

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: 151305	Period: From 10/01/2010 To 09/30/2011	Worksheet S Parts I-III Date/Time Prepared: 2/28/2012 2:06 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input type="checkbox"/> Electronically filed cost report	Date: 2/28/2012 Time: 2:06 pm	
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PULASKI MEMORIAL HOSPITAL for the cost reporting period beginning 10/01/2010 and ending 09/30/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	238,881	-10,096	0	344,916	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	27,006	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	265,887	-10,096	0	344,916	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: 151305			Period: From 10/01/2010 To 09/30/2011		Worksheet S-2 Part I Date/Time Prepared: 2/28/2012 1:55 pm				
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 616 EAST 13TH			PO Box:						1.00	
2.00	City: WINAMAC			State: IN		Zip Code: 46996-		County: PULASKI		2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
				1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00
								V	XVIII	XIX	
3.00	Hospital and Hospital-Based Component Identification:										
3.00	Hospital		PULASKI MEMORIAL HOSPITAL	151305	00015	1	10/01/2000	N	O	O	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF		PULASKI MEMORIAL HOSPITAL	15Z305	00015		10/01/2000	N	O	P	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		PULASKI MEMORIAL HOSPITAL	157078	00015		10/14/1982	N	P	N	12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice		PULASKI MEMORIAL HOSPICE	151550	00015		09/01/1997				14.00
15.00	Hospital-Based Health Clinic - RHC							N	N	N	15.00
16.00	Hospital-Based Health Clinic - FQHC							N	N	N	16.00
17.00	Hospital-Based (CMHC) 1										17.00
17.10	Hospital-Based (CORF) 1							N	N	N	17.10
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2010	09/30/2011		20.00	
21.00	Type of Control (see instructions)						2		21.00		
Inpatient PPS Information											
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N		N		22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.						2		N		23.00
		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0		24.00		
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.	0	0	0	0	0	0		25.00		
							1.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.								2	26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period? Enter (1) for urban or (2) for rural.								2	27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.								0	35.00	

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		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.					58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00				62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
64.00	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. 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		64.00
		Program Name 1.00	Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00

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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	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		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
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)						0	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)						0	76.00
						1.00		
80.00	Long Term Care Hospital PPS Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.						N	80.00

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			1.00			
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	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	97.00	
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N		106.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00	
			Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	Y	N
			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.		250,000	5,000,000	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.		Y		121.00	
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00	
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	

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			1.00			2.00		
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)			N				140.00
			1.00	2.00		3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.								
141.00	Name:		Contractor's Name:		Contractor's Number:			141.00
142.00	Street:		PO Box:					142.00
143.00	City:		State:		Zip Code:			143.00
							1.00	
144.00	Are provider based physicians' costs included in Worksheet A?					Y		144.00
145.00	If costs for renal services are claimed on Worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.					N		145.00
							1.00	2.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.			N				146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N				147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N				148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N				149.00
					Part A		Part B	
					1.00		2.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital			N		N		155.00
156.00	Subprovider - IPF			N		N		156.00
157.00	Subprovider - IRF			N		N		157.00
158.00	Subprovider - Other			N		N		158.00
159.00	SNF			N		N		159.00
160.00	HHA			N		N		160.00
161.00	CMHC					N		161.00
							1.00	
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N		165.00
			Name		County		State	
			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)							0
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151305	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part II Date/Time Prepared: 2/28/2012 1:55 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	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	01/12/2012		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.	0	1.00 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 relieved 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.		Y		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?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00

		Part B		
		Y/N	Date	
PS&R Data		3.00	4.00	
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	01/12/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
2/28/2012 1:55 pm

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	25	9,125	19,752.00		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)		25	9,125	19,752.00		7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00					13.00
14.00 Total (see instructions)		25	9,125	19,752.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0			17.00
18.00 SUBPROVIDER	42.00	0	0			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	101.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10					25.10
26.00 RURAL HEALTH CLINIC	88.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00					26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days						28.00
28.02 SUBPROVIDER - IRF	41.00					28.02
28.03 SUBPROVIDER	42.00					28.03
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: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
2/28/2012 1:55 pm

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	823	212	1,502		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	481	0	481		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	95		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,304	212	2,078		7.00
8.00 INTENSIVE CARE UNIT	0	0	0	0		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	0		127	197		13.00
14.00 Total (see instructions)	0	1,304	339	2,275		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0		17.00
18.00 SUBPROVIDER	0	0	0	0		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	0	2,320	0	4,404		22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE		1,454	0	1,454		24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0		25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0		26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	284		28.00
28.02 SUBPROVIDER - IRF	0	0	0	0		28.02
28.03 SUBPROVIDER	0	0	0	0		28.03
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: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
2/28/2012 1:55 pm

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	263	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	168.15	0.00	0	263	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0.00	0.00	0	0	17.00
18.00 SUBPROVIDER	0.00	0.00	0.00	0	0	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	0.00	0.00	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00	0.00	0.00			24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00	0.00	0.00			25.10
26.00 RURAL HEALTH CLINIC	0.00	0.00	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00 Total (sum of lines 14-26)	0.00	168.15	0.00			27.00
28.00 Observation Bed Days						28.00
28.02 SUBPROVIDER - IRF						28.02
28.03 SUBPROVIDER						28.03
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: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
2/28/2012 1:55 pm

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	91	601		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)	91	601		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF	0	0		17.00
18.00 SUBPROVIDER	0	0		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
25.10 CMHC - CORF				25.10
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
28.02 SUBPROVIDER - IRF				28.02
28.03 SUBPROVIDER				28.03
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

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 151305 Component CCN: 157078		Period: From 10/01/2010 To 09/30/2011		Worksheet S-4 Date/Time Prepared: 2/28/2012 1:55 pm	
				Home Health Agency I		PPS	
				1.00			
0.00	County					0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	
2.00	Unduplicated Census Count (see instructions)	0.00	143.00	0.00	0.00	0.00	
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	0.00		0.00	0.00	0.00	
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	
5.00	Other Administrative Personnel			0.00	0.00	0.00	
6.00	Direct Nursing Service			0.00	0.00	0.00	
7.00	Nursing Supervisor			0.00	0.00	0.00	
8.00	Physical Therapy Service			0.00	0.00	0.00	
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	
10.00	Occupational Therapy Service			0.00	0.00	0.00	
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	
12.00	Speech Pathology Service			0.00	0.00	0.00	
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	
14.00	Medical Social Service			0.00	0.00	0.00	
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	
16.00	Home Health Aide			0.00	0.00	0.00	
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	
18.00	Other (specify)			0.00	0.00	0.00	
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99915			
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	1,090	22	96	20	1,228	
22.00	Skilled Nursing Visit Charges	186,398	3,719	16,410	3,426	209,953	
23.00	Physical Therapy Visits	425	0	5	16	446	
24.00	Physical Therapy Visit Charges	79,370	0	934	2,990	83,294	
25.00	Occupational Therapy Visits	167	0	0	1	168	
26.00	Occupational Therapy Visit Charges	31,149	0	0	187	31,336	
27.00	Speech Pathology Visits	15	0	0	0	15	
28.00	Speech Pathology Visit Charges	2,803	0	0	0	2,803	
29.00	Medical Social Service Visits	0	0	0	0	0	
30.00	Medical Social Service Visit Charges	0	0	0	0	0	
31.00	Home Health Aide Visits	442	19	2	0	463	
32.00	Home Health Aide Visit Charges	34,882	1,486	158	0	36,526	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,139	41	103	37	2,320	
34.00	Other Charges	0	0	0	0	0	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	334,602	5,205	17,502	6,603	363,912	
36.00	Total Number of Episodes (standard/non outlier)	151		43	5	199	
37.00	Total Number of Outlier Episodes		1		0	1	
38.00	Total Non-Routine Medical Supply Charges	19,257	1,297	2,522	476	23,552	

HOSPITAL IDENTIFICATION DATA		Provider CCN: 151305		Period:		Worksheet S-9	
		Component CCN: 151550		From 10/01/2010 To 09/30/2011		Parts I & II Date/Time Prepared: 2/28/2012 1:55 pm	
		Unduplicated Days				Hospice I	
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	
		1.00	2.00	3.00	4.00	5.00	
PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	
2.00	Routine Home Care	618	61	114	117	87	
3.00	Inpatient Respite Care	0	0	0	0	0	
4.00	General Inpatient Care	0	0	0	0	0	
5.00	Total Hospice Days	618	61	114	117	87	
Part II - CENSUS DATA							
6.00	Number of Patients Receiving Hospice Care	0	0	0	0	0	
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00		7.00	
8.00	Average Length of Stay (line 5/line 6)	0.00	0.00	0.00	0.00	0.00	
9.00	Unduplicated Census Count	0	0	0	0	0	

HOSPITAL IDENTIFICATION DATA		Provider CCN: 151305 Component CCN: 151550	Period: From 10/01/2010 To 09/30/2011	Worksheet S-9 Parts I & II Date/Time Prepared: 2/28/2012 1:55 pm
		Hospice I		

		Unduplicated Days	
		Total (sum of cols. 1, 2 & 5)	
		6.00	
PART I - ENROLLMENT DAYS			
1.00	Continuous Home Care	0	1.00
2.00	Routine Home Care	766	2.00
3.00	Inpatient Respite Care	0	3.00
4.00	General Inpatient Care	0	4.00
5.00	Total Hospice Days	766	5.00
Part II - CENSUS DATA			
6.00	Number of Patients Receiving Hospice Care	0	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare		7.00
8.00	Average Length of Stay (line 5/line 6)	0.00	8.00
9.00	Unduplicated Census Count	0	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151305	Period: From 10/01/2010 To 09/30/2011	Worksheet S-10 Date/Time Prepared: 2/28/2012 1:55 pm
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			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)		0.462857	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
			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)		349,224	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		-349,224	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		-161,641	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		-161,641	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		-161,641	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet A
Date/Time Prepared:
2/28/2012 1:55 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT		1,278,380	1,278,380	28,492	1,306,872	1.00
4.00 EMPLOYEE BENEFITS	0	2,707,099	2,707,099	0	2,707,099	4.00
5.00 ADMINISTRATIVE & GENERAL	1,301,217	966,928	2,268,145	-5,169	2,262,976	5.00
7.00 OPERATION OF PLANT	212,826	330,075	542,901	0	542,901	7.00
8.00 LAUNDRY & LINEN SERVICE	19,195	37,177	56,372	0	56,372	8.00
9.00 HOUSEKEEPING	99,812	56,514	156,326	0	156,326	9.00
10.00 DIETARY	103,659	124,046	227,705	0	227,705	10.00
13.00 NURSING ADMINISTRATION	285,081	15,693	300,774	0	300,774	13.00
14.00 CENTRAL SERVICES & SUPPLY	38,793	30,555	69,348	0	69,348	14.00
15.00 PHARMACY	0	0	0	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	185,275	31,689	216,964	0	216,964	16.00
17.00 SOCIAL SERVICE	47,567	783	48,350	0	48,350	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1,147,131	78,833	1,225,964	0	1,225,964	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	54,343	3,703	58,046	0	58,046	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	352,366	69,040	421,406	0	421,406	50.00
52.00 DELIVERY ROOM & LABOR ROOM	20,416	4,591	25,007	0	25,007	52.00
53.00 ANESTHESIOLOGY	299,852	185,710	485,562	0	485,562	53.00
54.00 RADIOLOGY-DIAGNOSTIC	528,615	665,617	1,194,232	0	1,194,232	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	429,485	572,533	1,002,018	0	1,002,018	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	62,236	62,236	0	62,236	63.00
65.00 RESPIRATORY THERAPY	162,225	27,001	189,226	0	189,226	65.00
66.00 PHYSICAL THERAPY	341,949	10,435	352,384	0	352,384	66.00
67.00 OCCUPATIONAL THERAPY	65,573	260	65,833	0	65,833	67.00
68.00 SPEECH PATHOLOGY	56,211	5,183	61,394	0	61,394	68.00
69.00 ELECTROCARDIOLOGY	47,870	11,370	59,240	0	59,240	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	960,849	960,849	-353,754	607,095	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	353,754	353,754	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	1,081,891	1,081,891	0	1,081,891	73.00
73.01 DRUGS CHARGED TO PATIENTS	0	20,472	20,472	0	20,472	73.01
76.00 ONCOLOGY	93,088	34,996	128,084	0	128,084	76.00
76.01 CARDIAC REHAB	51,924	2,354	54,278	0	54,278	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 EMERGENCY	682,718	620,498	1,303,216	0	1,303,216	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10 CORF	0	0	0	0	0	99.10
101.00 HOME HEALTH AGENCY	371,966	75,480	447,446	0	447,446	101.00
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
116.00 HOSPICE	39,140	37,783	76,923	0	76,923	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	7,038,297	10,109,774	17,148,071	23,323	17,171,394	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01 HOMECARE	155,271	27,024	182,295	0	182,295	190.01
192.00 PHYSICIANS' PRIVATE OFFICES	1,105,608	373,555	1,479,163	0	1,479,163	192.00
194.00 MARKETING	45,102	74,601	119,703	-23,323	96,380	194.00
200.00 TOTAL (SUM OF LINES 118-199)	8,344,278	10,584,954	18,929,232	0	18,929,232	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet A
Date/Time Prepared:
2/28/2012 1:55 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	-17,519	1,289,353	1.00
4.00	EMPLOYEE BENEFITS	-97,280	2,609,819	4.00
5.00	ADMINISTRATIVE & GENERAL	-42,038	2,220,938	5.00
7.00	OPERATION OF PLANT	-278	542,623	7.00
8.00	LAUNDRY & LINEN SERVICE	0	56,372	8.00
9.00	HOUSEKEEPING	0	156,326	9.00
10.00	DIETARY	-32,744	194,961	10.00
13.00	NURSING ADMINISTRATION	0	300,774	13.00
14.00	CENTRAL SERVICES & SUPPLY	-18,551	50,797	14.00
15.00	PHARMACY	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	-5,286	211,678	16.00
17.00	SOCIAL SERVICE	0	48,350	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	1,225,964	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	58,046	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	421,406	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	25,007	52.00
53.00	ANESTHESIOLOGY	-459,401	26,161	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	1,194,232	54.00
57.00	CT SCAN	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	0	1,002,018	60.00
60.01	BLOOD LABORATORY	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	62,236	63.00
65.00	RESPIRATORY THERAPY	0	189,226	65.00
66.00	PHYSICAL THERAPY	0	352,384	66.00
67.00	OCCUPATIONAL THERAPY	0	65,833	67.00
68.00	SPEECH PATHOLOGY	0	61,394	68.00
69.00	ELECTROCARDIOLOGY	-5,263	53,977	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	-403	606,692	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	353,754	72.00
73.00	DRUGS CHARGED TO PATIENTS	-67,683	1,014,208	73.00
73.01	DRUGS CHARGED TO PATIENTS	0	20,472	73.01
76.00	ONCOLOGY	-2,018	126,066	76.00
76.01	CARDIAC REHAB	0	54,278	76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	EMERGENCY	0	1,303,216	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	0	0	95.00
99.10	CORF	0	0	99.10
101.00	HOME HEALTH AGENCY	0	447,446	101.00
SPECIAL PURPOSE COST CENTERS				
109.00	PANCREAS ACQUISITION	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	110.00
111.00	ISLET ACQUISITION	0	0	111.00
113.00	INTEREST EXPENSE	0	0	113.00
116.00	HOSPICE	0	76,923	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-748,464	16,422,930	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	HOMECARE	0	182,295	190.01
192.00	PHYSICIANS' PRIVATE OFFICES	0	1,479,163	192.00
194.00	MARKETING	0	96,380	194.00
200.00	TOTAL (SUM OF LINES 118-199)	-748,464	18,180,768	200.00

RECLASSIFICATIONS

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-6

Date/Time Prepared:
2/28/2012 1:55 pm

		Increases			
Cost Center		Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - PROPERTY INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FI XT	1.00	0	28,492	1.00
	TOTALS		0	28,492	
B - MARKETING					
1.00	ADMINISTRATIVE & GENERAL	5.00	8,863	14,460	1.00
	TOTALS		8,863	14,460	
C - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	353,754	1.00
	TOTALS		0	353,754	
500.00	Grand Total: Increases		8,863	396,706	500.00

RECLASSIFICATIONS

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-6

Date/Time Prepared:
2/28/2012 1:55 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - PROPERTY INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	28,492	12		1.00
	TOTALS		0	28,492			
B - MARKETING							
1.00	MARKETING	194.00	8,863	14,460	0		1.00
	TOTALS		8,863	14,460			
C - IMPLANTABLE DEVICES							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	353,754	0		1.00
	TOTALS		0	353,754			
500.00	Grand Total: Decreases		8,863	396,706			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/28/2012 1:55 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	189,325	0	0	0	1.00
2.00	Land Improvements	281,113	10,975	0	10,975	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	8,530,791	526,211	0	526,211	4.00
5.00	Fixed Equipment	3,620,989	169,448	0	169,448	5.00
6.00	Movable Equipment	7,065,433	453,942	0	453,942	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	19,687,651	1,160,576	0	1,160,576	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	19,687,651	1,160,576	0	1,160,576	10.00
SUMMARY OF CAPITAL						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,240,270	0	38,110	0	1.00
3.00	Total (sum of lines 1-2)	1,240,270	0	38,110	0	3.00
COMPUTATION OF RATIOS						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/28/2012 1:55 pm

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	189,325	0			1.00
2.00	Land Improvements	292,088	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	9,057,002	0			4.00
5.00	Fixed Equipment	3,790,437	0			5.00
6.00	Movable Equipment	7,519,375	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	20,848,227	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	20,848,227	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	NEW CAP REL COSTS-BLDG & FIXT	0	1,278,380			1.00
3.00	Total (sum of lines 1-2)	0	1,278,380			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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,240,270	0 1.00
3.00	Total (sum of lines 1-2)	0	0	0	1,240,270	0 3.00

RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 151305	Period: From 10/01/2010 To 09/30/2011	Worksheet A-7 Parts I-III Date/Time Prepared: 2/28/2012 1:55 pm
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Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	20,591	28,492	0	0	1,289,353	1.00
3.00	Total (sum of lines 1-2)	20,591	28,492	0	0	1,289,353	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8

Date/Time Prepared:
2/28/2012 1:55 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	
		Basis/Code (2)	Amount	Cost Center	Line #
		1.00	2.00	3.00	4.00
1.00	Investment income - buildings and fixtures (chapter 2)			NEW CAP REL COSTS-BLDG & FIXT	1.00
2.00	Investment income - movable equipment (chapter 2)			*** Cost Center Deleted ***	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	A-8-2	-5,263		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		11.00
12.00	Related organization transactions (chapter 10)	A-8-1	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)	A-8-3		ORESPIRATORY THERAPY	65.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY	66.00
25.00	Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***	114.00
26.00	Depreciation - buildings and fixtures			NEW CAP REL COSTS-BLDG & FIXT	1.00
27.00	Depreciation - movable equipment			*** Cost Center Deleted ***	2.00
28.00	Non-physician Anesthetist			*** Cost Center Deleted ***	19.00
29.00	Physicians' assistant				29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY	68.00
32.00	CAH HIT Adjustment for Depreciation and Interest				0.00
33.00	CAFETERIA VENDING - OTHER REV	B	-27,984	DIETARY	10.00
34.00	EMPLOYEE RX PROGRAM -OTHER REV	B	-67,683	DRUGS CHARGED TO PATIENTS	73.00
35.00	MEDICAL RECORDS FEES -OTHER REV	B	-5,286	MEDICAL RECORDS & LIBRARY	16.00
36.00	SALE OF SCRAP -OTHER REV	B	-292	CENTRAL SERVICES & SUPPLY	14.00
37.00	REBATES & REFUNDS - OTHER REV	B	-18,259	CENTRAL SERVICES & SUPPLY	14.00
38.00	BABY PHOTO - OTHER REV	B	-30	ADMINISTRATIVE & GENERAL	5.00
39.00	MED SUPPLY SALES -OTHER REV	B	-403	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
40.00	OTHER SERVICES -OTHER REV	B	-4,103	ADMINISTRATIVE & GENERAL	5.00
41.00	ICG - OTHER REV	B	-8	ADMINISTRATIVE & GENERAL	5.00
43.00	INVEST INC/UNRESTRICTED- INT EXP	A	-17,519	NEW CAP REL COSTS-BLDG & FIXT	1.00
44.00	NONOPERATING - OTHER EXP	A	1,025	ADMINISTRATIVE & GENERAL	5.00
45.00	BANK FEES -OTHER EXP	A	13,741	ADMINISTRATIVE & GENERAL	5.00
45.01	OTHER NONOPERATING REV -OTHER EXP	B	-377	ADMINISTRATIVE & GENERAL	5.00
45.02	TELEVISION	A	-278	OPERATION OF PLANT	7.00
45.03	PHYSICIAN RECRUITMENT- ADMIN	A	-49,497	ADMINISTRATIVE & GENERAL	5.00
45.04	BEREAVEMENT	A	-2,018	ONCOLOGY	76.00
45.05	LOBBYING EXPENSE	A	-2,789	ADMINISTRATIVE & GENERAL	5.00
45.06	DIETARY	A	-4,760	DIETARY	10.00
45.07	CRNA	A	-459,401	ANESTHESIOLOGY	53.00

Provider CCN: 151305

Period:
 From 10/01/2010
 To 09/30/2011

Worksheet A-8
 Date/Time Prepared:
 2/28/2012 1:55 pm

		Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
		Basis/Code (2)	Amount	Cost Center	Line #
		1.00	2.00	3.00	4.00
45.08	CRNA BENEFITS	A	-97,280	EMPLOYEE BENEFITS	4.00 45.08
45.09			0		0.00 45.09
45.10			0		0.00 45.10
45.11			0		0.00 45.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-748,464		50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8
Date/Time Prepared:
2/28/2012 1:55 pm

		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - buildings and fixtures (chapter 2)	0	1.00
2.00	Investment income - movable equipment (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 - buildings and fixtures	0	26.00
27.00	Depreciation - movable equipment	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	CAFETERIA VENDING - OTHER REV	0	33.00
34.00	EMPLOYEE RX PROGRAM -OTHER REV	0	34.00
35.00	MEDICAL RECORDS FEES -OTHER REV	0	35.00
36.00	SALE OF SCRAP -OTHER REV	0	36.00
37.00	REBATES & REFUNDS - OTHER REV	0	37.00
38.00	BABY PHOTO - OTHER REV	0	38.00
39.00	MED SUPPLY SALES -OTHER REV	0	39.00
40.00	OTHER SERVICES -OTHER REV	0	40.00
41.00	ICG - OTHER REV	0	41.00
43.00	INVEST INC/UNRESTRICT- INT EXP	11	43.00
44.00	NONOPERATING - OTHER EXP	0	44.00
45.00	BANK FEES -OTHER EXP	0	45.00
45.01	OTHER NONOPERATING REV -OTHER EXP	0	45.01
45.02	TELEVISION	0	45.02
45.03	PHYSICIAN RECRUITMENT- ADMIN	0	45.03
45.04	BEREAVEMENT	0	45.04
45.05	LOBBYING EXPENSE	0	45.05
45.06	DIETARY	0	45.06
45.07	CRNA	0	45.07
45.08	CRNA BENEFITS	0	45.08
45.09		0	45.09
45.10		0	45.10
45.11		0	45.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8-2

Date/Time Prepared:
2/28/2012 1:55 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	91.00	PHYSICIAN PRO FEES	580,276	0	1.00
2.00	60.00	PHYSICIAN PRO FEES	24,000	0	2.00
3.00	69.00	PHYSICIAN PRO FEES	5,263	5,263	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		TOTAL (lines 1.00 through 199.00)	609,539	5,263	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8-2

Date/Time Prepared:
2/28/2012 1:55 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	580,276	0	0	0	0	1.00
2.00	24,000	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	604,276					200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8-2

Date/Time Prepared:
2/28/2012 1:55 pm

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 16.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	0	0	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8-2

Date/Time Prepared:
2/28/2012 1:55 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	0	1.00
2.00	0	0	2.00
3.00	0	5,263	3.00
4.00	0	0	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	5,263	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151305	Period: From 10/01/2010 To 09/30/2011	Worksheet A-8-3 Part Date/Time Prepared: 2/28/2012 1:55 pm			
			Speech Pathology	Cost			
			1.00				
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)			1	1.00		
2.00	Line 1 multiplied by 15 hours per week			15	2.00		
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)			4	3.00		
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)			0	4.00		
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)			0	5.00		
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)			0	6.00		
7.00	Standard travel expense rate			0.00	7.00		
8.00	Optional travel expense rate per mile			0.00	8.00		
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	46.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	54.80	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	27.40	27.40	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
				1.00			
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)			0	14.00		
15.00	Therapists (column 2, line 9 times column 2, line 10)			2,548	15.00		
16.00	Assistants (column 3, line 9 times column 3, line 10)			0	16.00		
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)			2,548	17.00		
18.00	Aides (column 4, line 9 times column 4, line 10)			0	18.00		
19.00	Trainees (column 5, line 9 times column 5, line 10)			0	19.00		
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)			2,548	20.00		
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)			0.00	21.00		
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)			0	22.00		
23.00	Total salary equivalency (see instructions)			2,548	23.00		
Part III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)			110	24.00		
25.00	Assistants (line 4 times column 3, line 11)			0	25.00		
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)			110	26.00		
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)			0	27.00		
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)			110	28.00		
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)			0	29.00		
30.00	Assistants (column 3, line 10 times column 3, line 12)			0	30.00		
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)			0	31.00		
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)			0	32.00		
33.00	Standard travel allowance and standard travel expense (line 28)			0	33.00		
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)			0	34.00		
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)			0	35.00		
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)			0	36.00		
37.00	Assistants (line 6 times column 3, line 11)			0	37.00		
38.00	Subtotal (sum of lines 36 and 37)			0	38.00		
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)			0	39.00		
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)			0	40.00		
41.00	Assistants (column 3, line 12.01 times column 3, line 10)			0	41.00		
42.00	Subtotal (sum of lines 40 and 41)			0	42.00		
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)			0	43.00		
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)			0	44.00		
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)			0	45.00		

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151305				Period: From 10/01/2010 To 09/30/2011	Worksheet A-8-3 Part Date/Time Prepared: 2/28/2012 1:55 pm
		Speech Pathology				Cost	
						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						0 46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	54.80	0.00	0.00	0.00	0.00	52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0	54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0	55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					2,548	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35)					0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					2,548	63.00
64.00	Total cost of outside supplier services (from your records)					1,268	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					110	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					110	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					0	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet B
Part I
Date/Time Prepared:
2/28/2012 1:55 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
GENERAL SERVICE COST CENTERS							
1.00 NEW CAP REL COSTS-BLDG & FIXT	1,289,353	1,289,353					1.00
4.00 EMPLOYEE BENEFITS	2,609,819	22,084		2,631,903			4.00
5.00 ADMINISTRATIVE & GENERAL	2,220,938	204,898		425,720	2,851,556	2,851,556	5.00
7.00 OPERATION OF PLANT	542,623	128,669		69,630	740,922	137,827	7.00
8.00 LAUNDRY & LINEN SERVICE	56,372	12,542		6,280	75,194	13,988	8.00
9.00 HOUSEKEEPING	156,326	7,813		32,656	196,795	36,608	9.00
10.00 DIETARY	194,961	62,251		33,914	291,126	54,156	10.00
13.00 NURSING ADMINISTRATION	300,774	20,959		93,270	415,003	77,199	13.00
14.00 CENTRAL SERVICES & SUPPLY	50,797	31,875		12,692	95,364	17,740	14.00
15.00 PHARMACY	0	16,146		0	16,146	3,003	15.00
16.00 MEDICAL RECORDS & LIBRARY	211,678	34,126		60,617	306,421	57,001	16.00
17.00 SOCIAL SERVICE	48,350	0		15,563	63,913	11,889	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	1,225,964	155,544		375,308	1,756,816	326,805	30.00
31.00 INTENSIVE CARE UNIT	0	0		0	0	0	31.00
41.00 SUBPROVIDER - IRF	0	0		0	0	0	41.00
42.00 SUBPROVIDER	0	0		0	0	0	42.00
43.00 NURSERY	58,046	3,354		17,779	79,179	14,729	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	421,406	90,376		115,284	627,066	116,647	50.00
52.00 DELIVERY ROOM & LABOR ROOM	25,007	42,251		6,680	73,938	13,754	52.00
53.00 ANESTHESIOLOGY	26,161	2,833		0	28,994	5,393	53.00
54.00 RADIOLOGY-DIAGNOSTIC	1,194,232	74,814		172,947	1,441,993	268,241	54.00
57.00 CT SCAN	0	0		0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0		0	0	0	59.00
60.00 LABORATORY	1,002,018	25,188		140,515	1,167,721	217,221	60.00
60.01 BLOOD LABORATORY	0	0		0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	62,236	875		0	63,111	11,740	63.00
65.00 RESPIRATORY THERAPY	189,226	16,313		53,075	258,614	48,108	65.00
66.00 PHYSICAL THERAPY	352,384	36,855		111,876	501,115	93,218	66.00
67.00 OCCUPATIONAL THERAPY	65,833	0		21,454	87,287	16,237	67.00
68.00 SPEECH PATHOLOGY	61,394	0		18,391	79,785	14,842	68.00
69.00 ELECTROCARDIOLOGY	53,977	0		15,662	69,639	12,954	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	606,692	0		0	606,692	112,857	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	353,754	0		0	353,754	65,806	72.00
73.00 DRUGS CHARGED TO PATIENTS	1,014,208	0		0	1,014,208	188,664	73.00
73.01 DRUGS CHARGED TO PATIENTS	20,472	0		0	20,472	3,808	73.01
76.00 ONCOLOGY	126,066	13,021		30,456	169,543	31,539	76.00
76.01 CARDIAC REHAB	54,278	9,333		16,988	80,599	14,993	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	0	0		0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	0	89.00
91.00 EMERGENCY	1,303,216	111,231		223,366	1,637,813	304,668	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 AMBULANCE SERVICES	0	0		0	0	0	95.00
99.10 CORF	0	0		0	0	0	99.10
101.00 HOME HEALTH AGENCY	447,446	10,917		121,696	580,059	107,903	101.00
SPECIAL PURPOSE COST CENTERS							
109.00 PANCREAS ACQUISITION	0	0		0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0		0	0	0	110.00
111.00 ISLET ACQUISITION	0	0		0	0	0	111.00
113.00 INTEREST EXPENSE	0	0		0	0	0	113.00
116.00 HOSPICE	76,923	3,979		12,805	93,707	17,431	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	16,422,930	1,138,247		2,204,624	15,844,545	2,416,969	118.00
NONREIMBURSABLE COST CENTERS							
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,396		0	9,396	1,748	190.00
190.01 HOMECARE	182,295	2,500		50,800	235,595	43,826	190.01
192.00 PHYSICIANS' PRIVATE OFFICES	1,479,163	139,210		361,723	1,980,096	368,339	192.00
194.00 MARKETING	96,380	0		14,756	111,136	20,674	194.00
200.00 Cross Foot Adjustments	0	0		0	0	0	200.00
201.00 Negative Cost Centers	0	0		0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	18,180,768	1,289,353		2,631,903	18,180,768	2,851,556	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet B
Part I
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Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
	7.00	8.00	9.00	10.00	13.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT	878,749					7.00
8.00 LAUNDRY & LINEN SERVICE	9,858	99,040				8.00
9.00 HOUSEKEEPING	6,141	2,817	242,361			9.00
10.00 DIETARY	48,932	0	15,717	409,931		10.00
13.00 NURSING ADMINISTRATION	16,474	0	5,291	0	513,967	13.00
14.00 CENTRAL SERVICES & SUPPLY	25,056	0	8,048	0	3,777	14.00
15.00 PHARMACY	12,692	0	4,076	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	26,824	0	8,616	0	0	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	130,453	26,980	39,271	409,931	266,564	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	2,637	4,513	847	0	16,104	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	71,040	20,235	22,818	0	75,185	50.00
52.00 DELIVERY ROOM & LABOR ROOM	33,211	0	10,667	0	5,460	52.00
53.00 ANESTHESIOLOGY	2,227	0	715	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	58,807	15,708	18,888	0	0	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	19,799	539	6,359	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	688	0	221	0	0	63.00
65.00 RESPIRATORY THERAPY	12,823	0	4,119	0	0	65.00
66.00 PHYSICAL THERAPY	38,713	8,975	12,434	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
76.00 ONCOLOGY	10,235	67	3,287	0	27,711	76.00
76.01 CARDIAC REHAB	7,337	0	2,356	0	17,795	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 EMERGENCY	87,433	17,236	28,083	0	101,371	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10 CORF	0	0	0	0	0	99.10
101.00 HOME HEALTH AGENCY	8,581	0	2,756	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
116.00 HOSPICE	3,128	0	1,005	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	633,089	97,070	195,574	409,931	513,967	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,386	0	2,372	0	0	190.00
190.01 HOMECARE	1,965	0	631	0	0	190.01
192.00 PHYSICIANS' PRIVATE OFFICES	236,309	1,970	43,784	0	0	192.00
194.00 MARKETING	0	0	0	0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	878,749	99,040	242,361	409,931	513,967	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

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Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
		14.00	15.00	16.00	17.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
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
14.00	CENTRAL SERVICES & SUPPLY	149,985					14.00
15.00	PHARMACY	0	35,917				15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	398,862			16.00
17.00	SOCIAL SERVICE	0	0	0	75,802		17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0	16,094	69,944	3,042,858	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	0	0	1,183	0	119,192	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	34,905	5,002	972,898	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	3,080	0	140,110	52.00
53.00	ANESTHESIOLOGY	0	0	6,524	0	43,853	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	96,375	0	1,900,012	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	67,082	0	1,478,721	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	2,141	0	77,901	63.00
65.00	RESPIRATORY THERAPY	0	0	9,622	0	333,286	65.00
66.00	PHYSICAL THERAPY	0	0	15,387	0	669,842	66.00
67.00	OCCUPATIONAL THERAPY	0	0	2,985	0	106,509	67.00
68.00	SPEECH PATHOLOGY	0	0	1,864	0	96,491	68.00
69.00	ELECTROCARDIOLOGY	0	0	5,956	0	88,549	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	115,402	0	23,356	0	858,307	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	34,583	0	6,999	0	461,142	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	35,486	66,229	0	1,304,587	73.00
73.01	DRUGS CHARGED TO PATIENTS	0	431	804	0	25,515	73.01
76.00	ONCOLOGY	0	0	1,184	0	243,566	76.00
76.01	CARDIAC REHAB	0	0	1,015	0	124,095	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	0	0	36,077	0	2,212,681	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	0	0	0	699,299	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	0	0	0	856	116,127	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	149,985	35,917	398,862	75,802	15,115,541	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	20,902	190.00
190.01	HOMECARE	0	0	0	0	282,017	190.01
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	2,630,498	192.00
194.00	MARKETING	0	0	0	0	131,810	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	149,985	35,917	398,862	75,802	18,180,768	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

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Part I
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT			1.00
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
14.00	CENTRAL SERVICES & SUPPLY			14.00
15.00	PHARMACY			15.00
16.00	MEDICAL RECORDS & LIBRARY			16.00
17.00	SOCIAL SERVICE			17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	3,042,858	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	119,192	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	972,898	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	140,110	52.00
53.00	ANESTHESIOLOGY	0	43,853	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	1,900,012	54.00
57.00	CT SCAN	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	0	1,478,721	60.00
60.01	BLOOD LABORATORY	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	77,901	63.00
65.00	RESPIRATORY THERAPY	0	333,286	65.00
66.00	PHYSICAL THERAPY	0	669,842	66.00
67.00	OCCUPATIONAL THERAPY	0	106,509	67.00
68.00	SPEECH PATHOLOGY	0	96,491	68.00
69.00	ELECTROCARDIOLOGY	0	88,549	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	858,307	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	461,142	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,304,587	73.00
73.01	DRUGS CHARGED TO PATIENTS	0	25,515	73.01
76.00	ONCOLOGY	0	243,566	76.00
76.01	CARDIAC REHAB	0	124,095	76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	EMERGENCY	0	2,212,681	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	0	0	95.00
99.10	CORF	0	0	99.10
101.00	HOME HEALTH AGENCY	0	699,299	101.00
SPECIAL PURPOSE COST CENTERS				
109.00	PANCREAS ACQUISITION	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	110.00
111.00	ISLET ACQUISITION	0	0	111.00
113.00	INTEREST EXPENSE	0	0	113.00
116.00	HOSPICE	0	116,127	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	15,115,541	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	20,902	190.00
190.01	HOMECARE	0	282,017	190.01
192.00	PHYSICIANS' PRIVATE OFFICES	0	2,630,498	192.00
194.00	MARKETING	0	131,810	194.00
200.00	Cross Foot Adjustments	0	0	200.00
201.00	Negative Cost Centers	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	18,180,768	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet B
Part II
Date/Time Prepared:
2/28/2012 1:55 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	EMPLOYEE BENEFITS	0	22,084	22,084	22,084		4.00
5.00	ADMINISTRATIVE & GENERAL	0	204,898	204,898	3,573	208,471	5.00
7.00	OPERATION OF PLANT	0	128,669	128,669	584	10,077	7.00
8.00	LAUNDRY & LINEN SERVICE	0	12,542	12,542	53	1,023	8.00
9.00	HOUSEKEEPING	0	7,813	7,813	274	2,676	9.00
10.00	DIETARY	0	62,251	62,251	285	3,959	10.00
13.00	NURSING ADMINISTRATION	0	20,959	20,959	783	5,644	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	31,875	31,875	106	1,297	14.00
15.00	PHARMACY	0	16,146	16,146	0	220	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	34,126	34,126	509	4,167	16.00
17.00	SOCIAL SERVICE	0	0	0	131	869	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	155,544	155,544	3,149	23,893	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	0	3,354	3,354	149	1,077	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	90,376	90,376	967	8,528	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	42,251	42,251	56	1,006	52.00
53.00	ANESTHESIOLOGY	0	2,833	2,833	0	394	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	74,814	74,814	1,451	19,611	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	25,188	25,188	1,179	15,881	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	875	875	0	858	63.00
65.00	RESPIRATORY THERAPY	0	16,313	16,313	445	3,517	65.00
66.00	PHYSICAL THERAPY	0	36,855	36,855	939	6,815	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	180	1,187	67.00
68.00	SPEECH PATHOLOGY	0	0	0	154	1,085	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	131	947	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	8,251	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,811	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	13,793	73.00
73.01	DRUGS CHARGED TO PATIENTS	0	0	0	0	278	73.01
76.00	ONCOLOGY	0	13,021	13,021	256	2,306	76.00
76.01	CARDIAC REHAB	0	9,333	9,333	143	1,096	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	0	111,231	111,231	1,874	22,274	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	10,917	10,917	1,021	7,889	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	0	3,979	3,979	107	1,274	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,138,247	1,138,247	18,499	176,703	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,396	9,396	0	128	190.00
190.01	HOMECARE	0	2,500	2,500	426	3,204	190.01
192.00	PHYSICIANS' PRIVATE OFFICES	0	139,210	139,210	3,035	26,925	192.00
194.00	MARKETING	0	0	0	124	1,511	194.00
200.00	Cross Foot Adjustments			0			200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,289,353	1,289,353	22,084	208,471	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet B
Part II
Date/Time Prepared:
2/28/2012 1:55 pm

Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
	7.00	8.00	9.00	10.00	13.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT	139,330					7.00
8.00 LAUNDRY & LINEN SERVICE	1,563	15,181				8.00
9.00 HOUSEKEEPING	974	432	12,169			9.00
10.00 DIETARY	7,758	0	789	75,042		10.00
13.00 NURSING ADMINISTRATION	2,612	0	266	0	30,264	13.00
14.00 CENTRAL SERVICES & SUPPLY	3,973	0	404	0	222	14.00
15.00 PHARMACY	2,012	0	205	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	4,253	0	433	0	0	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	20,684	4,134	1,972	75,042	15,696	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	418	692	43	0	948	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	11,264	3,102	1,146	0	4,427	50.00
52.00 DELIVERY ROOM & LABOR ROOM	5,266	0	536	0	322	52.00
53.00 ANESTHESIOLOGY	353	0	36	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	9,324	2,408	948	0	0	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	3,139	83	319	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	109	0	11	0	0	63.00
65.00 RESPIRATORY THERAPY	2,033	0	207	0	0	65.00
66.00 PHYSICAL THERAPY	6,138	1,376	624	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
76.00 ONCOLOGY	1,623	10	165	0	1,632	76.00
76.01 CARDIAC REHAB	1,163	0	118	0	1,048	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 EMERGENCY	13,863	2,642	1,410	0	5,969	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10 CORF	0	0	0	0	0	99.10
101.00 HOME HEALTH AGENCY	1,361	0	138	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
116.00 HOSPICE	496	0	50	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	100,379	14,879	9,820	75,042	30,264	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,171	0	119	0	0	190.00
190.01 HOMECARE	312	0	32	0	0	190.01
192.00 PHYSICIANS' PRIVATE OFFICES	37,468	302	2,198	0	0	192.00
194.00 MARKETING	0	0	0	0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	139,330	15,181	12,169	75,042	30,264	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet B
Part II
Date/Time Prepared:
2/28/2012 1:55 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
		14.00	15.00	16.00	17.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
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
14.00	CENTRAL SERVICES & SUPPLY	37,877					14.00
15.00	PHARMACY	0	18,583				15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	43,488			16.00
17.00	SOCIAL SERVICE	0	0	0	1,000		17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0	1,755	923	302,792	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	0	0	129	0	6,810	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	3,805	66	123,681	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	336	0	49,773	52.00
53.00	ANESTHESIOLOGY	0	0	711	0	4,327	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	10,513	0	119,069	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	7,313	0	53,102	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	233	0	2,086	63.00
65.00	RESPIRATORY THERAPY	0	0	1,049	0	23,564	65.00
66.00	PHYSICAL THERAPY	0	0	1,677	0	54,424	66.00
67.00	OCCUPATIONAL THERAPY	0	0	325	0	1,692	67.00
68.00	SPEECH PATHOLOGY	0	0	203	0	1,442	68.00
69.00	ELECTROCARDIOLOGY	0	0	649	0	1,727	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,144	0	2,546	0	39,941	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	8,733	0	763	0	14,307	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	18,360	7,220	0	39,373	73.00
73.01	DRUGS CHARGED TO PATIENTS	0	223	88	0	589	73.01
76.00	ONCOLOGY	0	0	129	0	19,142	76.00
76.01	CARDIAC REHAB	0	0	111	0	13,012	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	0	0	3,933	0	163,196	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	0	0	0	21,326	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	0	0	0	11	5,917	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	37,877	18,583	43,488	1,000	1,061,292	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	10,814	190.00
190.01	HOMECARE	0	0	0	0	6,474	190.01
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	209,138	192.00
194.00	MARKETING	0	0	0	0	1,635	194.00
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	37,877	18,583	43,488	1,000	1,289,353	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet B
Part II
Date/Time Prepared:
2/28/2012 1:55 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT			1.00
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
14.00	CENTRAL SERVICES & SUPPLY			14.00
15.00	PHARMACY			15.00
16.00	MEDICAL RECORDS & LIBRARY			16.00
17.00	SOCIAL SERVICE			17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	302,792	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	6,810	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	123,681	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	49,773	52.00
53.00	ANESTHESIOLOGY	0	4,327	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	119,069	54.00
57.00	CT SCAN	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	0	53,102	60.00
60.01	BLOOD LABORATORY	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	2,086	63.00
65.00	RESPIRATORY THERAPY	0	23,564	65.00
66.00	PHYSICAL THERAPY	0	54,424	66.00
67.00	OCCUPATIONAL THERAPY	0	1,692	67.00
68.00	SPEECH PATHOLOGY	0	1,442	68.00
69.00	ELECTROCARDIOLOGY	0	1,727	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	39,941	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	14,307	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	39,373	73.00
73.01	DRUGS CHARGED TO PATIENTS	0	589	73.01
76.00	ONCOLOGY	0	19,142	76.00
76.01	CARDIAC REHAB	0	13,012	76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	EMERGENCY	0	163,196	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	0	0	95.00
99.10	CORF	0	0	99.10
101.00	HOME HEALTH AGENCY	0	21,326	101.00
SPECIAL PURPOSE COST CENTERS				
109.00	PANCREAS ACQUISITION	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	110.00
111.00	ISLET ACQUISITION	0	0	111.00
113.00	INTEREST EXPENSE	0	0	113.00
116.00	HOSPICE	0	5,917	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,061,292	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,814	190.00
190.01	HOMECARE	0	6,474	190.01
192.00	PHYSICIANS' PRIVATE OFFICES	0	209,138	192.00
194.00	MARKETING	0	1,635	194.00
200.00	Cross Foot Adjustments	0	0	200.00
201.00	Negative Cost Centers	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,289,353	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet B-1
Date/Time Prepared:
2/28/2012 1:55 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)						
	1.00	4.00					
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	61,888					1.00
4.00	EMPLOYEE BENEFITS	1,060	8,044,426				4.00
5.00	ADMINISTRATIVE & GENERAL	9,835	1,301,217	-2,851,556	15,329,212		5.00
7.00	OPERATION OF PLANT	6,176	212,826	0	740,922	53,660	7.00
8.00	LAUNDRY & LINEN SERVICE	602	19,195	0	75,194	602	8.00
9.00	HOUSEKEEPING	375	99,812	0	196,795	375	9.00
10.00	DIETARY	2,988	103,659	0	291,126	2,988	10.00
13.00	NURSING ADMINISTRATION	1,006	285,081	0	415,003	1,006	13.00
14.00	CENTRAL SERVICES & SUPPLY	1,530	38,793	0	95,364	1,530	14.00
15.00	PHARMACY	775	0	0	16,146	775	15.00
16.00	MEDICAL RECORDS & LIBRARY	1,638	185,275	0	306,421	1,638	16.00
17.00	SOCIAL SERVICE	0	47,567	0	63,913	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	7,466	1,147,131	0	1,756,816	7,966	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	161	54,343	0	79,179	161	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	4,338	352,366	0	627,066	4,338	50.00
52.00	DELIVERY ROOM & LABOR ROOM	2,028	20,416	0	73,938	2,028	52.00
53.00	ANESTHESIOLOGY	136	0	0	28,994	136	53.00
54.00	RADIOLOGY-DIAGNOSTIC	3,591	528,615	0	1,441,993	3,591	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	1,209	429,485	0	1,167,721	1,209	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	42	0	0	63,111	42	63.00
65.00	RESPIRATORY THERAPY	783	162,225	0	258,614	783	65.00
66.00	PHYSICAL THERAPY	1,769	341,949	0	501,115	2,364	66.00
67.00	OCCUPATIONAL THERAPY	0	65,573	0	87,287	0	67.00
68.00	SPEECH PATHOLOGY	0	56,211	0	79,785	0	68.00
69.00	ELECTROCARDIOLOGY	0	47,870	0	69,639	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	606,692	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	353,754	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	1,014,208	0	73.00
73.01	DRUGS CHARGED TO PATIENTS	0	0	0	20,472	0	73.01
76.00	ONCOLOGY	625	93,088	0	169,543	625	76.00
76.01	CARDIAC REHAB	448	51,924	0	80,599	448	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	5,339	682,718	0	1,637,813	5,339	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	524	371,966	0	580,059	524	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	191	39,140	0	93,707	191	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	54,635	6,738,445	-2,851,556	12,992,989	38,659	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	451	0	0	9,396	451	190.00
190.01	HOMECARE	120	155,271	0	235,595	120	190.01
192.00	PHYSICIANS' PRIVATE OFFICES	6,682	1,105,608	0	1,980,096	14,430	192.00
194.00	MARKETING	0	45,102	0	111,136	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,289,353	2,631,903		2,851,556	878,749	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	20.833651	0.327171		0.186021	16.376239	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		22,084		208,471	139,330	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.002745		0.013600	2.596534	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet B-1
Date/Time Prepared:
2/28/2012 1:55 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100%)	
		8.00	9.00	10.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE	111,166					8.00
9.00	HOUSEKEEPING	3,162	46,077				9.00
10.00	DIETARY	0	2,988	5,649			10.00
13.00	NURSING ADMINISTRATION	0	1,006	0	61,374		13.00
14.00	CENTRAL SERVICES & SUPPLY	0	1,530	0	451	2,547,640	14.00
15.00	PHARMACY	0	775	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	1,638	0	0	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	30,283	7,466	5,649	31,831	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	5,066	161	0	1,923	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	22,713	4,338	0	8,978	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	2,028	0	652	0	52.00
53.00	ANESTHESIOLOGY	0	136	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	17,631	3,591	0	0	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	605	1,209	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	42	0	0	0	63.00
65.00	RESPIRATORY THERAPY	0	783	0	0	0	65.00
66.00	PHYSICAL THERAPY	10,074	2,364	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,960,216	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	587,424	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
76.00	ONCOLOGY	75	625	0	3,309	0	76.00
76.01	CARDIAC REHAB	0	448	0	2,125	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	19,346	5,339	0	12,105	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	524	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	HOSPICE	0	191	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	108,955	37,182	5,649	61,374	2,547,640	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	451	0	0	0	190.00
190.01	HOMECARE	0	120	0	0	0	190.01
192.00	PHYSICIANS' PRIVATE OFFICES	2,211	8,324	0	0	0	192.00
194.00	MARKETING	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	99,040	242,361	409,931	513,967	149,985	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.890920	5.259913	72.567003	8.374344	0.058872	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	15,181	12,169	75,042	30,264	37,877	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.136562	0.264101	13.284121	0.493108	0.014867	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet B-1
Date/Time Prepared:
2/28/2012 1:55 pm

Cost Center Description	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (ALLOCATION OF TIME)	
	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS				
1.00 NEW CAP REL COSTS-BLDG & FIXT				1.00
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
14.00 CENTRAL SERVICES & SUPPLY				14.00
15.00 PHARMACY	5,625,949			15.00
16.00 MEDICAL RECORDS & LIBRARY	0	33,476,918		16.00
17.00 SOCIAL SERVICE	0	0	10,001	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS	0	1,350,750	9,228	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	31.00
41.00 SUBPROVIDER - IRF	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	42.00
43.00 NURSERY	0	99,275	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	2,929,492	660	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	258,524	0	52.00
53.00 ANESTHESIOLOGY	0	547,535	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	8,089,765	0	54.00
57.00 CT SCAN	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 LABORATORY	0	5,630,022	0	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	179,693	0	63.00
65.00 RESPIRATORY THERAPY	0	807,575	0	65.00
66.00 PHYSICAL THERAPY	0	1,291,373	0	66.00
67.00 OCCUPATIONAL THERAPY	0	250,559	0	67.00
68.00 SPEECH PATHOLOGY	0	156,445	0	68.00
69.00 ELECTROCARDIOLOGY	0	499,903	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,960,216	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	587,424	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	5,558,495	5,558,495	0	73.00
73.01 DRUGS CHARGED TO PATIENTS	67,454	67,454	0	73.01
76.00 ONCOLOGY	0	99,351	0	76.00
76.01 CARDIAC REHAB	0	85,186	0	76.01
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00 EMERGENCY	0	3,027,881	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 AMBULANCE SERVICES	0	0	0	95.00
99.10 CORF	0	0	0	99.10
101.00 HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS				
109.00 PANCREAS ACQUISITION	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	111.00
113.00 INTEREST EXPENSE	0	0	0	113.00
116.00 HOSPICE	0	0	113	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	5,625,949	33,476,918	10,001	118.00
NONREIMBURSABLE COST CENTERS				
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
190.01 HOMECARE	0	0	0	190.01
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00 MARKETING	0	0	0	194.00
200.00 Cross Foot Adjustments				200.00
201.00 Negative Cost Centers				201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	35,917	398,862	75,802	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.006384	0.011915	7.579442	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	18,583	43,488	1,000	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.003303	0.001299	0.099990	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet C
Part I
Date/Time Prepared:
2/28/2012 1:55 pm

		Title XVIII		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS		3,042,858	0	0	30.00
31.00	INTENSIVE CARE UNIT		0	0	0	31.00
41.00	SUBPROVIDER - IRF		0	0	0	41.00
42.00	SUBPROVIDER		0	0	0	42.00
43.00	NURSERY		119,192	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM		972,898	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM		140,110	0	0	52.00
53.00	ANESTHESIOLOGY		43,853	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC		1,900,012	0	0	54.00
57.00	CT SCAN		0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00
59.00	CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	LABORATORY		1,478,721	0	0	60.00
60.01	BLOOD LABORATORY		0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.		77,901	0	0	63.00
65.00	RESPIRATORY THERAPY	0	333,286	0	0	65.00
66.00	PHYSICAL THERAPY	0	669,842	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	106,509	0	0	67.00
68.00	SPEECH PATHOLOGY	0	96,491	0	0	68.00
69.00	ELECTROCARDIOLOGY		88,549	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY		0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		858,307	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS		461,142	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS		1,304,587	0	0	73.00
73.01	DRUGS CHARGED TO PATIENTS		25,515	0	0	73.01
76.00	ONCOLOGY		243,566	0	0	76.00
76.01	CARDIAC REHAB		124,095	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC		0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
91.00	EMERGENCY		2,212,681	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		379,469	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES		0	0	0	95.00
99.10	CORF		0	0	0	99.10
101.00	HOME HEALTH AGENCY		699,299	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION		0	0	0	109.00
110.00	INTESTINAL ACQUISITION		0	0	0	110.00
111.00	ISLET ACQUISITION		0	0	0	111.00
113.00	INTEREST EXPENSE					113.00
116.00	HOSPICE		116,127	0	0	116.00
200.00	Subtotal (see instructions)	0	15,495,010	0	0	200.00
201.00	Less Observation Beds		379,469			201.00
202.00	Total (see instructions)	0	15,115,541	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet C
Part I
Date/Time Prepared:
2/28/2012 1:55 pm

		Title XVIII			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,155,577		1,155,577			30.00
31.00	INTENSIVE CARE UNIT	0		0			31.00
41.00	SUBPROVIDER - IRF	0		0			41.00
42.00	SUBPROVIDER	0		0			42.00
43.00	NURSERY	99,275		99,275			43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	653,105	2,276,387	2,929,492	0.332105	0.000000	50.00
52.00	DELIVERY ROOM & LABOR ROOM	188,850	69,674	258,524	0.541961	0.000000	52.00
53.00	ANESTHESIOLOGY	133,446	414,089	547,535	0.080092	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	607,675	7,482,090	8,089,765	0.234866	0.000000	54.00
57.00	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	LABORATORY	853,316	4,776,706	5,630,022	0.262649	0.000000	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	93,589	86,104	179,693	0.433523	0.000000	63.00
65.00	RESPIRATORY THERAPY	526,449	281,126	807,575	0.412700	0.000000	65.00
66.00	PHYSICAL THERAPY	201,579	1,089,794	1,291,373	0.518705	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	92,512	158,047	250,559	0.425086	0.000000	67.00
68.00	SPEECH PATHOLOGY	24,605	131,840	156,445	0.616773	0.000000	68.00
69.00	ELECTROCARDIOLOGY	131,365	368,538	499,903	0.177132	0.000000	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	858,147	1,102,069	1,960,216	0.437863	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	514,686	72,738	587,424	0.785024	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,146,001	3,412,494	5,558,495	0.234701	0.000000	73.00
73.01	DRUGS CHARGED TO PATIENTS	67,454	0	67,454	0.378258	0.000000	73.01
76.00	ONCOLOGY	0	99,351	99,351	2.451571	0.000000	76.00
76.01	CARDIAC REHAB	0	85,186	85,186	1.456753	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
91.00	EMERGENCY	81,169	2,946,712	3,027,881	0.730769	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	195,173	195,173	1.944270	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
99.10	CORF	0	0	0			99.10
101.00	HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS							
109.00	PANCREAS ACQUISITION	0	0	0			109.00
110.00	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	ISLET ACQUISITION	0	0	0			111.00
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	0	0	0			116.00
200.00	Subtotal (see instructions)	8,428,800	25,048,118	33,476,918			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	8,428,800	25,048,118	33,476,918			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151305	Period: From 10/01/2010 To 09/30/2011	Worksheet C Part I Date/Time Prepared: 2/28/2012 1:55 pm
		Title XVIII	Hospital	Cost
Cost Center Description	PPS Inpatient Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS			30.00
31.00	INTENSIVE CARE UNIT			31.00
41.00	SUBPROVIDER - IRF			41.00
42.00	SUBPROVIDER			42.00
43.00	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.000000		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	ANESTHESIOLOGY	0.000000		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	CT SCAN	0.000000		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	LABORATORY	0.000000		60.00
60.01	BLOOD LABORATORY	0.000000		60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	RESPIRATORY THERAPY	0.000000		65.00
66.00	PHYSICAL THERAPY	0.000000		66.00
67.00	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	SPEECH PATHOLOGY	0.000000		68.00
69.00	ELECTROCARDIOLOGY	0.000000		69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	DRUGS CHARGED TO PATIENTS	0.000000		73.01
76.00	ONCOLOGY	0.000000		76.00
76.01	CARDIAC REHAB	0.000000		76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER			89.00
91.00	EMERGENCY	0.000000		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	0.000000		95.00
99.10	CORF			99.10
101.00	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
109.00	PANCREAS ACQUISITION			109.00
110.00	INTESTINAL ACQUISITION			110.00
111.00	ISLET ACQUISITION			111.00
113.00	INTEREST EXPENSE			113.00
116.00	HOSPICE			116.00
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: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet C
Part I
Date/Time Prepared:
2/28/2012 1:55 pm

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS		3,042,858	0	0	30.00	
31.00	INTENSIVE CARE UNIT		0	0	0	31.00	
41.00	SUBPROVIDER - IRF		0	0	0	41.00	
42.00	SUBPROVIDER		0	0	0	42.00	
43.00	NURSERY		119,192	0	0	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM		972,898	0	0	50.00	
52.00	DELIVERY ROOM & LABOR ROOM		140,110	0	0	52.00	
53.00	ANESTHESIOLOGY		43,853	0	0	53.00	
54.00	RADIOLOGY-DIAGNOSTIC		1,900,012	0	0	54.00	
57.00	CT SCAN		0	0	0	57.00	
58.00	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00	
59.00	CARDIAC CATHETERIZATION		0	0	0	59.00	
60.00	LABORATORY		1,478,721	0	0	60.00	
60.01	BLOOD LABORATORY		0	0	0	60.01	
63.00	BLOOD STORING, PROCESSING & TRANS.		77,901	0	0	63.00	
65.00	RESPIRATORY THERAPY	0	333,286	0	0	65.00	
66.00	PHYSICAL THERAPY	0	669,842	0	0	66.00	
67.00	OCCUPATIONAL THERAPY	0	106,509	0	0	67.00	
68.00	SPEECH PATHOLOGY	0	96,491	0	0	68.00	
69.00	ELECTROCARDIOLOGY		88,549	0	0	69.00	
70.00	ELECTROENCEPHALOGRAPHY		0	0	0	70.00	
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		858,307	0	0	71.00	
72.00	IMPL. DEV. CHARGED TO PATIENTS		461,142	0	0	72.00	
73.00	DRUGS CHARGED TO PATIENTS		1,304,587	0	0	73.00	
73.01	DRUGS CHARGED TO PATIENTS		25,515	0	0	73.01	
76.00	ONCOLOGY		243,566	0	0	76.00	
76.01	CARDIAC REHAB		124,095	0	0	76.01	
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC		0	0	0	88.00	
89.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00	
91.00	EMERGENCY		2,212,681	0	0	91.00	
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		379,469	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES		0	0	0	95.00	
99.10	CORF		0	0	0	99.10	
101.00	HOME HEALTH AGENCY		699,299	0	0	101.00	
SPECIAL PURPOSE COST CENTERS							
109.00	PANCREAS ACQUISITION		0	0	0	109.00	
110.00	INTESTINAL ACQUISITION		0	0	0	110.00	
111.00	ISLET ACQUISITION		0	0	0	111.00	
113.00	INTEREST EXPENSE					113.00	
116.00	HOSPICE		116,127	0	0	116.00	
200.00	Subtotal (see instructions)	0	15,495,010	0	0	200.00	
201.00	Less Observation Beds		379,469			201.00	
202.00	Total (see instructions)	0	15,115,541	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet C
Part I
Date/Time Prepared:
2/28/2012 1:55 pm

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1,155,577		1,155,577			30.00
31.00 INTENSIVE CARE UNIT	0		0			31.00
41.00 SUBPROVIDER - IRF	0		0			41.00
42.00 SUBPROVIDER	0		0			42.00
43.00 NURSERY	99,275		99,275			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	653,105	2,276,387	2,929,492	0.332105	0.000000	50.00
52.00 DELIVERY ROOM & LABOR ROOM	188,850	69,674	258,524	0.541961	0.000000	52.00
53.00 ANESTHESIOLOGY	133,446	414,089	547,535	0.080092	0.000000	53.00
54.00 RADIOLOGY-DIAGNOSTIC	607,675	7,482,090	8,089,765	0.234866	0.000000	54.00
57.00 CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00 LABORATORY	853,316	4,776,706	5,630,022	0.262649	0.000000	60.00
60.01 BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	93,589	86,104	179,693	0.433523	0.000000	63.00
65.00 RESPIRATORY THERAPY	526,449	281,126	807,575	0.412700	0.000000	65.00
66.00 PHYSICAL THERAPY	201,579	1,089,794	1,291,373	0.518705	0.000000	66.00
67.00 OCCUPATIONAL THERAPY	92,512	158,047	250,559	0.425086	0.000000	67.00
68.00 SPEECH PATHOLOGY	24,605	131,840	156,445	0.616773	0.000000	68.00
69.00 ELECTROCARDIOLOGY	131,365	368,538	499,903	0.177132	0.000000	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	858,147	1,102,069	1,960,216	0.437863	0.000000	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	514,686	72,738	587,424	0.785024	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	2,146,001	3,412,494	5,558,495	0.234701	0.000000	73.00
73.01 DRUGS CHARGED TO PATIENTS	67,454	0	67,454	0.378258	0.000000	73.01
76.00 ONCOLOGY	0	99,351	99,351	2.451571	0.000000	76.00
76.01 CARDIAC REHAB	0	85,186	85,186	1.456753	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
91.00 EMERGENCY	81,169	2,946,712	3,027,881	0.730769	0.000000	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	195,173	195,173	1.944270	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
99.10 CORF	0	0	0			99.10
101.00 HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0			109.00
110.00 INTESTINAL ACQUISITION	0	0	0			110.00
111.00 ISLET ACQUISITION	0	0	0			111.00
113.00 INTEREST EXPENSE						113.00
116.00 HOSPICE	0	0	0			116.00
200.00 Subtotal (see instructions)	8,428,800	25,048,118	33,476,918			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	8,428,800	25,048,118	33,476,918			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet C
Part I
Date/Time Prepared:
2/28/2012 1:55 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
31.00	INTENSIVE CARE UNIT				31.00
41.00	SUBPROVIDER - IRF				41.00
42.00	SUBPROVIDER				42.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000			50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	ANESTHESIOLOGY	0.000000			53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	CT SCAN	0.000000			57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	LABORATORY	0.000000			60.00
60.01	BLOOD LABORATORY	0.000000			60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
65.00	RESPIRATORY THERAPY	0.000000			65.00
66.00	PHYSICAL THERAPY	0.000000			66.00
67.00	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	SPEECH PATHOLOGY	0.000000			68.00
69.00	ELECTROCARDIOLOGY	0.000000			69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000			73.00
73.01	DRUGS CHARGED TO PATIENTS	0.000000			73.01
76.00	ONCOLOGY	0.000000			76.00
76.01	CARDIAC REHAB	0.000000			76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES	0.000000			95.00
99.10	CORF				99.10
101.00	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
109.00	PANCREAS ACQUISITION				109.00
110.00	INTESTINAL ACQUISITION				110.00
111.00	ISLET ACQUISITION				111.00
113.00	INTEREST EXPENSE				113.00
116.00	HOSPICE				116.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151305	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part II Date/Time Prepared: 2/28/2012 1:55 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	123,681	2,929,492	0.042219	250,450	10,574	50.00
52.00	DELIVERY ROOM & LABOR ROOM	49,773	258,524	0.192528	0	0	52.00
53.00	ANESTHESIOLOGY	4,327	547,535	0.007903	36,694	290	53.00
54.00	RADIOLOGY-DIAGNOSTIC	119,069	8,089,765	0.014718	239,795	3,529	54.00
57.00	CT SCAN	0	0	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	LABORATORY	53,102	5,630,022	0.009432	350,907	3,310	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	2,086	179,693	0.011609	63,117	733	63.00
65.00	RESPIRATORY THERAPY	23,564	807,575	0.029179	95,679	2,792	65.00
66.00	PHYSICAL THERAPY	54,424	1,291,373	0.042144	57,418	2,420	66.00
67.00	OCCUPATIONAL THERAPY	1,692	250,559	0.006753	24,547	166	67.00
68.00	SPEECH PATHOLOGY	1,442	156,445	0.009217	5,560	51	68.00
69.00	ELECTROCARDIOLOGY	1,727	499,903	0.003455	103,367	357	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	39,941	1,960,216	0.020376	576,848	11,754	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	14,307	587,424	0.024355	357,210	8,700	72.00
73.00	DRUGS CHARGED TO PATIENTS	39,373	5,558,495	0.007083	1,015,878	7,195	73.00
73.01	DRUGS CHARGED TO PATIENTS	589	67,454	0.008732	0	0	73.01
76.00	ONCOLOGY	19,142	99,351	0.192670	0	0	76.00
76.01	CARDIAC REHAB	13,012	85,186	0.152748	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	EMERGENCY	163,196	3,027,881	0.053898	12,098	652	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	195,173	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	724,447	32,222,066		3,189,568	52,523	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151305	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part IV Date/Time Prepared: 2/28/2012 1:55 pm
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Cost Center Description	Title XVIII				Hospital	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
76.00 ONCOLOGY	0	0	0	0	0	76.00
76.01 CARDIAC REHAB	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES						95.00
200.00 Total (Lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151305	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part IV Date/Time Prepared: 2/28/2012 1:55 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	2,929,492	0.000000	0.000000	250,450	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	258,524	0.000000	0.000000	0	52.00
53.00	ANESTHESIOLOGY	0	547,535	0.000000	0.000000	36,694	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	8,089,765	0.000000	0.000000	239,795	54.00
57.00	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	LABORATORY	0	5,630,022	0.000000	0.000000	350,907	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	179,693	0.000000	0.000000	63,117	63.00
65.00	RESPIRATORY THERAPY	0	807,575	0.000000	0.000000	95,679	65.00
66.00	PHYSICAL THERAPY	0	1,291,373	0.000000	0.000000	57,418	66.00
67.00	OCCUPATIONAL THERAPY	0	250,559	0.000000	0.000000	24,547	67.00
68.00	SPEECH PATHOLOGY	0	156,445	0.000000	0.000000	5,560	68.00
69.00	ELECTROCARDIOLOGY	0	499,903	0.000000	0.000000	103,367	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,960,216	0.000000	0.000000	576,848	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	587,424	0.000000	0.000000	357,210	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	5,558,495	0.000000	0.000000	1,015,878	73.00
73.01	DRUGS CHARGED TO PATIENTS	0	67,454	0.000000	0.000000	0	73.01
76.00	ONCOLOGY	0	99,351	0.000000	0.000000	0	76.00
76.01	CARDIAC REHAB	0	85,186	0.000000	0.000000	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	EMERGENCY	0	3,027,881	0.000000	0.000000	12,098	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	195,173	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	0	32,222,066			3,189,568	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet D
Part IV
Date/Time Prepared:
2/28/2012 1:55 pm

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)	Cost
		11.00	12.00	13.00	
Title XVIII Hospital Cost					
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
57.00	CT SCAN	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	LABORATORY	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
65.00	RESPIRATORY THERAPY	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
73.01	DRUGS CHARGED TO PATIENTS	0	0	0	73.01
76.00	ONCOLOGY	0	0	0	76.00
76.01	CARDIAC REHAB	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00	EMERGENCY	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151305	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 2/28/2012 1:55 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	
			1.00	2.00	
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.332105	0	823,660	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0.541961	0	446	0	52.00
53.00 ANESTHESIOLOGY	0.080092	0	160,121	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.234866	0	2,632,837	0	54.00
57.00 CT SCAN	0.000000	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00 LABORATORY	0.262649	0	1,914,989	0	60.00
60.01 BLOOD LABORATORY	0.000000	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0.433523	0	46,785	0	63.00
65.00 RESPIRATORY THERAPY	0.412700	0	72,053	0	65.00
66.00 PHYSICAL THERAPY	0.518705	0	384,334	0	66.00
67.00 OCCUPATIONAL THERAPY	0.425086	0	74,597	0	67.00
68.00 SPEECH PATHOLOGY	0.616773	0	3,712	0	68.00
69.00 ELECTROCARDIOLOGY	0.177132	0	216,405	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.437863	0	489,430	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0.785024	0	56,290	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.234701	0	1,712,525	0	73.00
73.01 DRUGS CHARGED TO PATIENTS	0.378258	0	0	0	73.01
76.00 ONCOLOGY	2.451571	0	49,079	0	76.00
76.01 CARDIAC REHAB	1.456753	0	50,456	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0.000000				88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
91.00 EMERGENCY	0.730769	0	747,142	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.944270	0	82,550	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES	0.000000		0		95.00
200.00 Subtotal (see instructions)		0	9,517,411	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	9,517,411	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151305	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 2/28/2012 1:55 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			
	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				
50.00 OPERATING ROOM	0	273,542	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	242	0	52.00
53.00 ANESTHESIOLOGY	0	12,824	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	618,364	0	54.00
57.00 CT SCAN	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 LABORATORY	0	502,970	0	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	20,282	0	63.00
65.00 RESPIRATORY THERAPY	0	29,736	0	65.00
66.00 PHYSICAL THERAPY	0	199,356	0	66.00
67.00 OCCUPATIONAL THERAPY	0	31,710	0	67.00
68.00 SPEECH PATHOLOGY	0	2,289	0	68.00
69.00 ELECTROCARDIOLOGY	0	38,332	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	214,303	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	44,189	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	401,931	0	73.00
73.01 DRUGS CHARGED TO PATIENTS	0	0	0	73.01
76.00 ONCOLOGY	0	120,321	0	76.00
76.01 CARDIAC REHAB	0	73,502	0	76.01
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00 EMERGENCY	0	545,988	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	160,499	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 AMBULANCE SERVICES		0		95.00
200.00 Subtotal (see instructions)	0	3,290,380	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	3,290,380	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151305 Component CCN: 15Z305	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 2/28/2012 1:55 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost
		PPS Reimbursed Services (see instructions)	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					
50.00 OPERATING ROOM	0.332105	0	0	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0.541961	0	0	0	52.00
53.00 ANESTHESIOLOGY	0.080092	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.234866	0	0	0	54.00
57.00 CT SCAN	0.000000	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00 LABORATORY	0.262649	0	0	0	60.00
60.01 BLOOD LABORATORY	0.000000	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0.433523	0	0	0	63.00
65.00 RESPIRATORY THERAPY	0.412700	0	0	0	65.00
66.00 PHYSICAL THERAPY	0.518705	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0.425086	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0.616773	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0.177132	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.437863	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0.785024	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.234701	0	0	0	73.00
73.01 DRUGS CHARGED TO PATIENTS	0.378258	0	0	0	73.01
76.00 ONCOLOGY	2.451571	0	0	0	76.00
76.01 CARDIAC REHAB	1.456753	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0.000000				88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
91.00 EMERGENCY	0.730769	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.944270	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES	0.000000		0		95.00
200.00 Subtotal (see instructions)		0	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)			0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151305 Component CCN: 15Z305	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 2/28/2012 1:55 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Costs				
	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					
50.00 OPERATING ROOM	0	0	0		50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00 ANESTHESIOLOGY	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00 CT SCAN	0	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00 LABORATORY	0	0	0		60.00
60.01 BLOOD LABORATORY	0	0	0		60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00 RESPIRATORY THERAPY	0	0	0		65.00
66.00 PHYSICAL THERAPY	0	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	0	0	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
73.01 DRUGS CHARGED TO PATIENTS	0	0	0		73.01
76.00 ONCOLOGY	0	0	0		76.00
76.01 CARDIAC REHAB	0	0	0		76.01
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00 EMERGENCY	0	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES		0			95.00
200.00 Subtotal (see instructions)	0	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 151305	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part I Date/Time Prepared: 2/28/2012 1:55 pm
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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	302,792	65,285	237,507	1,786	132.98	30.00
31.00 INTENSIVE CARE UNIT	0		0	0	0.00	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00 SUBPROVIDER	0	0	0	0	0.00	42.00
43.00 NURSERY	6,810		6,810	197	34.57	43.00
200.00 Total (lines 30-199)	309,602		244,317	1,983		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151305		Period: From 10/01/2010 To 09/30/2011		Worksheet D Part I Date/Time Prepared: 2/28/2012 1:55 pm	
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	212	28,192				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
41.00	SUBPROVIDER - IRF	0	0				41.00
42.00	SUBPROVIDER	0	0				42.00
43.00	NURSERY	127	4,390				43.00
200.00	Total (lines 30-199)	339	32,582				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151305	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part II Date/Time Prepared: 2/28/2012 1:55 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	123,681	2,929,492	0.042219	120,396	5,083	50.00
52.00	DELIVERY ROOM & LABOR ROOM	49,773	258,524	0.192528	109,832	21,146	52.00
53.00	ANESTHESIOLOGY	4,327	547,535	0.007903	35,994	284	53.00
54.00	RADIOLOGY-DIAGNOSTIC	119,069	8,089,765	0.014718	70,268	1,034	54.00
57.00	CT SCAN	0	0	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	LABORATORY	53,102	5,630,022	0.009432	115,978	1,094	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	2,086	179,693	0.011609	4,616	54	63.00
65.00	RESPIRATORY THERAPY	23,564	807,575	0.029179	34,318	1,001	65.00
66.00	PHYSICAL THERAPY	54,424	1,291,373	0.042144	1,092	46	66.00
67.00	OCCUPATIONAL THERAPY	1,692	250,559	0.006753	219	1	67.00
68.00	SPEECH PATHOLOGY	1,442	156,445	0.009217	10,955	101	68.00
69.00	ELECTROCARDIOLOGY	1,727	499,903	0.003455	8,460	29	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	39,941	1,960,216	0.020376	121,587	2,477	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	14,307	587,424	0.024355	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	39,373	5,558,495	0.007083	321,185	2,275	73.00
73.01	DRUGS CHARGED TO PATIENTS	589	67,454	0.008732	0	0	73.01
76.00	ONCOLOGY	19,142	99,351	0.192670	0	0	76.00
76.01	CARDIAC REHAB	13,012	85,186	0.152748	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	EMERGENCY	163,196	3,027,881	0.053898	27,977	1,508	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	195,173	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	724,447	32,222,066		982,877	36,133	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151305		Period: From 10/01/2010 To 09/30/2011		Worksheet D Part III Date/Time Prepared: 2/28/2012 1:55 pm	
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 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	0	0	0	0	0	43.00
200.00	Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151305		Period: From 10/01/2010 To 09/30/2011		Worksheet D Part III Date/Time Prepared: 2/28/2012 1:55 pm	
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)	Cost	
		6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,786	0.00	212	0	30.00	
31.00	INTENSIVE CARE UNIT	0	0.00	0	0	31.00	
41.00	SUBPROVIDER - IRF	0	0.00	0	0	41.00	
42.00	SUBPROVIDER	0	0.00	0	0	42.00	
43.00	NURSERY	197	0.00	127	0	43.00	
200.00	Total (lines 30-199)	1,983		339	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151305	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part IV Date/Time Prepared: 2/28/2012 1:55 pm
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Cost Center Description	Title XIX				Hospital		Total Cost (sum of col 1 through col 4)
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0	0	0	0	0		50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0		52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0		54.00
57.00 CT SCAN	0	0	0	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0		59.00
60.00 LABORATORY	0	0	0	0	0		60.00
60.01 BLOOD LABORATORY	0	0	0	0	0		60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0		63.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0		65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0		73.00
73.01 DRUGS CHARGED TO PATIENTS	0	0	0	0	0		73.01
76.00 ONCOLOGY	0	0	0	0	0		76.00
76.01 CARDIAC REHAB	0	0	0	0	0		76.01
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	0	0	0	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0		89.00
91.00 EMERGENCY	0	0	0	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 AMBULANCE SERVICES							95.00
200.00 Total (Lines 50-199)	0	0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet D
Part IV
Date/Time Prepared:
2/28/2012 1:55 pm

Cost Center Description		Title XIX			Hospital		Cost
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	2,929,492	0.000000	0.000000	120,396	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	258,524	0.000000	0.000000	109,832	52.00
53.00	ANESTHESIOLOGY	0	547,535	0.000000	0.000000	35,994	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	8,089,765	0.000000	0.000000	70,268	54.00
57.00	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	LABORATORY	0	5,630,022	0.000000	0.000000	115,978	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	179,693	0.000000	0.000000	4,616	63.00
65.00	RESPIRATORY THERAPY	0	807,575	0.000000	0.000000	34,318	65.00
66.00	PHYSICAL THERAPY	0	1,291,373	0.000000	0.000000	1,092	66.00
67.00	OCCUPATIONAL THERAPY	0	250,559	0.000000	0.000000	219	67.00
68.00	SPEECH PATHOLOGY	0	156,445	0.000000	0.000000	10,955	68.00
69.00	ELECTROCARDIOLOGY	0	499,903	0.000000	0.000000	8,460	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,960,216	0.000000	0.000000	121,587	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	587,424	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	5,558,495	0.000000	0.000000	321,185	73.00
73.01	DRUGS CHARGED TO PATIENTS	0	67,454	0.000000	0.000000	0	73.01
76.00	ONCOLOGY	0	99,351	0.000000	0.000000	0	76.00
76.01	CARDIAC REHAB	0	85,186	0.000000	0.000000	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	EMERGENCY	0	3,027,881	0.000000	0.000000	27,977	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	195,173	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	0	32,222,066			982,877	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet D
Part IV
Date/Time Prepared:
2/28/2012 1:55 pm

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)	Hospital	Cost
ANCILLARY SERVICE COST CENTERS		11.00	12.00	13.00		
50.00	OPERATING ROOM	0	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	ANESTHESIOLOGY	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	CT SCAN	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	LABORATORY	0	0	0		60.00
60.01	BLOOD LABORATORY	0	0	0		60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	RESPIRATORY THERAPY	0	0	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	SPEECH PATHOLOGY	0	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
73.01	DRUGS CHARGED TO PATIENTS	0	0	0		73.01
76.00	ONCOLOGY	0	0	0		76.00
76.01	CARDIAC REHAB	0	0	0		76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	EMERGENCY	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151305	Period: From 10/01/2010 To 09/30/2011	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 2/28/2012 1:55 pm
Cost Center Description		Cost		
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,362	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,786	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)		1,786	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		120	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)		361	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		24	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)		71	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		823	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)		120	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)		361	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		145.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		145.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,042,858	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)		3,480	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)		10,295	25.00
26.00	Total swing-bed cost (see instructions)		656,468	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,386,390	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,254,852	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		1,254,852	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.901730	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)		702.60	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)		2,386,390	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)		1,336.16	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,099,660	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,099,660	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151305	Period: From 10/01/2010 To 09/30/2011	Worksheet D-1 Date/Time Prepared: 2/28/2012 1:55 pm	
Cost Center Description			Title XVIII	Hospital	Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				1,143,674	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				2,243,334	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)				160,339	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				482,354	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				642,693	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)				284	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,336.16	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				379,469	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151305		Period: From 10/01/2010 To 09/30/2011		Worksheet D-1 Date/Time Prepared: 2/28/2012 1:55 pm	
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: 151305	Period: From 10/01/2010 To 09/30/2011	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 2/28/2012 1:55 pm
Cost Center Description				Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,362	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,786	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)		1,786	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)		481	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)		95	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		212	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)		197	15.00
16.00	Nursery days (title V or XIX only)		127	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		139.61	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		139.61	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		139.61	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		139.61	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,042,858	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)		67,152	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)		13,263	25.00
26.00	Total swing-bed cost (see instructions)		656,067	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,386,791	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,254,852	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		1,254,852	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.902050	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)		702.60	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)		2,386,791	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)		1,336.39	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		283,315	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)		283,315	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151305	Period: From 10/01/2010 To 09/30/2011	Worksheet D-1 Date/Time Prepared: 2/28/2012 1:55 pm		
Cost Center Description			Title XIX	Hospital	Cost		
	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)	119,192	197	605.04	127	76,840	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					323,502	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					683,657	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)					284	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,336.39	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					379,535	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151305		Period: From 10/01/2010 To 09/30/2011		Worksheet D-1 Date/Time Prepared: 2/28/2012 1:55 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151305	Period: From 10/01/2010 To 09/30/2011	Worksheet D-3 Date/Time Prepared: 2/28/2012 1:55 pm
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		560,870		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.332105	250,450	83,176	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.541961	0	0	52.00
53.00	ANESTHESIOLOGY	0.080092	36,694	2,939	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.234866	239,795	56,320	54.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.262649	350,907	92,165	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0.433523	63,117	27,363	63.00
65.00	RESPIRATORY THERAPY	0.412700	95,679	39,487	65.00
66.00	PHYSICAL THERAPY	0.518705	57,418	29,783	66.00
67.00	OCCUPATIONAL THERAPY	0.425086	24,547	10,435	67.00
68.00	SPEECH PATHOLOGY	0.616773	5,560	3,429	68.00
69.00	ELECTROCARDIOLOGY	0.177132	103,367	18,310	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.437863	576,848	252,580	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.785024	357,210	280,418	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.234701	1,015,878	238,428	73.00
73.01	DRUGS CHARGED TO PATIENTS	0.378258	0	0	73.01
76.00	ONCOLOGY	2.451571	0	0	76.00
76.01	CARDIAC REHAB	1.456753	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	EMERGENCY	0.730769	12,098	8,841	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.944270	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		3,189,568	1,143,674	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		3,189,568		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151305	Period: From 10/01/2010	Worksheet D-3
	Component CCN: 15Z305	To 09/30/2011	

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		108,202		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.332105	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.541961	0	0	52.00
53.00	ANESTHESIOLOGY	0.080092	1,601	128	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.234866	25,243	5,929	54.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.262649	52,025	13,664	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0.433523	1,557	675	63.00
65.00	RESPIRATORY THERAPY	0.412700	24,241	10,004	65.00
66.00	PHYSICAL THERAPY	0.518705	102,892	53,371	66.00
67.00	OCCUPATIONAL THERAPY	0.425086	49,995	21,252	67.00
68.00	SPEECH PATHOLOGY	0.616773	1,656	1,021	68.00
69.00	ELECTROCARDIOLOGY	0.177132	2,467	437	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.437863	49,410	21,635	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.785024	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.234701	0	0	73.00
73.01	DRUGS CHARGED TO PATIENTS	0.378258	63,454	24,002	73.01
76.00	ONCOLOGY	2.451571	0	0	76.00
76.01	CARDIAC REHAB	1.456753	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	EMERGENCY	0.730769	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.944270	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		374,541	152,118	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)		374,541		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151305	Period: From 10/01/2010 To 09/30/2011	Worksheet D-3 Date/Time Prepared: 2/28/2012 1:55 pm
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		135,417		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY		63,655		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.332105	120,396	39,984	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.541961	109,832	59,525	52.00
53.00	ANESTHESIOLOGY	0.080092	35,994	2,883	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.234866	70,268	16,504	54.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.262649	115,978	30,462	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0.433523	4,616	2,001	63.00
65.00	RESPIRATORY THERAPY	0.412700	34,318	14,163	65.00
66.00	PHYSICAL THERAPY	0.518705	1,092	566	66.00
67.00	OCCUPATIONAL THERAPY	0.425086	219	93	67.00
68.00	SPEECH PATHOLOGY	0.616773	10,955	6,757	68.00
69.00	ELECTROCARDIOLOGY	0.177132	8,460	1,499	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.437863	121,587	53,238	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.785024	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.234701	321,185	75,382	73.00
73.01	DRUGS CHARGED TO PATIENTS	0.378258	0	0	73.01
76.00	ONCOLOGY	2.451571	0	0	76.00
76.01	CARDIAC REHAB	1.456753	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
91.00	EMERGENCY	0.730769	27,977	20,445	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.944270	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		982,877	323,502	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)		982,877		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151305	Period: From 10/01/2010 To 09/30/2011	Worksheet D-3	
		Component CCN: 15Z305		Date/Time Prepared: 2/28/2012 1:55 pm	
		Title XIX	Swing Beds - SNF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.332105	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.541961	0	0	52.00
53.00	ANESTHESIOLOGY	0.080092	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.234866	0	0	54.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.262649	0	0	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0.433523	0	0	63.00
65.00	RESPIRATORY THERAPY	0.412700	0	0	65.00
66.00	PHYSICAL THERAPY	0.518705	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0.425086	0	0	67.00
68.00	SPEECH PATHOLOGY	0.616773	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.177132	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.437863	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.785024	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.234701	0	0	73.00
73.01	DRUGS CHARGED TO PATIENTS	0.378258	0	0	73.01
76.00	ONCOLOGY	2.451571	0	0	76.00
76.01	CARDIAC REHAB	1.456753	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
91.00	EMERGENCY	0.730769	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.944270	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		0	0	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)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151305	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 2/28/2012 1:55 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			3,290,380 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)			3,290,380 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)			3,323,284 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)			31,337 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,497,729 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)			1,794,218 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)			1,794,218 30.00
31.00	Primary payer payments			742 31.00
32.00	Subtotal (line 30 minus line 31)			1,793,476 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)			327,067 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			327,067 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			308,121 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			2,120,543 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)			2,120,543 40.00
41.00	Interim payments			2,130,639 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)			-10,096 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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet E-1
Part I
Date/Time Prepared:
2/28/2012 1:55 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,650,120		1,843,652	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	05/05/2011	110,689	05/05/2011	72,940	3.01	
3.02		09/13/2011	16,785	09/03/2011	8,412	3.02	
3.03		09/30/2011	39,595	09/30/2011	205,635	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)		167,069		286,987	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,817,189		2,130,639	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		238,881		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		10,096	6.02	
7.00	Total Medicare program liability (see instructions)		2,056,070		2,120,543	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151305

Period: From 10/01/2010

Worksheet E-1

Component CCN: 15Z305

To 09/30/2011

Part I
Date/Time Prepared:
2/28/2012 1:55 pm

Title XVIII

Swing Beds - SNF

Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		626,660		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	05/05/2011	118,440		0	3.01
3.02		09/03/2011	23,367		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)		141,807		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)		768,467		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		27,006		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		795,473		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 151305	Period: From 10/01/2010 To 09/30/2011	Worksheet E-2
		Component CCN: 15Z305		Date/Time Prepared: 2/28/2012 1:55 pm
		Title XVIII	Swing Beds - SNF	Cost
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	649,120	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	153,639	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	481	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	802,759	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	802,759	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	802,759	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	7,286	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	795,473	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	795,473	0	19.00
20.00	Interim payments	768,467	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	27,006	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 151305	Period: From 10/01/2010 To 09/30/2011	Worksheet E-2
		Component CCN: 15Z305	Date/Time Prepared: 2/28/2012 1:55 pm	
		Title XIX	Swing Beds - SNF	PPS
		Part A		Part B
		1.00		2.00
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		0	2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)		0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days		0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	8.00
9.00	Primary payer payments (see instructions)		0	9.00
10.00	Subtotal (line 8 minus line 9)		0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	11.00
12.00	Subtotal (line 10 minus line 11)		0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	16.00
17.00	Reimbursable bad debts (see instructions)		0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)		0	19.00
20.00	Interim payments		0	20.00
21.00	Tentative settlement (for contractor use only)		0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)		0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151305	Period: From 10/01/2010 To 09/30/2011	Worksheet E-3 Part V Date/Time Prepared: 2/28/2012 1:55 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services			2,243,334 1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 thru 3)			2,243,334 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5) . For CAH (see instructions)			2,265,767 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2,265,767 19.00
20.00	Deductibles (exclude professional component)			231,304 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			2,034,463 22.00
23.00	Coinsurance			550 23.00
24.00	Subtotal (line 22 minus line 23)			2,033,913 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			22,157 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			22,157 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			20,177 27.00
28.00	Subtotal (sum of lines 24 and 25 or 26)			2,056,070 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (line 28, plus or minus lines 29)			2,056,070 30.00
31.00	Interim payments			1,817,189 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)			238,881 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151305	Period: From 10/01/2010 To 09/30/2011	Worksheet E-3 Part VII Date/Time Prepared: 2/28/2012 1:55 pm
		Title XIX	Hospital	Cost
				1.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		683,657	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)		683,657	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)		683,657	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		0	8.00
9.00	Ancillary service charges		982,877	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)		982,877	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)		982,877	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		299,220	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)		683,657	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.		683,657	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)		683,657	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)		683,657	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		683,657	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)		683,657	40.00
41.00	Interim payments		338,741	41.00
42.00	Balance due provider/program (line 40 minus 41)		344,916	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: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet G

Date/Time Prepared:
2/28/2012 1:55 pm

		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	3,887,508	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	2,380,173	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	475,714	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,743,395	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,726,093	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	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	2,786,343	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	4,512,436	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	429,340	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	429,340	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	11,685,171	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	491,057	0	0	0	37.00
38.00	Salaries, wages, and fees payable	857,271	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	348,443	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	0	0	0	0	43.00
44.00	Other current liabilities	345,208	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,041,979	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	382,165	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	53,824	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	435,989	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,477,968	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	9,207,203				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	9,207,203	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	11,685,171	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet G-1

Date/Time Prepared:
2/28/2012 1:55 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		9,129,030	
2.00	Net income (loss) (From Wkst. G-3, line 29)		78,173			2.00
3.00	Total (sum of line 1 and line 2)		9,207,203		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		9,207,203		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		9,207,203		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet G-1

Date/Time Prepared:
2/28/2012 1:55 pm

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet G-2 Parts

Date/Time Prepared:
2/28/2012 1:55 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,254,852		1,254,852	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	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)	1,254,852		1,254,852	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	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)	1,254,852		1,254,852	17.00
18.00	Ancillary services	7,403,632	25,605,201	33,008,833	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		717,418	717,418	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	170,879	170,879	26.00
27.00	HOMECARE	0	209,787	209,787	27.00
27.01	PHYSICIAN OFFICES	186,036	1,575,595	1,761,631	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,844,520	28,278,880	37,123,400	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		18,929,232		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		18,929,232		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151305

Period:
From 10/01/2010
To 09/30/2011

Worksheet G-3

Date/Time Prepared:
2/28/2012 1:55 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	37,123,400	1.00
2.00	Less contractual allowances and discounts on patients' accounts	18,541,920	2.00
3.00	Net patient revenues (line 1 minus line 2)	18,581,480	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	18,929,232	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-347,752	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 OPERATING	348,485	24.00
24.01	TOTAL NONOPERATING INCOME	77,440	24.01
25.00	Total other income (sum of lines 6-24)	425,925	25.00
26.00	Total (line 5 plus line 25)	78,173	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)	78,173	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151305

Period:

Worksheet H

HHA CCN: 157078

From 10/01/2010
To 09/30/2011

Date/Time Prepared:
2/28/2012 1:55 pm

Home Health
Agency I

PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	1.00
2.00	Capital Related - Movable Equipment			0		0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	68,697	0	0	0	76,080	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	200,806	0	0	0	0	6.00
7.00	Physical Therapy	26,644	0	0	0	0	7.00
8.00	Occupational Therapy	10,435	0	0	0	0	8.00
9.00	Speech Pathology	1,059	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	63,725	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	371,366	0	0	0	76,080	24.00

Column, 6 line 24 should agree with the Worksheet A, column 7, line 101, or subscript as applicable.

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151305

Period: From 10/01/2010

Worksheet H

HHA CCN: 157078

To 09/30/2011

Date/Time Prepared: 2/28/2012 1:55 pm

Home Health Agency I

PPS

	Total (sum of col. 1 thru 5)	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
	6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00 Capital Related - Bldg. & Fixtures	0	0	0	0	0	1.00
2.00 Capital Related - Movable Equipment	0	0	0	0	0	2.00
3.00 Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00 Transportation	0	0	0	0	0	4.00
5.00 Administrative and General	144,777	0	144,777	0	144,777	5.00
HHA REIMBURSABLE SERVICES						
6.00 Skilled Nursing Care	200,806	0	200,806	0	200,806	6.00
7.00 Physical Therapy	26,644	0	26,644	0	26,644	7.00
8.00 Occupational Therapy	10,435	0	10,435	0	10,435	8.00
9.00 Speech Pathology	1,059	0	1,059	0	1,059	9.00
10.00 Medical Social Services	0	0	0	0	0	10.00
11.00 Home Health Aide	63,725	0	63,725	0	63,725	11.00
12.00 Supplies (see instructions)	0	0	0	0	0	12.00
13.00 Drugs	0	0	0	0	0	13.00
14.00 DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES						
15.00 Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00 Respiratory Therapy	0	0	0	0	0	16.00
17.00 Private Duty Nursing	0	0	0	0	0	17.00
18.00 Clinic	0	0	0	0	0	18.00
19.00 Health Promotion Activities	0	0	0	0	0	19.00
20.00 Day Care Program	0	0	0	0	0	20.00
21.00 Home Delivered Meals Program	0	0	0	0	0	21.00
22.00 Homemaker Service	0	0	0	0	0	22.00
23.00 All Others (specify)	0	0	0	0	0	23.00
24.00 Total (sum of lines 1-23)	447,446	0	447,446	0	447,446	24.00

Column, 6 line 24 should agree with the Worksheet A, column 7, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST	Provider CCN: 151305	Period: From 10/01/2010	Worksheet H-1 Part I Date/Time Prepared: 2/28/2012 1:55 pm
	HHA CCN: 157078	To 09/30/2011	
		Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	
		Bldgs & Fixtures	Movable Equipment			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	144,777	0	0	0	5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	200,806	0	0	0	6.00
7.00	Physical Therapy	26,644	0	0	0	7.00
8.00	Occupational Therapy	10,435	0	0	0	8.00
9.00	Speech Pathology	1,059	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	10.00
11.00	Home Health Aide	63,725	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	447,446	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 151305	Period: From 10/01/2010	Worksheet H-1 Part I
		HHA CCN: 157078	To 09/30/2011	Date/Time Prepared: 2/28/2012 1:55 pm
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	Subtotal (col s. 0-4) 4A.00	Administrative & General 5.00	Total (col s. 4A + 5) 6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures	0		1.00
2.00	Capital Related - Movable Equipment	0		2.00
3.00	Plant Operation & Maintenance	0		3.00
4.00	Transportation			4.00
5.00	Administrative and General	144,777	144,777	5.00
HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	200,806	96,052	296,858
7.00	Physical Therapy	26,644	12,745	39,389
8.00	Occupational Therapy	10,435	4,991	15,426
9.00	Speech Pathology	1,059	507	1,566
10.00	Medical Social Services	0	0	0
11.00	Home Health Aide	63,725	30,482	94,207
12.00	Supplies (see instructions)	0	0	0
13.00	Drugs	0	0	0
14.00	DME	0	0	0
HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0	0
16.00	Respiratory Therapy	0	0	0
17.00	Private Duty Nursing	0	0	0
18.00	Clinic	0	0	0
19.00	Health Promotion Activities	0	0	0
20.00	Day Care Program	0	0	0
21.00	Home Delivered Meals Program	0	0	0
22.00	Homemaker Service	0	0	0
23.00	All Others (specify)	0	0	0
24.00	Total (sum of lines 1-23)	302,669		447,446

COST ALLOCATION - HHA STATISTICAL BASIS	Provider CCN: 151305	Period: From 10/01/2010	Worksheet H-1 Part II Date/Time Prepared: 2/28/2012 1:55 pm
	HHA CCN: 157078	To 09/30/2011	
		Home Health Agency I	PPS

	Capital Related Costs				Transportation (MILEAGE)	Reconciliation	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)				
	1.00	2.00	3.00	4.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation (see instructions)	0	0	0	0	0	4.00
5.00	Administrative and General	0	0	0	0	-144,777	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-144,777	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	0	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		26.00

COST ALLOCATION - HHA STATISTICAL BASIS	Provider CCN: 151305	Period: From 10/01/2010	Worksheet H-1 Part II Date/Time Prepared: 2/28/2012 1:55 pm
	HHA CCN: 157078	To 09/30/2011	
		Home Health Agency I	PPS

		Administrative & General (ACCUM. COST)	
		5.00	
GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures		1.00
2.00	Capital Related - Movable Equipment		2.00
3.00	Plant Operation & Maintenance		3.00
4.00	Transportation (see instructions)		4.00
5.00	Administrative and General	302,669	5.00
HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	200,806	6.00
7.00	Physical Therapy	26,644	7.00
8.00	Occupational Therapy	10,435	8.00
9.00	Speech Pathology	1,059	9.00
10.00	Medical Social Services	0	10.00
11.00	Home Health Aide	63,725	11.00
12.00	Supplies (see instructions)	0	12.00
13.00	Drugs	0	13.00
14.00	DME	0	14.00
HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	15.00
16.00	Respiratory Therapy	0	16.00
17.00	Private Duty Nursing	0	17.00
18.00	Clinic	0	18.00
19.00	Health Promotion Activities	0	19.00
20.00	Day Care Program	0	20.00
21.00	Home Delivered Meals Program	0	21.00
22.00	Homemaker Service	0	22.00
23.00	All Others (specify)	0	23.00
24.00	Total (sum of lines 1-23)	302,669	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	144,777	25.00
26.00	Unit Cost Multiplier	0.478334	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151305

Period: From 10/01/2010

Worksheet H-2

HHA CCN: 157078

To 09/30/2011

Part I
Date/Time Prepared:
2/28/2012 1:55 pm

Home Health
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	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal 4A	ADMINISTRATIVE & GENERAL 5.00	
		NEW BLDG & FIXT 1.00					
1.00 Administrative and General	0	10,917		121,696	132,613	24,669	1.00
2.00 Skilled Nursing Care	296,858	0		0	296,858	55,222	2.00
3.00 Physical Therapy	39,389	0		0	39,389	7,327	3.00
4.00 Occupational Therapy	15,426	0		0	15,426	2,870	4.00
5.00 Speech Pathology	1,566	0		0	1,566	291	5.00
6.00 Medical Social Services	0	0		0	0	0	6.00
7.00 Home Health Aide	94,207	0		0	94,207	17,524	7.00
8.00 Supplies (see instructions)	0	0		0	0	0	8.00
9.00 Drugs	0	0		0	0	0	9.00
10.00 DME	0	0		0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0		0	0	0	11.00
12.00 Respiratory Therapy	0	0		0	0	0	12.00
13.00 Private Duty Nursing	0	0		0	0	0	13.00
14.00 Clinic	0	0		0	0	0	14.00
15.00 Health Promotion Activities	0	0		0	0	0	15.00
16.00 Day Care Program	0	0		0	0	0	16.00
17.00 Home Delivered Meals Program	0	0		0	0	0	17.00
18.00 Homemaker Service	0	0		0	0	0	18.00
19.00 All Others (specify)	0	0		0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	447,446	10,917		121,696	580,059	107,903	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151305

Period:

Worksheet H-2

HHA CCN: 157078

From 10/01/2010
To 09/30/2011

Part I
Date/Time Prepared:
2/28/2012 1:55 pm

Home Health
Agency I

PPS

		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	13.00	
1.00	Administrative and General	8,581	0	2,756	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	8,581	0	2,756	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151305

Period:

Worksheet H-2

HHA CCN: 157078

From 10/01/2010

Part I

To 09/30/2011

Date/Time Prepared:

2/28/2012 1:55 pm

		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Home Health Agency I	Subtotal	
		14.00	15.00	16.00	17.00		24.00	
1.00	Administrative and General	0	0	0	0	0	168,619	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	352,080	2.00
3.00	Physical Therapy	0	0	0	0	0	46,716	3.00
4.00	Occupational Therapy	0	0	0	0	0	18,296	4.00
5.00	Speech Pathology	0	0	0	0	0	1,857	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	111,731	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	699,299	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 151305	Period: From 10/01/2010	Worksheet H-2
		HHA CCN: 157078	To 09/30/2011	Part I
				Date/Time Prepared: 2/28/2012 1:55 pm
			Home Health Agency I	PPS

	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
	25.00	26.00	27.00	28.00	
1.00	Administrative and General	0	168,619		1.00
2.00	Skilled Nursing Care	0	352,080	111,870	2.00
3.00	Physical Therapy	0	46,716	14,844	3.00
4.00	Occupational Therapy	0	18,296	5,813	4.00
5.00	Speech Pathology	0	1,857	590	5.00
6.00	Medical Social Services	0	0	0	6.00
7.00	Home Health Aide	0	111,731	35,502	7.00
8.00	Supplies (see instructions)	0	0	0	8.00
9.00	Drugs	0	0	0	9.00
10.00	DME	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	13.00
14.00	Clinic	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	15.00
16.00	Day Care Program	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	17.00
18.00	Homemaker Service	0	0	0	18.00
19.00	All Others (specify)	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	699,299	168,619	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.317741	21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151305
HHA CCN: 157078

Period:
From 10/01/2010
To 09/30/2011

Worksheet H-2
Part II
Date/Time Prepared:
2/28/2012 1:55 pm

		CAPITAL RELATED COSTS		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)		
	NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)						
	1.00	4.00	5A	5.00	7.00			
1.00	Administrative and General	524	371,966	0	132,613	524	1.00	
2.00	Skilled Nursing Care	0	0	0	296,858	0	2.00	
3.00	Physical Therapy	0	0	0	39,389	0	3.00	
4.00	Occupational Therapy	0	0	0	15,426	0	4.00	
5.00	Speech Pathology	0	0	0	1,566	0	5.00	
6.00	Medical Social Services	0	0	0	0	0	6.00	
7.00	Home Health Aide	0	0	0	94,207	0	7.00	
8.00	Supplies (see instructions)	0	0	0	0	0	8.00	
9.00	Drugs	0	0	0	0	0	9.00	
10.00	DME	0	0	0	0	0	10.00	
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00	
12.00	Respiratory Therapy	0	0	0	0	0	12.00	
13.00	Private Duty Nursing	0	0	0	0	0	13.00	
14.00	Clinic	0	0	0	0	0	14.00	
15.00	Health Promotion Activities	0	0	0	0	0	15.00	
16.00	Day Care Program	0	0	0	0	0	16.00	
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00	
18.00	Homemaker Service	0	0	0	0	0	18.00	
19.00	All Others (specify)	0	0	0	0	0	19.00	
20.00	Total (sum of lines 1-19)	524	371,966		580,059	524	20.00	
21.00	Total cost to be allocated	10,917	121,696		107,903	8,581	21.00	
22.00	Unit cost multiplier	20.833969	0.327170		0.186021	16.375954	22.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151305
HHA CCN: 157078

Period:
From 10/01/2010
To 09/30/2011

Worksheet H-2
Part II
Date/Time Prepared:
2/28/2012 1:55 pm
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		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100%)	
		8.00	9.00	10.00	13.00	14.00	
1.00	Administrative and General	0	524	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	524	0	0	0	20.00
21.00	Total cost to be allocated	0	2,756	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	5.259542	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 151305 HHA CCN: 157078	Period: From 10/01/2010 To 09/30/2011	Worksheet H-2 Part II Date/Time Prepared: 2/28/2012 1:55 pm PPS
		Home Health Agency I	

	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (ALLOCATION OF TIME)	
	15.00	16.00	17.00	
1.00 Administrative and General	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	2.00
3.00 Physical Therapy	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	4.00
5.00 Speech Pathology	0	0	0	5.00
6.00 Medical Social Services	0	0	0	6.00
7.00 Home Health Aide	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	8.00
9.00 Drugs	0	0	0	9.00
10.00 DME	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	13.00
14.00 Clinic	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	15.00
16.00 Day Care Program	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	17.00
18.00 Homemaker Service	0	0	0	18.00
19.00 All Others (specify)	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	0	20.00
21.00 Total cost to be allocated	0	0	0	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 151305 HHA CCN: 157078		Period: From 10/01/2010 To 09/30/2011		Worksheet H-3 Parts I-II Date/Time Prepared: 2/28/2012 1:55 pm	
		Title XVIII		Home Health Agency I		PPS	
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	
		0	1.00	2.00	3.00	4.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	463,950		463,950	1,510	1.00
2.00	Physical Therapy	3.00	61,560	0	61,560	503	2.00
3.00	Occupational Therapy	4.00	24,109	0	24,109	197	3.00
4.00	Speech Pathology	5.00	2,447	0	2,447	20	4.00
5.00	Medical Social Services	6.00	0		0	0	5.00
6.00	Home Health Aide	7.00	147,233		147,233	2,174	6.00
7.00	Total (sum of lines 1-6)		699,299	0	699,299	4,404	7.00
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits		
					Part B		
					Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	
Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	755	473		8.00
9.00	Physical Therapy		99915	299	147		9.00
10.00	Occupational Therapy		99915	107	61		10.00
11.00	Speech Pathology		99915	11	4		11.00
12.00	Medical Social Services		99915	0	0		12.00
13.00	Home Health Aide		99915	225	238		13.00
14.00	Total (sum of lines 8-13)			1,397	923		14.00
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	
		0	1.00	2.00	3.00	4.00	
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	16.00
Cost Center Description		From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)		
		0	1.00	2.00	3.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy		66.00	0.518705	0	0	1.00
2.00	Occupational Therapy		67.00	0.425086	0	0	2.00
3.00	Speech Pathology		68.00	0.616773	0	0	3.00
4.00	Cost of Medical Supplies		71.00	0.437863	0	0	4.00
5.00	Cost of Drugs		73.00	0.234701	0	0	5.00
5.01	Cost of Drugs 1		73.01	0.378258	0	0	5.01

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151305
HHA CCN: 157078

Period:
From 10/01/2010
To 09/30/2011

Worksheet H-3
Parts I-III
Date/Time Prepared:
2/28/2012 1:55 pm
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Title XVIII

Home Health Agency I

Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Part A	Program Visits			
			Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	5.00	6.00	7.00	8.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
Cost Per Visit Computation						
1.00	Skilled Nursing Care	307.25	755	473		1.00
2.00	Physical Therapy	122.39	299	147		2.00
3.00	Occupational Therapy	122.38	107	61		3.00
4.00	Speech Pathology	122.35	11	4		4.00
5.00	Medical Social Services	0.00	0	0		5.00
6.00	Home Health Aide	67.72	225	238		6.00
7.00	Total (sum of lines 1-6)		1,397	923		7.00
Cost Center Description						
		5.00	6.00	7.00	8.00	9.00
Limitation Cost Computation						
8.00	Skilled Nursing Care					8.00
9.00	Physical Therapy					9.00
10.00	Occupational Therapy					10.00
11.00	Speech Pathology					11.00
12.00	Medical Social Services					12.00
13.00	Home Health Aide					13.00
14.00	Total (sum of lines 8-13)					14.00
Program Covered Charges						
Cost Center Description	Ratio (col. 3 ÷ col. 4)	Part A	Part B			
			Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	5.00	6.00	7.00	8.00		
Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	0.000000	0	23,551	0	15.00
16.00	Cost of Drugs	0.000000	0	0	0	16.00
Cost Center Description						
			Transfer to Part I as Indicated			
			4.00			
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy		col. 2, line 2.00			1.00
2.00	Occupational Therapy		col. 2, line 3.00			2.00
3.00	Speech Pathology		col. 2, line 4.00			3.00
4.00	Cost of Medical Supplies		col. 2, line 15.00			4.00
5.00	Cost of Drugs		col. 2, line 16.00			5.00
5.01	Cost of Drugs 1		col. 2, line 16.01			5.01

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151305

Period: From 10/01/2010

Worksheet H-3

HHA CCN: 157078

To 09/30/2011

Parts I-III
Date/Time Prepared:
2/28/2012 1:55 pm

Title XVIII

Home Health Agency I

PPS

Cost Center Description	Cost of Services			Total Program Cost (sum of col.s. 9-10)	
	Part A	Part B			
		Not Subject to Deductibles & Coi nsurance	Subject to Deductibles & Coi nsurance		
9.00	10.00	11.00	12.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION					
Cost Per Visit Computation					
1.00	Skilled Nursing Care	231,974	145,329	377,303	1.00
2.00	Physical Therapy	36,595	17,991	54,586	2.00
3.00	Occupational Therapy	13,095	7,465	20,560	3.00
4.00	Speech Pathology	1,346	489	1,835	4.00
5.00	Medical Social Services	0	0	0	5.00
6.00	Home Health Aide	15,237	16,117	31,354	6.00
7.00	Total (sum of lines 1-6)	298,247	187,391	485,638	7.00
Cost Center Description					
		10.00	11.00	12.00	
Limitation Cost Computation					
8.00	Skilled Nursing Care				8.00
9.00	Physical Therapy				9.00
10.00	Occupational Therapy				10.00
11.00	Speech Pathology				11.00
12.00	Medical Social Services				12.00
13.00	Home Health Aide				13.00
14.00	Total (sum of lines 8-13)				14.00
Cost of Services					
Cost Center Description	Part A	Part B			
		Not Subject to Deductibles & Coi nsurance	Subject to Deductibles & Coi nsurance		
	9.00	10.00	11.00		
Supplies and Drugs Cost Computations					
15.00	Cost of Medical Supplies	0	0	0	15.00
16.00	Cost of Drugs	0	0	0	16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 151305 HHA CCN: 157078	Period: From 10/01/2010 To 09/30/2011	Worksheet H-4 Part I-II Date/Time Prepared: 2/28/2012 1:55 pm
		Title XVII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	2.00
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	8.00
9.00	Primary payer amounts	0	0	9.00
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		203,431	135,724
12.00	Total PPS Reimbursement - Full Episodes with Outliers		1,610	0
13.00	Total PPS Reimbursement - LUPA Episodes		4,051	8,386
14.00	Total PPS Reimbursement - PEP Episodes		1,381	1,163
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		107	0
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)			0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		210,580	145,273
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		210,580	145,273
25.00	Coinsurance billed to program patients (from your records)			0
26.00	Net cost (line 24 minus line 25)		210,580	145,273
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		210,580	145,273
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		210,580	145,273
32.00	Interim payments (see instructions)		210,580	145,273
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 32 and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	0

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

Provider CCN: 151305
HHA CCN: 157078

Period:
From 10/01/2010
To 09/30/2011

Worksheet H-5
Date/Time Prepared:
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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		210,579		145,273	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			1		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		1		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		210,580		145,273	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		210,580		145,273	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151305

Period: From 10/01/2010

Worksheet K

Hospice CCN: 151550

To 09/30/2011

Date/Time Prepared: 2/28/2012 1:55 pm

		Hospice I					
		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	4,847	0	2,156	0	35,627	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	16,990	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	15,244	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	2,059	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	39,140	0	2,156	0	35,627	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151305

Period: From 10/01/2010

Worksheet K

Hospice CCN: 151550

To 09/30/2011

Date/Time Prepared: 2/28/2012 1:55 pm

		Hospice I					
		Total (col. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	42,630	0	42,630	0	42,630	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	16,990	0	16,990	0	16,990	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	15,244	0	15,244	0	15,244	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	2,059	0	2,059	0	2,059	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	76,923	0	76,923	0	76,923	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151305

Period: From 10/01/2010

Worksheet K-1

Hospice CCN: 151550

To 09/30/2011

Date/Time Prepared: 2/28/2012 1:55 pm

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	4,847	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	16,990	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	15,244	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	20,091	0	0	0	16,990	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151305

Period: From 10/01/2010

Worksheet K-1

Hospice CCN: 151550

To 09/30/2011

Date/Time Prepared: 2/28/2012 1:55 pm

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	0	4,847	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services		0	0	0	9.00
10.00	Nursing Care		0	0	16,990	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	0	0	0	15,244	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services		0	0	0	15.00
16.00	Spiritual Counseling		0	0	0	16.00
17.00	Dietary Counseling		0	0	0	17.00
18.00	Counseling - Other		0	0	0	18.00
19.00	Home Health Aide and Homemaker		2,059	0	2,059	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	2,059	0	39,140	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151305

Period: From 10/01/2010

Worksheet K-4

Hospice CCN: 151550

To 09/30/2011

Part I
Date/Time Prepared:
2/28/2012 1:55 pm

		CAPITAL RELATED COST				Hospice I	
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
			1.00	2.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	42,630	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	16,990	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	15,244	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	2,059	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	76,923	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151305

Period: From 10/01/2010

Worksheet K-4

Hospice CCN: 151550

To 09/30/2011

Part I
Date/Time Prepared:
2/28/2012 1:55 pm

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)	
		5.00	5A	6.00	7.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.		0			1.00
2.00	Capital Related Costs-Movable Equip.		0			2.00
3.00	Plant Operation and Maintenance		0			3.00
4.00	Transportation - Staff		0			4.00
5.00	Volunteer Service Coordination	0				5.00
6.00	Administrative and General	0	42,630			6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services	0	0	0	0	9.00
10.00	Nursing Care	0	16,990	21,120	38,110	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	15,244	18,950	34,194	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	2,059	2,560	4,619	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	20.00
21.00	Other	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	33.00
34.00	Other	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	34,293	42,630	76,923	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151305

Period: From 10/01/2010

Worksheet K-4

Hospice CCN: 151550

To 09/30/2011

Part II
Date/Time Prepared:
2/28/2012 1:55 pm

		CAPITAL RELATED COST		PLANT OPERATION & MAINT. (SQ. FT.)	TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICES COORDINATOR (HOURS)	
		BUILDINGS & FIXTURES (SQ. FT.)	MOVABLE EQUIPMENT (\$ VALUE)				
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0	0				2.00
3.00	Plant Operation and Maintenance	0	0	0			3.00
4.00	Transportation - Staff	0	0	0	0		4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)	0	0	0	0	0	39.00
40.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	40.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151305

Period: From 10/01/2010

Worksheet K-4

Hospice CCN: 151550

To 09/30/2011

Part II
Date/Time Prepared:
2/28/2012 1:55 pm

Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	
		6A	6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0		1.00
2.00	Capital Related Costs-Movable Equip.	0		2.00
3.00	Plant Operation and Maintenance	0		3.00
4.00	Transportation - Staff	0		4.00
5.00	Volunteer Service Coordination			5.00
6.00	Administrative and General	-42,630	34,293	6.00
INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	0	7.00
8.00	Inpatient - Respite Care	0	0	8.00
VISITING SERVICES				
9.00	Physician Services	0	0	9.00
10.00	Nursing Care	0	16,990	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	15,244	12.00
13.00	Occupational Therapy	0	0	13.00
14.00	Speech/ Language Pathology	0	0	14.00
15.00	Medical Social Services	0	0	15.00
16.00	Spiritual Counseling	0	0	16.00
17.00	Dietary Counseling	0	0	17.00
18.00	Counseling - Other	0	0	18.00
19.00	Home Health Aide and Homemaker	0	2,059	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00	Other	0	0	21.00
OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	0	22.00
23.00	Analgesics	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	24.00
25.00	Other - Specify	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	26.00
27.00	Patient Transportation	0	0	27.00
28.00	Imaging Services	0	0	28.00
29.00	Labs and Diagnostics	0	0	29.00
30.00	Medical Supplies	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	31.00
32.00	Radiation Therapy	0	0	32.00
33.00	Chemotherapy	0	0	33.00
34.00	Other	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0	35.00
36.00	Volunteer Program Costs	0	0	36.00
37.00	Fundraising	0	0	37.00
38.00	Other Program Costs	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		42,630	39.00
40.00	Unit Cost Multiplier		1.243111	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151305

Period: From 10/01/2010

Worksheet K-5

Hospice CCN: 151550

To 09/30/2011

Part I
Date/Time Prepared:
2/28/2012 1:55 pm

Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal 4A	ADMINISTRATIVE & GENERAL 5.00	
		NEW BLDG & FIXT					
		1.00	4.00				
1.00 Administrative and General	0	3,979	12,805	16,784	3,122	1.00	
2.00 Inpatient - General Care	0	0	0	0	0	2.00	
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00	
4.00 Physician Services	0	0	0	0	0	4.00	
5.00 Nursing Care	38,110	0	0	38,110	7,089	5.00	
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00	
7.00 Physical Therapy	34,194	0	0	34,194	6,361	7.00	
8.00 Occupational Therapy	0	0	0	0	0	8.00	
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00	
10.00 Medical Social Services	0	0	0	0	0	10.00	
11.00 Spiritual Counseling	0	0	0	0	0	11.00	
12.00 Dietary Counseling	0	0	0	0	0	12.00	
13.00 Counseling - Other	0	0	0	0	0	13.00	
14.00 Home Health Aide and Homemaker	4,619	0	0	4,619	859	14.00	
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00	
16.00 Other	0	0	0	0	0	16.00	
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00	
18.00 Analgesics	0	0	0	0	0	18.00	
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00	
20.00 Other - Specify	0	0	0	0	0	20.00	
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00	
22.00 Patient Transportation	0	0	0	0	0	22.00	
23.00 Imaging Services	0	0	0	0	0	23.00	
24.00 Labs and Diagnostics	0	0	0	0	0	24.00	
25.00 Medical Supplies	0	0	0	0	0	25.00	
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00	
27.00 Radiation Therapy	0	0	0	0	0	27.00	
28.00 Chemotherapy	0	0	0	0	0	28.00	
29.00 Other	0	0	0	0	0	29.00	
30.00 Bereavement Program Costs	0	0	0	0	0	30.00	
31.00 Volunteer Program Costs	0	0	0	0	0	31.00	
32.00 Fundraising	0	0	0	0	0	32.00	
33.00 Other Program Costs	0	0	0	0	0	33.00	
34.00 Total (sum of lines 1 thru 33) (2)	76,923	3,979	12,805	93,707	17,431	34.00	
35.00 Unit Cost Multiplier (see instructions)				0.000000		35.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS	Provider CCN: 151305	Period: From 10/01/2010 To 09/30/2011	Worksheet K-5 Part I Date/Time Prepared: 2/28/2012 1:55 pm
	Hospice CCN: 151550		

Cost Center Description	Hospice I					
	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	NURSING ADMINISTRATION 13.00	
1.00 Administrative and General	3,128	0	1,005	0	0	1.00
2.00 Inpatient - General Care	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	4.00
5.00 Nursing Care	0	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	3,128	0	1,005	0	0	34.00
35.00 Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151305

Period: From 10/01/2010

Worksheet K-5

Hospice CCN: 151550

To 09/30/2011

Part I
Date/Time Prepared:
2/28/2012 1:55 pm

Cost Center Description		Hospice I				Subtotal (col s. 4A-23)	
		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE		
		14.00	15.00	16.00	17.00	24.00	
1.00	Administrative and General	0	0	0	856	24,895	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	45,199	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	40,555	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	5,478	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	856	116,127	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151305

Period: From 10/01/2010

Worksheet K-5

Hospice CCN: 151550

To 09/30/2011

Part I
Date/Time Prepared:
2/28/2012 1:55 pm

Cost Center Description		Hospice I					
		Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (col.s. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (col.s. 26 ± 27)		
		25.00	26.00	27.00	28.00		
1.00	Administrative and General						1.00
2.00	Inpatient - General Care	0	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0	0		3.00
4.00	Physician Services	0	0	0	0		4.00
5.00	Nursing Care	0	45,199	12,334	57,533		5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0		6.00
7.00	Physical Therapy	0	40,555	11,066	51,621		7.00
8.00	Occupational Therapy	0	0	0	0		8.00
9.00	Speech/ Language Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Spiritual Counseling	0	0	0	0		11.00
12.00	Dietary Counseling	0	0	0	0		12.00
13.00	Counseling - Other	0	0	0	0		13.00
14.00	Home Health Aide and Homemaker	0	5,478	1,495	6,973		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00
16.00	Other	0	0	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0		17.00
18.00	Analgesics	0	0	0	0		18.00
19.00	Sedatives / Hypnotics	0	0	0	0		19.00
20.00	Other - Specify	0	0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0		21.00
22.00	Patient Transportation	0	0	0	0		22.00
23.00	Imaging Services	0	0	0	0		23.00
24.00	Labs and Diagnostics	0	0	0	0		24.00
25.00	Medical Supplies	0	0	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0		26.00
27.00	Radiation Therapy	0	0	0	0		27.00
28.00	Chemotherapy	0	0	0	0		28.00
29.00	Other	0	0	0	0		29.00
30.00	Bereavement Program Costs	0	0	0	0		30.00
31.00	Volunteer Program Costs	0	0	0	0		31.00
32.00	Fundraising	0	0	0	0		32.00
33.00	Other Program Costs	0	0	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	116,127	0.272876	116,127		34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151305

Period:

Worksheet K-5

Hospice CCN: 151550

From 10/01/2010
To 09/30/2011

Part II
Date/Time Prepared:
2/28/2012 1:55 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		NEW BLDG & FIXT (SQUARE FEET)						
		1.00		4.00	5A	5.00	7.00	
1.00	Administrative and General	191		39,140	0	16,784	191	1.00
2.00	Inpatient - General Care	0		0	0	0	0	2.00
3.00	Inpatient - Respite Care	0		0	0	0	0	3.00
4.00	Physician Services	0		0	0	0	0	4.00
5.00	Nursing Care	0		0	0	38,110	0	5.00
6.00	Nursing Care-Continuous Home Care	0		0	0	0	0	6.00
7.00	Physical Therapy	0		0	0	34,194	0	7.00
8.00	Occupational Therapy	0		0	0	0	0	8.00
9.00	Speech/ Language Pathology	0		0	0	0	0	9.00
10.00	Medical Social Services	0		0	0	0	0	10.00
11.00	Spiritual Counseling	0		0	0	0	0	11.00
12.00	Dietary Counseling	0		0	0	0	0	12.00
13.00	Counseling - Other	0		0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0		0	0	4,619	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0		0	0	0	0	15.00
16.00	Other	0		0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0		0	0	0	0	17.00
18.00	Analgesics	0		0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0		0	0	0	0	19.00
20.00	Other - Specify	0		0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0		0	0	0	0	21.00
22.00	Patient Transportation	0		0	0	0	0	22.00
23.00	Imaging Services	0		0	0	0	0	23.00
24.00	Labs and Diagnostics	0		0	0	0	0	24.00
25.00	Medical Supplies	0		0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0		0	0	0	0	26.00
27.00	Radiation Therapy	0		0	0	0	0	27.00
28.00	Chemotherapy	0		0	0	0	0	28.00
29.00	Other	0		0	0	0	0	29.00
30.00	Bereavement Program Costs	0		0	0	0	0	30.00
31.00	Volunteer Program Costs	0		0	0	0	0	31.00
32.00	Fundraising	0		0	0	0	0	32.00
33.00	Other Program Costs	0		0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	191		39,140		93,707	191	34.00
35.00	Total cost to be allocated	3,979		12,805		17,431	3,128	35.00
36.00	Unit Cost Multiplier (see instructions)	20.832461		0.327159		0.186016	16.376963	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151305
Hospice CCN: 151550

Period:
From 10/01/2010
To 09/30/2011

Worksheet K-5
Part II
Date/Time Prepared:
2/28/2012 1:55 pm

Cost Center Description		Hospice I					
		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100%)	
		8.00	9.00	10.00	13.00	14.00	
1.00	Administrative and General	0	191	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	191	0	0	0	34.00
35.00	Total cost to be allocated	0	1,005	0	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	5.261780	0.000000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151305

Period:

Worksheet K-5

Hospice CCN: 151550

From 10/01/2010
To 09/30/2011

Part II
Date/Time Prepared:
2/28/2012 1:55 pm

Cost Center Description		PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (ALLOCATION OF TIME)	Hospice I	
		15.00	16.00	17.00		
1.00	Administrative and General	0	0	113		1.00
2.00	Inpatient - General Care	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0		3.00
4.00	Physician Services	0	0	0		4.00
5.00	Nursing Care	0	0	0		5.00
6.00	Nursing Care-Continuous Home Care	0	0	0		6.00
7.00	Physical Therapy	0	0	0		7.00
8.00	Occupational Therapy	0	0	0		8.00
9.00	Speech/ Language Pathology	0	0	0		9.00
10.00	Medical Social Services	0	0	0		10.00
11.00	Spiritual Counseling	0	0	0		11.00
12.00	Dietary Counseling	0	0	0		12.00
13.00	Counseling - Other	0	0	0		13.00
14.00	Home Health Aide and Homemaker	0	0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0		15.00
16.00	Other	0	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0		17.00
18.00	Analgesics	0	0	0		18.00
19.00	Sedatives / Hypnotics	0	0	0		19.00
20.00	Other - Specify	0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0		21.00
22.00	Patient Transportation	0	0	0		22.00
23.00	Imaging Services	0	0	0		23.00
24.00	Labs and Diagnostics	0	0	0		24.00
25.00	Medical Supplies	0	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0		26.00
27.00	Radiation Therapy	0	0	0		27.00
28.00	Chemotherapy	0	0	0		28.00
29.00	Other	0	0	0		29.00
30.00	Bereavement Program Costs	0	0	0		30.00
31.00	Volunteer Program Costs	0	0	0		31.00
32.00	Fundraising	0	0	0		32.00
33.00	Other Program Costs	0	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	113		34.00
35.00	Total cost to be allocated	0	0	856		35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	7.575221		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 151305

Period: From 10/01/2010

Worksheet K-5

Hospice CCN: 151550

To 09/30/2011

Part III
Date/Time Prepared:
2/28/2012 1:55 pm

Cost Center Description		Hospice I			
		Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)
		0	1.00	2.00	3.00
ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.518705	0	0 1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.425086	0	0 2.00
3.00	SPEECH PATHOLOGY	68.00	0.616773	0	0 3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.234701	0	0 4.00
4.01	DRUGS CHARGED TO PATIENTS	73.01	0.378258	0	0 4.01
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00			5.00
6.00	LABORATORY	60.00	0.262649	0	0 6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0 6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.437863	0	0 7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00			8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00			9.00
10.00	ONCOLOGY	76.00	2.451571	0	0 10.00
10.01	CARDIAC REHAB	76.01	1.456753	0	0 10.01
11.00	Totals (sum of lines 1-10)				0 11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 151305

Period: From 10/01/2010

Worksheet K-6

Hospice CCN: 151550

To 09/30/2011

Date/Time Prepared: 2/28/2012 1:55 pm

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				116,127	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				766	2.00
3.00	Average cost per diem (line 1 divided by line 2)				151.60	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	618				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	93,689				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		61			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		9,248			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	114				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	17,282				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		117			10.00
11.00	Aggregate NF cost (line 3 times line 10)		17,737			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			87		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			13,189		13.00