

Worksheet G-3

Date/Time Prepared:
5/15/2012 10:58 am

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	58,901,440	1.00
2.00	Less contractual allowances and discounts on patients' accounts	28,088,922	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,812,518	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	28,741,359	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,071,159	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	78,593	24.00
25.00	Total other income (sum of lines 6-24)	78,593	25.00
26.00	Total (line 5 plus line 25)	2,149,752	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)	2,149,752	29.00