

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: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet S Parts I-III Date/Time Prepared: 2/23/2012 2:36 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input type="checkbox"/> Electronically filed cost report 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.	Date: 2/23/2012	Time: 2:36 pm
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 FAYETTE REGIONAL HEALTH SYSTEM 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 XVIII			HIT	Title XIX	
	Title V	Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	33,704	82,230	0	-45,099	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	12,887	0		-40,306	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	-1	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 Skilled Nursing Facility	0	0	0		0	7.00
8.00 Nursing Facility	0				0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00 CMHC I	0		0		0	12.00
200.00 Total	0	46,590	82,230	0	-85,405	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: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part I Date/Time Prepared: 2/23/2012 2:34 pm		
		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.					Y			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	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
				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	7,500,000	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	Y	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.					Y		145.00
							1.00	2.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.			N				146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N				147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N				148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N				149.00
					Part A		Part B	
					1.00		2.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital			N		N		155.00
156.00	Subprovider - IPF			N		N		156.00
157.00	Subprovider - IRF			N		N		157.00
158.00	Subprovider - 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	Zip Code	CBSA	FTE/Campus
			0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5							0.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					N		167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							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: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part II Date/Time Prepared: 2/23/2012 2:34 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
Financial Data and Reports					
			Y/N	Type	Date
			1.00	2.00	3.00
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	01/18/2012	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

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		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.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
					Y/N
					Date
					1.00
					2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 150064

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

Worksheet S-2
Part II
Date/Time Prepared:
2/23/2012 2:34 pm

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	01/18/2012	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: 150064

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

Worksheet S-3
Part I
Date/Time Prepared:
2/23/2012 2:34 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	45	16,425	0.00		1.00
2.00 HMO						2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		45	16,425	0.00		7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,380	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)		57	20,805	0.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	40.00	0	0			16.00
17.00 SUBPROVIDER - IRF	41.00	16	5,840			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)		73				27.00
28.00 Observation Bed Days						28.00
28.01 SUBPROVIDER - IPF	40.00					28.01
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: 150064

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

Worksheet S-3
Part I
Date/Time Prepared:
2/23/2012 2:34 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	2,145	259	3,611		1.00
2.00 HMO		402	1,014			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		22	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	249	0	271		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,394	259	3,882		7.00
8.00 INTENSIVE CARE UNIT	0	1,183	124	2,033		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		23	495		13.00
14.00 Total (see instructions)	0	3,577	406	6,410		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF	0	0	0	0		16.00
17.00 SUBPROVIDER - IRF	0	764	58	959		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	4,986	377	17,105		22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE		0	0	0		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		180	819		28.00
28.01 SUBPROVIDER - IPF	0	0	0	0		28.01
28.02 SUBPROVIDER - IRF	0	0	0	0		28.02
28.03 SUBPROVIDER	0	0	0	0		28.03
29.00 Ambulance Trips		1,049				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)			29	43		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150064

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

Worksheet S-3
Part I
Date/Time Prepared:
2/23/2012 2:34 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	901	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	508.81	0.00	0	901	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0.00	0.00	0	0	16.00
17.00 SUBPROVIDER - IRF	0.00	8.79	0.00	0	61	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	517.60	0.00			27.00
28.00 Observation Bed Days						28.00
28.01 SUBPROVIDER - IPF						28.01
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: 150064

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

Worksheet S-3
Part I
Date/Time Prepared:
2/23/2012 2:34 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)	103	1,645		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)	103	1,645		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF	0	0		16.00
17.00 SUBPROVIDER - IRF	3	74		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
28.01 SUBPROVIDER - IPF				28.01
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 WAGE INDEX INFORMATION

Provider CCN: 150064

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

Worksheet S-3
Part II
Date/Time Prepared:
2/23/2012 2:34 pm

		Worksheet A Line Number	Amount Reported	Salary Adjustments for Vacation, Holiday, Sick, Other Paid Time Off, Severance, and Bonus, Paid to Employees and Not Reflected in Column 2	Recl assifi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	
		1.00	2.00	2.50	3.00	4.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	25,094,568	0	0	25,094,568	1.00
2.00	Non-physician anesthetist Part A		11,501	0	0	11,501	2.00
3.00	Non-physician anesthetist Part B		420,104	0	0	420,104	3.00
4.00	Physician-Part A		449,235	0	0	449,235	4.00
4.01	Physicians - Part A - direct teaching		0	0	0	0	4.01
5.00	Physician-Part B		2,073,350	0	0	2,073,350	5.00
6.00	Non-physician-Part B		0	0	0	0	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0	7.00
7.01	Contracted interns and residents (in approved programs)		0	0	0	0	7.01
8.00	Home office personnel		0	0	0	0	8.00
9.00	SNF	44.00	0	0	0	0	9.00
10.00	Excluded area salaries (see instructions)		6,380,834	0	68,379	6,449,213	10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		445,768	0	0	445,768	11.00
12.00	Management and administrative services		0	0	0	0	12.00
13.00	Contract labor: physician-Part A		409,222	0	0	409,222	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0	14.00
15.00	Home office: physician Part A		0	0	0	0	15.00
16.00	Teaching physician salaries (see instructions)		0	0	0	0	16.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24		4,248,066	0	0	4,248,066	17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV Line 25		0	0	0	0	18.00
19.00	Excluded areas		1,290,124	0	0	1,290,124	19.00
20.00	Non-physician anesthetist Part A		0	0	0	0	20.00
21.00	Non-physician anesthetist Part B		0	0	0	0	21.00
22.00	Physician Part A		60,846	0	0	60,846	22.00
23.00	Physician Part B		237,181	0	0	237,181	23.00
24.00	Wage-related costs (RHC/FOHC)		0	0	0	0	24.00
25.00	Interns & residents (in an approved program)		0	0	0	0	25.00
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits	4.00	198,118	0	115,722	313,840	26.00
27.00	Administrative & General	5.00	2,204,220	0	-574,765	1,629,455	27.00
28.00	Administrative & General under contract (see inst.)		571,101	0	0	571,101	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0	29.00
30.00	Operation of Plant	7.00	447,604	0	11,771	459,375	30.00
31.00	Laundry & Linen Service	8.00	22,588	0	426	23,014	31.00
32.00	Housekeeping	9.00	539,063	0	10,169	549,232	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0	33.00
34.00	Dietary	10.00	499,244	0	-286,257	212,987	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0	35.00
36.00	Cafeteria	11.00	0	0	295,675	295,675	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0	37.00
38.00	Nursing Administration	13.00	391,769	0	5,710	397,479	38.00
39.00	Central Services and Supply	14.00	90,717	0	1,711	92,428	39.00
40.00	Pharmacy	15.00	687,147	0	6,802	693,949	40.00
41.00	Medical Records & Medical Records Library	16.00	739,259	0	69,045	808,304	41.00
42.00	Social Service	17.00	0	0	0	0	42.00
43.00	Other General Service	18.00	0	0	0	0	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150064

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

Worksheet S-3
Part II
Date/Time Prepared:
2/23/2012 2:34 pm

		Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		5.00	6.00	
PART II - WAGE DATA				
SALARIES				
1.00	Total salaries (see instructions)	1,072,773.00	23.39	1.00
2.00	Non-physician anesthetist Part A	111.00	103.61	2.00
3.00	Non-physician anesthetist Part B	4,050.00	103.73	3.00
4.00	Physician-Part A	3,777.00	118.94	4.00
4.01	Physicians - Part A - direct teaching	0.00	0.00	4.01
5.00	Physician-Part B	22,918.00	90.47	5.00
6.00	Non-physician-Part B	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	0.00	0.00	7.00
7.01	Contracted interns and residents (in approved programs)	0.00	0.00	7.01
8.00	Home office personnel	0.00	0.00	8.00
9.00	SNF	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)	255,342.00	25.26	10.00
OTHER WAGES & RELATED COSTS				
11.00	Contract labor (see instructions)	5,064.00	88.03	11.00
12.00	Management and administrative services	0.00	0.00	12.00
13.00	Contract labor: physician-Part A	4,726.00	86.59	13.00
14.00	Home office salaries & wage-related costs	0.00	0.00	14.00
15.00	Home office: physician Part A	0.00	0.00	15.00
16.00	Teaching physician salaries (see instructions)	0.00	0.00	16.00
WAGE-RELATED COSTS				
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24			17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV Line 25			18.00
19.00	Excluded areas			19.00
20.00	Non-physician anesthetist Part A			20.00
21.00	Non-physician anesthetist Part B			21.00
22.00	Physician Part A			22.00
23.00	Physician Part B			23.00
24.00	Wage-related costs (RHC/FQHC)			24.00
25.00	Interns & residents (in an approved program)			25.00
OVERHEAD COSTS - DIRECT SALARIES				
26.00	Employee Benefits	10,369.00	30.27	26.00
27.00	Administrative & General	92,156.00	17.68	27.00
28.00	Administrative & General under contract (see inst.)	16,382.00	34.86	28.00
29.00	Maintenance & Repairs	0.00	0.00	29.00
30.00	Operation of Plant	33,376.00	13.76	30.00
31.00	Laundry & Linen Service	2,095.00	10.99	31.00
32.00	Housekeeping	56,138.00	9.78	32.00
33.00	Housekeeping under contract (see instructions)	0.00	0.00	33.00
34.00	Dietary	15,801.00	13.48	34.00
35.00	Dietary under contract (see instructions)	0.00	0.00	35.00
36.00	Cafeteria	22,737.00	13.00	36.00
37.00	Maintenance of Personnel	0.00	0.00	37.00
38.00	Nursing Administration	12,348.00	32.19	38.00
39.00	Central Services and Supply	5,855.00	15.79	39.00
40.00	Pharmacy	20,777.00	33.40	40.00
41.00	Medical Records & Medical Records Library	39,444.00	20.49	41.00
42.00	Social Service	0.00	0.00	42.00
43.00	Other General Service	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150064

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

Worksheet S-3
Part III
Date/Time Prepared:
2/23/2012 2:34 pm

	Worksheet A Line Number	Amount Reported	Salary Adjustments for Vacation, Holiday, Sick, Other Paid Time Off, Severance, and Bonus, Paid to Employees and Not Reflected in Column 2	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	
	1.00	2.00	2.50	3.00	4.00	
PART III - HOSPITAL WAGE INDEX SUMMARY						
1.00	Net salaries (see instructions)	22,711,479	0	0	22,711,479	1.00
2.00	Excluded area salaries (see instructions)	6,380,834	0	68,379	6,449,213	2.00
3.00	Subtotal salaries (line 1 minus line 2)	16,330,645	0	-68,379	16,262,266	3.00
4.00	Subtotal other wages & related costs (see inst.)	854,990	0	0	854,990	4.00
5.00	Subtotal wage-related costs (see inst.)	4,308,912	0	0	4,308,912	5.00
6.00	Total (sum of lines 3 thru 5)	21,494,547	0	-68,379	21,426,168	6.00
7.00	Total overhead cost (see instructions)	6,390,830	0	-343,991	6,046,839	7.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet S-3 Part III Date/Time Prepared: 2/23/2012 2:34 pm
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		Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY				
1.00	Net salaries (see instructions)	1,062,076.00	21.38	1.00
2.00	Excluded area salaries (see instructions)	255,342.00	25.26	2.00
3.00	Subtotal salaries (line 1 minus line 2)	806,734.00	20.16	3.00
4.00	Subtotal other wages & related costs (see inst.)	9,790.00	87.33	4.00
5.00	Subtotal wage-related costs (see inst.)	0.00	26.50	5.00
6.00	Total (sum of lines 3 thru 5)	816,524.00	26.24	6.00
7.00	Total overhead cost (see instructions)	327,478.00	18.46	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet S-3 Part IV Date/Time Prepared: 2/23/2012 2:34 pm
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		766,101	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost		0	3.00
4.00	Prior Year Pension Service Cost		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		3,034,050	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		144,484	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		1,645,682	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		165,389	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		80,511	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		5,836,217	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150064

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

Worksheet S-3
Part V
Date/Time Prepared:
2/23/2012 2:34 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	445,768	0	1.00
2.00	Hospital	445,768	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis	0	0	17.00
18.00		0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 150064 Component CCN: 157097		Period: From 10/01/2010 To 09/30/2011		Worksheet S-4 Date/Time Prepared: 2/23/2012 2:34 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	1.00	
2.00	Unduplicated Census Count (see instructions)	0.00	304.00	0.00	0.00	0.00	2.00	
		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					3.00	
4.00	Director(s) and Assistant Director(s)	0.00					4.00	
5.00	Other Administrative Personnel	0.00					5.00	
6.00	Direct Nursing Service	0.00					6.00	
7.00	Nursing Supervisor	0.00					7.00	
8.00	Physical Therapy Service	0.00					8.00	
9.00	Physical Therapy Supervisor	0.00					9.00	
10.00	Occupational Therapy Service	0.00					10.00	
11.00	Occupational Therapy Supervisor	0.00					11.00	
12.00	Speech Pathology Service	0.00					12.00	
13.00	Speech Pathology Supervisor	0.00					13.00	
14.00	Medical Social Service	0.00					14.00	
15.00	Medical Social Service Supervisor	0.00					15.00	
16.00	Home Health Aide	0.00					16.00	
17.00	Home Health Aide Supervisor	0.00					17.00	
18.00	Other (specify)	0.00					18.00	
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		19.00	
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	99915					20.00	
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)		
		Without Outliers	With Outliers					
		1.00	2.00	3.00	4.00	5.00		
PPS ACTIVITY DATA								
21.00	Skilled Nursing Visits	2,261	148	115	35	2,559	21.00	
22.00	Skilled Nursing Visit Charges	260,015	17,020	13,225	4,025	294,285	22.00	
23.00	Physical Therapy Visits	442	9	18	8	477	23.00	
24.00	Physical Therapy Visit Charges	55,250	1,125	2,250	1,000	59,625	24.00	
25.00	Occupational Therapy Visits	232	0	3	12	247	25.00	
26.00	Occupational Therapy Visit Charges	29,000	0	375	1,500	30,875	26.00	
27.00	Speech Pathology Visits	1	0	0	0	1	27.00	
28.00	Speech Pathology Visit Charges	135	0	0	0	135	28.00	
29.00	Medical Social Service Visits	29	1	0	1	31	29.00	
30.00	Medical Social Service Visit Charges	5,220	180	0	180	5,580	30.00	
31.00	Home Health Aide Visits	1,578	67	8	18	1,671	31.00	
32.00	Home Health Aide Visit Charges	108,882	4,623	552	1,242	115,299	32.00	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,543	225	144	74	4,986	33.00	
34.00	Other Charges	0	0	0	0	0	34.00	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	458,502	22,948	16,402	7,947	505,799	35.00	
36.00	Total Number of Episodes (standard/non outlier)	279		54	6	339	36.00	
37.00	Total Number of Outlier Episodes		5		0	5	37.00	
38.00	Total Non-Routine Medical Supply Charges	22,614	1,819	984	19	25,436	38.00	

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 150064

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

Worksheet S-7

Date/Time Prepared:
2/23/2012 2:34 pm

		1.00	2.00		
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.				1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.				2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	3.00
4.00		RUL	0	0	4.00
5.00		RVX	0	0	5.00
6.00		RVL	0	0	6.00
7.00		RHX	0	0	7.00
8.00		RHL	0	0	8.00
9.00		RMX	0	0	9.00
10.00		RML	0	23	10.00
11.00		RLX	0	0	11.00
12.00		RUC	0	0	12.00
13.00		RUB	0	0	13.00
14.00		RUA	0	8	14.00
15.00		RVC	0	21	15.00
16.00		RVB	0	7	16.00
17.00		RVA	0	10	17.00
18.00		RHC	0	0	18.00
19.00		RHB	0	7	19.00
20.00		RHA	0	41	20.00
21.00		RMC	0	16	21.00
22.00		RMB	0	25	22.00
23.00		RMA	0	42	23.00
24.00		RLB	0	0	24.00
25.00		RLA	0	0	25.00
26.00		ES3	0	0	26.00
27.00		ES2	0	0	27.00
28.00		ES1	0	0	28.00
29.00		HE2	0	0	29.00
30.00		HE1	0	2	30.00
31.00		HD2	0	0	31.00
32.00		HD1	0	0	32.00
33.00		HC2	0	0	33.00
34.00		HC1	0	0	34.00
35.00		HB2	0	0	35.00
36.00		HB1	0	0	36.00
37.00		LE2	0	0	37.00
38.00		LE1	0	0	38.00
39.00		LD2	0	0	39.00
40.00		LD1	0	0	40.00
41.00		LC2	0	0	41.00
42.00		LC1	0	0	42.00
43.00		LB2	0	0	43.00
44.00		LB1	0	0	44.00
45.00		CE2	0	0	45.00
46.00		CE1	0	0	46.00
47.00		CD2	0	0	47.00
48.00		CD1	0	0	48.00
49.00		CC2	0	0	49.00
50.00		CC1	0	0	50.00
51.00		CB2	0	0	51.00
52.00		CB1	0	12	52.00
53.00		CA2	0	0	53.00
54.00		CA1	0	28	54.00
55.00		SE3	0	0	55.00
56.00		SE2	0	0	56.00
57.00		SE1	0	0	57.00
58.00		SSC	0	0	58.00
59.00		SSB	0	0	59.00
60.00		SSA	0	0	60.00
61.00		IB2	0	0	61.00
62.00		IB1	0	0	62.00
63.00		IA2	0	0	63.00
64.00		IA1	0	0	64.00
65.00		BB2	0	0	65.00
66.00		BB1	0	0	66.00
67.00		BA2	0	0	67.00
68.00		BA1	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 150064

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

Worksheet S-7

Date/Time Prepared:
2/23/2012 2:34 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	7	7	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	249	249	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
SNF SERVICES						
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).					201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		0			207.00

HOSPITAL IDENTIFICATION DATA

Provider CCN: 150064
Component CCN: 151548

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

Worksheet S-9
Parts I & II
Date/Time Prepared:
2/23/2012 2:34 pm

		Unduplicated Days				All Other	
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility		
		1.00	2.00	3.00	4.00		
PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	1.00
2.00	Routine Home Care	1,554	0	0	0	0	2.00
3.00	Inpatient Respite Care	0	0	0	0	0	3.00
4.00	General Inpatient Care	0	0	0	0	0	4.00
5.00	Total Hospice Days	1,554	0	0	0	0	5.00
Part II - CENSUS DATA							
6.00	Number of Patients Receiving Hospice Care	0	0	0	0	0	6.00
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	8.00
9.00	Unduplicated Census Count	0	0	0	0	0	9.00

HOSPITAL IDENTIFICATION DATA		Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet S-9 Parts I & II Date/Time Prepared: 2/23/2012 2:34 pm
		Component CCN: 151548	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	1,554	2.00
3.00	Inpatient Respite Care	0	3.00
4.00	General Inpatient Care	0	4.00
5.00	Total Hospice Days	1,554	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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150064

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

Worksheet A
Date/Time Prepared:
2/23/2012 2:34 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		2,566,682	2,566,682	0	2,566,682	1.00
4.00 EMPLOYEE BENEFITS	198,118	5,937,065	6,135,183	115,722	6,250,905	4.00
5.00 ADMINISTRATIVE & GENERAL	2,204,220	3,117,337	5,321,557	-543,673	4,777,884	5.00
7.00 OPERATION OF PLANT	447,604	1,963,441	2,411,045	-849,754	1,561,291	7.00
7.01 OPERATION OF PLANT	0	0	0	861,525	861,525	7.01
8.00 LAUNDRY & LINEN SERVICE	22,588	151,378	173,966	426	174,392	8.00
9.00 HOUSEKEEPING	539,063	145,062	684,125	10,169	694,294	9.00
10.00 DIETARY	499,244	358,523	857,767	-498,591	359,176	10.00
11.00 CAFETERIA	0	0	0	508,009	508,009	11.00
13.00 NURSING ADMINISTRATION	391,769	8,675	400,444	5,710	406,154	13.00
14.00 CENTRAL SERVICES & SUPPLY	90,717	1,292,517	1,383,234	-27,570	1,355,664	14.00
15.00 PHARMACY	687,147	1,478,534	2,165,681	6,802	2,172,483	15.00
16.00 MEDICAL RECORDS & LIBRARY	739,259	326,292	1,065,551	69,045	1,134,596	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1,874,420	227,304	2,101,724	-335,212	1,766,512	30.00
31.00 INTENSIVE CARE UNIT	1,099,637	69,819	1,169,456	15,380	1,184,836	31.00
40.00 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00 SUBPROVIDER - IRF	430,825	116,214	547,039	6,279	553,318	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	0	0	0	362,021	362,021	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	1,648,477	514,168	2,162,645	23,994	2,186,639	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	1,343,884	2,625,401	3,969,285	22,088	3,991,373	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	786,211	1,160,841	1,947,052	14,832	1,961,884	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	418,641	57,643	476,284	6,102	482,386	65.00
66.00 PHYSICAL THERAPY	906,110	35,790	941,900	11,864	953,764	66.00
69.01 CARDIAC REHAB	152,044	24,024	176,068	2,216	178,284	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	29,281	29,281	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	74.00
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	1,072,794	703,737	1,776,531	15,311	1,791,842	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00 CLINIC	2,617,866	428,291	3,046,157	145,147	3,191,304	93.00
93.01 BIC	973,921	1,278,865	2,252,786	4,035	2,256,821	93.01
93.02 UCIC	0	0	0	0	0	93.02
93.03 CIC	0	0	0	0	0	93.03
93.04 RIC	0	0	0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	579,503	192,067	771,570	8,401	779,971	95.00
99.10 CORF	0	0	0	0	0	99.10
101.00 HOME HEALTH AGENCY	759,161	123,308	882,469	-34,820	847,649	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
116.00 HOSPICE	0	38,340	38,340	45,830	84,170	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	20,483,223	24,941,318	45,424,541	569	45,425,110	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
191.01 FMH DIAGNOSTIC CENTE	70,183	220	70,403	5,972	76,375	191.01
191.02 WELLNESS	85,790	116,805	202,595	1,250	203,845	191.02
192.00 PHYSICIANS' PRIVATE OFFICES	2,183,459	1,715,519	3,898,978	-123,433	3,775,545	192.00
192.01 RFE	0	4,378	4,378	0	4,378	192.01
192.02 MARKETING	55,514	259,784	315,298	-33,264	282,034	192.02
192.03 FOUNDATION	0	0	0	0	0	192.03
192.04 BROOKVILLE CLINIC	0	0	0	0	0	192.04
192.05 ATOD	0	0	0	0	0	192.05
192.06 HEART CENTER	0	0	0	0	0	192.06
192.07 WVCP	1,456,486	173,296	1,629,782	137,831	1,767,613	192.07
192.08 OCCUPATIONAL MED	0	1,888	1,888	0	1,888	192.08
192.09 HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.09

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 150064		Period: From 10/01/2010 To 09/30/2011		Worksheet A Date/Time Prepared: 2/23/2012 2:34 pm	
Cost Center Description	Salaries 1.00	Other 2.00	Total (col. 1 + col. 2) 3.00	Reclassifications (See A-6) 4.00	Reclassified Trial Balance (col. 3 +- col. 4) 5.00			
192.10 HOSPITALIST	759,913	365,137	1,125,050	11,075	1,136,125	192.10		
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00		
200.00 TOTAL (SUM OF LINES 118-199)	25,094,568	27,578,345	52,672,913	0	52,672,913	200.00		

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150064

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

Worksheet A
Date/Time Prepared:
2/23/2012 2:34 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	-805,117	1,761,565	1.00
4.00	EMPLOYEE BENEFITS	0	6,250,905	4.00
5.00	ADMINISTRATIVE & GENERAL	-263,424	4,514,460	5.00
7.00	OPERATION OF PLANT	-2,663	1,558,628	7.00
7.01	OPERATION OF PLANT	0	861,525	7.01
8.00	LAUNDRY & LINEN SERVICE	0	174,392	8.00
9.00	HOUSEKEEPING	0	694,294	9.00
10.00	DIETARY	0	359,176	10.00
11.00	CAFETERIA	-227,422	280,587	11.00
13.00	NURSING ADMINISTRATION	-1,768	404,386	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	1,355,664	14.00
15.00	PHARMACY	-147,597	2,024,886	15.00
16.00	MEDICAL RECORDS & LIBRARY	-13,751	1,120,845	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	1,766,512	30.00
31.00	INTENSIVE CARE UNIT	0	1,184,836	31.00
40.00	SUBPROVIDER - I PF	0	0	40.00
41.00	SUBPROVIDER - I RF	0	553,318	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	362,021	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	-838,232	1,348,407	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	3,991,373	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	1,961,884	60.00
60.01	BLOOD LABORATORY	0	0	60.01
65.00	RESPIRATORY THERAPY	-6,592	475,794	65.00
66.00	PHYSICAL THERAPY	-140,054	813,710	66.00
69.01	CARDIAC REHAB	0	178,284	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	29,281	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	RENAL DIALYSIS	0	0	74.00
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	-617,976	1,173,866	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	CLINIC	-1,563,166	1,628,138	93.00
93.01	BIC	-320,103	1,936,718	93.01
93.02	UCIC	0	0	93.02
93.03	CIC	0	0	93.03
93.04	RIC	0	0	93.04
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	-59,084	720,887	95.00
99.10	CORF	0	0	99.10
101.00	HOME HEALTH AGENCY	0	847,649	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
116.00	HOSPICE	0	84,170	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-5,006,949	40,418,161	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	RESEARCH	0	0	191.00
191.01	FMH DIAGNOSTIC CENTE	0	76,375	191.01
191.02	WELLNESS	0	203,845	191.02
192.00	PHYSICIANS' PRIVATE OFFICES	0	3,775,545	192.00
192.01	RFE	0	4,378	192.01
192.02	MARKETING	0	282,034	192.02
192.03	FOUNDATION	0	0	192.03
192.04	BROOKVILLE CLINIC	0	0	192.04
192.05	ATOD	0	0	192.05
192.06	HEART CENTER	0	0	192.06
192.07	WVCP	0	1,767,613	192.07
192.08	OCCUPATIONAL MED	0	1,888	192.08
192.09	HOME MEDICAL EQUIPMENT	0	0	192.09
192.10	HOSPITALIST	0	1,136,125	192.10
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 150064		Period: From 10/01/2010 To 09/30/2011	Worksheet A Date/Time Prepared: 2/23/2012 2:34 pm
Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation			
	6.00	7.00			
200.00 TOTAL (SUM OF LINES 118-199)	-5,006,949	47,665,964			200.00

RECLASSIFICATIONS

Provider CCN: 150064

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

Worksheet A-6

Date/Time Prepared:
2/23/2012 2:34 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
A - CAFETERIA						
1.00	CAFETERIA	11.00	295,675	212,334	1.00	
	TOTALS		295,675	212,334		
B - NUSERY						
1.00	NURSERY	43.00	325,961	36,060	1.00	
	TOTALS		325,961	36,060		
C - COACH RECLASS						
1.00	EMPLOYEE BENEFITS	4.00	115,722	0	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	208,942	0	2.00	
3.00	OPERATION OF PLANT	7.00	11,771	0	3.00	
4.00	LAUNDRY & LINEN SERVICE	8.00	426	0	4.00	
5.00	HOUSEKEEPING	9.00	10,169	0	5.00	
6.00	DIETARY	10.00	9,418	0	6.00	
7.00	NURSING ADMINISTRATION	13.00	5,710	0	7.00	
8.00	CENTRAL SERVICES & SUPPLY	14.00	1,711	0	8.00	
9.00	PHARMACY	15.00	6,802	0	9.00	
10.00	MEDICAL RECORDS & LIBRARY	16.00	69,045	0	10.00	
11.00	ADULTS & PEDIATRICS	30.00	26,809	0	11.00	
12.00	INTENSIVE CARE UNIT	31.00	15,380	0	12.00	
13.00	SUBPROVIDER - IRF	41.00	6,279	0	13.00	
14.00	OPERATING ROOM	50.00	23,994	0	14.00	
15.00	RADIOLOGY-DIAGNOSTIC	54.00	22,088	0	15.00	
16.00	LABORATORY	60.00	14,832	0	16.00	
17.00	RESPIRATORY THERAPY	65.00	6,102	0	17.00	
18.00	PHYSICAL THERAPY	66.00	11,864	0	18.00	
19.00	CARDIAC REHAB	69.01	2,216	0	19.00	
20.00	EMERGENCY	91.00	15,311	0	20.00	
21.00	CLINIC	93.00	10,846	0	21.00	
22.00	BIC	93.01	4,035	0	22.00	
23.00	AMBULANCE SERVICES	95.00	8,401	0	23.00	
24.00	HOME HEALTH AGENCY	101.00	11,010	0	24.00	
25.00	FMH DIAGNOSTIC CENTE	191.01	5,972	0	25.00	
26.00	WELLNESS	191.02	1,250	0	26.00	
27.00	PHYSICIANS' PRIVATE OFFICES	192.00	10,868	0	27.00	
28.00	MARKETING	192.02	4,724	0	28.00	
29.00	WVCP	192.07	137,831	0	29.00	
30.00	HOSPITALIST	192.10	11,075	0	30.00	
	TOTALS		790,603	0		
D - MARKETING						
1.00	ADMINISTRATIVE & GENERAL	5.00	6,896	31,092	1.00	
	TOTALS		6,896	31,092		
E - HOSPICE						
1.00	HOSPICE	116.00	45,830	0	1.00	
	TOTALS		45,830	0		
F - HOSPITAL UTILITIES						
1.00	OPERATION OF PLANT	7.01	0	861,525	1.00	
	TOTALS		0	861,525		
G - PROVIDER BASED CLINIC						
1.00	CLINIC	93.00	122,135	12,166	1.00	
	TOTALS		122,135	12,166		
H - IMPLANTABLE DEVICES						
1.00	IMPL. DEV. CHARGED TO	72.00	0	29,281	1.00	
	PATIENTS		0	29,281		
	TOTALS		0	29,281		
500.00	Grand Total: Increases		1,587,100	1,182,458	500.00	

RECLASSIFICATIONS

Provider CCN: 150064

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

Worksheet A-6

Date/Time Prepared: 2/23/2012 2:34 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA							
1.00	DIETARY	10.00	295,675	212,334	0		1.00
	TOTALS		295,675	212,334			
B - NURSERY							
1.00	ADULTS & PEDIATRICS	30.00	325,961	36,060	0		1.00
	TOTALS		325,961	36,060			
C - COACH RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	790,603	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
	TOTALS		790,603	0			
D - MARKETING							
1.00	MARKETING	192.02	6,896	31,092	0		1.00
	TOTALS		6,896	31,092			
E - HOSPICE							
1.00	HOME HEALTH AGENCY	101.00	45,830	0	0		1.00
	TOTALS		45,830	0			
F - HOSPITAL UTILITIES							
1.00	OPERATION OF PLANT	7.00	0	861,525	0		1.00
	TOTALS		0	861,525			
G - PROVIDER BASED CLINIC							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	122,135	12,166	0		1.00
	TOTALS		122,135	12,166			
H - IMPLANTABLE DEVICES							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	29,281	0		1.00
	TOTALS		0	29,281			
500.00	Grand Total: Decreases		1,587,100	1,182,458			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150064

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/23/2012 2:34 pm

	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
		1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,940,313	43,210	0	43,210	203,458	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	51,471,884	310,694	0	310,694	71,161	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	21,881,326	681,900	0	681,900	424,991	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	75,293,523	1,035,804	0	1,035,804	699,610	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	75,293,523	1,035,804	0	1,035,804	699,610	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	1,230,119	0	1,336,563	0	0	1.00
3.00	Total (sum of lines 1-2)	1,230,119	0	1,336,563	0	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	75,629,717	0	75,629,717	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	75,629,717	0	75,629,717	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150064

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/23/2012 2:34 pm

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,780,065	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	51,711,417	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	22,138,235	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	75,629,717	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	75,629,717	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	2,566,682			1.00
3.00	Total (sum of lines 1-2)	0	2,566,682			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	1,191,667	0 1.00
3.00	Total (sum of lines 1-2)	0	0	0	1,191,667	0 3.00

RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet A-7 Parts I-III Date/Time Prepared: 2/23/2012 2:34 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	1,227,205	0	0	-657,307	1,761,565	1.00
3.00	Total (sum of lines 1-2)	1,227,205	0	0	-657,307	1,761,565	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150064

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

Worksheet A-8
Date/Time Prepared:
2/23/2012 2:34 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)				3.00
4.00	Trade, quantity, and time discounts (chapter 8)				4.00
5.00	Refunds and rebates of expenses (chapter 8)				5.00
6.00	Rental of provider space by suppliers (chapter 8)				6.00
7.00	Telephone services (pay stations excluded) (chapter 21)				7.00
8.00	Television and radio service (chapter 21)				8.00
9.00	Parking lot (chapter 21)				9.00
10.00	Provider-based physician adjustment	A-8-2	-2,684,610		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)				11.00
12.00	Related organization transactions (chapter 10)	A-8-1			12.00
13.00	Laundry and linen service				13.00
14.00	Cafeteria-employees and guests				14.00
15.00	Rental of quarters to employee and others				15.00
16.00	Sale of medical and surgical supplies to other than patients				16.00
17.00	Sale of drugs to other than patients				17.00
18.00	Sale of medical records and abstracts	A	-13,751	MEDICAL RECORDS & LIBRARY	18.00
19.00	Nursing school (tuition, fees, books, etc.)				19.00
20.00	Vending machines				20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)				21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments				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				0.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		*** Cost Center Deleted ***	67.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		*** Cost Center Deleted ***	68.00
32.00	CAH HIT Adjustment for Depreciation and Interest				0.00
33.00	INVESTMENT FEE EXP-N/O REV	B	211,913	NEW CAP REL COSTS-BLDG & FIXT	1.00
34.00	INTEREST INCOME OPER-N/O REV	B	-109,336	NEW CAP REL COSTS-BLDG & FIXT	1.00
35.00	GAIN OF SALE INVEST-N/O REV	B	-880,579	NEW CAP REL COSTS-BLDG & FIXT	1.00
36.00	LOSS ON SALE INVEST-N/O REV	B	382,695	NEW CAP REL COSTS-BLDG & FIXT	1.00
37.00	DIVIDEND INCOME OPER-N/O REV	B	-371,336	NEW CAP REL COSTS-BLDG & FIXT	1.00
38.00	INTEREST INCOME BOARD-N/O REV	B	-22	NEW CAP REL COSTS-BLDG & FIXT	1.00
39.00	VENDOR REBATE/REFUND-OTHER REV	B	-7,769	ADMINISTRATIVE & GENERAL	5.00
40.00	PURCHASE DISC EARNED-OTHER REV	B	9,267	ADMINISTRATIVE & GENERAL	5.00
41.00	W/C DEPT OTHER REV-OTHER REV	B	-735	ADMINISTRATIVE & GENERAL	5.00
42.00	MISC GEN FUND REV-OTHER REV	B	8,559	ADMINISTRATIVE & GENERAL	5.00
43.00	COMMUNITY EMT	B	-2,200	ADMINISTRATIVE & GENERAL	5.00
44.00	SALE SCRAP & WASTE-OTHER REV	B	-687	OPERATION OF PLANT	7.00
45.00	CAFETERIA SALES-OTHER REV	B	-219,972	CAFETERIA	11.00
45.01	CAFÉ VEND MACHIN-OTHER REV	B	-7,450	CAFETERIA	11.00
45.02	EDUCATION & TRAINING-OTHER REV	B	-1,768	NURSING ADMINISTRATIVE	13.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150064

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

Worksheet A-8

Date/Time Prepared:
2/23/2012 2:34 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
45.03	PHARMACY DRUG REBATE-OTHER REV	B	-1,184	PHARMACY	15.00 45.03
45.04	EMPLOYEE DRUG SALES-OTHER REV	B	-132,413	PHARMACY	15.00 45.04
45.05	PHARMACY STUDENT REIMB - OTHER REV	B	-14,000	PHARMACY	15.00 45.05
45.06	AQUATIC THERAPY-OTHER REV	B	-4,425	PHYSICAL THERAPY	66.00 45.06
45.07	OCCUPATION MED-OTHER REV	B	-210	PHYSICAL THERAPY	66.00 45.07
45.08	PHY TH SCHOOL REV-OTHER REV	B	-135,098	PHYSICAL THERAPY	66.00 45.08
45.09	PHYSICAL NIGHT-OTHER REV	B	3,762	PHYSICAL THERAPY	66.00 45.09
45.10	FIRST STEPS REV - OTHER REV	B	-4,083	PHYSICAL THERAPY	66.00 45.10
45.11	MEDICAL STAFF SVCS- OTHER REV	B	-2,950	ADMINISTRATIVE & GENERAL	5.00 45.11
45.12	HELPLINE -OTHER REV	B	-59,084	AMBULANCE SERVICES	95.00 45.12
45.13	EKG FEES BILLING SVC - OTHER REV	B	-4,605	RESPIRATORY THERAPY	65.00 45.13
45.14	STRESS/CARDIOLITE -OTHER REV	B	-1,987	RESPIRATORY THERAPY	65.00 45.14
45.15	PFS BILLING SVC -OTHER REV	B	-1,784	ADMINISTRATIVE & GENERAL	5.00 45.15
45.16	IHHA DUES	A	-1,575	ADMINISTRATIVE & GENERAL	5.00 45.16
45.17	ANESTHESIA OFFSET	A	-36,891	OPERATING ROOM	50.00 45.17
45.18	TELEVISION	A	-13,662	ADMINISTRATIVE & GENERAL	5.00 45.18
45.19	TELEVISION ELECTRICITY	A	-1,976	OPERATION OF PLANT	7.00 45.19
45.20	24TH ST OLD DEPRECIATION	A	-18,346	NEW CAP REL COSTS-BLDG & FI XT	1.00 45.20
45.21	24TH ST NEW DEPRECIATION	A	-20,106	NEW CAP REL COSTS-BLDG & FI XT	1.00 45.21
45.22	PHYSICIAN RECRUITMENT	A	-250,575	ADMINISTRATIVE & GENERAL	5.00 45.22
45.23	ER PURCHASED SERVICES	A	-617,976	EMERGENCY	91.00 45.23
45.24			0		0.00 45.24
45.25			0		0.00 45.25
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,006,949		50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150064

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

Worksheet A-8
Date/Time Prepared:
2/23/2012 2:34 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	INVESTMENT FEE EXP-N/O REV	14	33.00
34.00	INTEREST INCOME OPER-N/O REV	11	34.00
35.00	GAIN OF SALE INVEST-N/O REV	14	35.00
36.00	LOSS ON SALE INVEST-N/O REV	14	36.00
37.00	DIVIDEND INCOME OPER-N/O REV	14	37.00
38.00	INTEREST INCOME BOARD-N/O REV	11	38.00
39.00	VENDOR REBATE/REFUND-OTHER REV	0	39.00
40.00	PURCHASE DISC EARNED-OTHER REV	0	40.00
41.00	W/C DEPT OTHER REV-OTHER REV	0	41.00
42.00	MISC GEN FUND REV-OTHER REV	0	42.00
43.00	COMMUNITY ED EMT	0	43.00
44.00	SALE SCRAP & WASTE-OTHER REV	0	44.00
45.00	CAFETERIA SALES-OTHER REV	0	45.00
45.01	CAFÉ VEND MACHIN-OTHER REV	0	45.01
45.02	EDUCATION & TRAINING-OTHER REV	0	45.02
45.03	PHARMACY DRUG REBATE-OTHER REV	0	45.03
45.04	EMPLOYEE DRUG SALES-OTHER REV	0	45.04
45.05	PHARMACY STUDENT REIMB - OTHER REV	0	45.05
45.06	AQUATIC THERAPY-OTHER REV	0	45.06
45.07	OCCUPATION MED-OTHER REV	0	45.07
45.08	PHY TH SCHOOL REV-OTHER REV	0	45.08
45.09	PHYSICAL NIGHT-OTHER REV	0	45.09
45.10	FIRST STEPS REV - OTHER REV	0	45.10
45.11	MEDICAL STAFF SVCS- OTHER REV	0	45.11
45.12	HELPLINE -OTHER REV	0	45.12
45.13	EKG FEES BILLING SVC - OTHER REV	0	45.13
45.14	STRESS/CARDIOLITE -OTHER REV	0	45.14
45.15	PFS BILLING SVC -OTHER REV	0	45.15

ADJUSTMENTS TO EXPENSES

Provider CCN: 150064

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

Worksheet A-8

Date/Time Prepared:
2/23/2012 2:34 pm

		Wkst. A-7 Ref.	
		5.00	
45.16	IHHA DUES	0	45.16
45.17	ANESTHESIA OFFSET	0	45.17
45.18	TELEVISION	0	45.18
45.19	TELEVISION ELECTRICITY	0	45.19
45.20	24TH ST OLD DEPRECIATION	9	45.20
45.21	24TH ST NEW DEPRECIATION	9	45.21
45.22	PHYSICIAN RECRUITMENT	0	45.22
45.23	ER PURCHASED SERVICES	0	45.23
45.24		0	45.24
45.25		0	45.25
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: 150064

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

Worksheet A-8-2

Date/Time Prepared:
2/23/2012 2:34 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	50.00	OR ANESTHESIOLOGY	816,202	793,884	1.00
2.00	93.00	PROVIDER BASED PHYSICIANS	1,705,666	1,425,356	2.00
3.00	93.01	BIC	432,322	274,213	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)	2,954,190	2,493,453	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150064

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

Worksheet A-8-2

Date/Time Prepared:
2/23/2012 2:34 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	22,318	182,900	169	14,861	743	1.00
2.00	280,310	142,500	2,080	142,500	7,125	2.00
3.00	158,109	142,500	1,638	112,219	5,611	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	460,737		3,887	269,580	13,479	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150064

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

Worksheet A-8-2

Date/Time Prepared:
2/23/2012 2:34 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	14,861	1.00
2.00	0	0	0	0	142,500	2.00
3.00	0	0	0	0	112,219	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	269,580	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150064

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

Worksheet A-8-2

Date/Time Prepared:
2/23/2012 2:34 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	7,457	801,341	1.00
2.00	137,810	1,563,166	2.00
3.00	45,890	320,103	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	191,157	2,684,610	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150064

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

Worksheet B
Part I
Date/Time Prepared:
2/23/2012 2:34 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	1,761,565	1,761,565					1.00
4.00 EMPLOYEE BENEFITS	6,250,905	7,008		6,257,913			4.00
5.00 ADMINISTRATIVE & GENERAL	4,514,460	146,463		419,537	5,080,460	5,080,460	5.00
7.00 OPERATION OF PLANT	1,558,628	699,226		118,403	2,376,257	283,487	7.00
7.01 OPERATION OF PLANT	861,525	0		0	861,525	102,780	7.01
8.00 LAUNDRY & LINEN SERVICE	174,392	1,806		5,932	182,130	21,728	8.00
9.00 HOUSEKEEPING	694,294	8,387		141,563	844,244	100,718	9.00
10.00 DIETARY	359,176	12,431		54,897	426,504	50,882	10.00
11.00 CAFETERIA	280,587	18,052		76,210	374,849	44,719	11.00
13.00 NURSING ADMINISTRATION	404,386	0		102,449	506,835	60,465	13.00
14.00 CENTRAL SERVICES & SUPPLY	1,355,664	11,836		23,823	1,391,323	165,985	14.00
15.00 PHARMACY	2,024,886	11,453		122,039	2,158,378	257,494	15.00
16.00 MEDICAL RECORDS & LIBRARY	1,120,845	13,286		208,339	1,342,470	160,157	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	1,766,512	67,714		428,920	2,263,146	269,993	30.00
31.00 INTENSIVE CARE UNIT	1,184,836	40,927		275,952	1,501,715	179,155	31.00
40.00 SUBPROVIDER - I PF	0	0		0	0	0	40.00
41.00 SUBPROVIDER - I RF	553,318	41,985		112,663	707,966	84,460	41.00
42.00 SUBPROVIDER	0	0		0	0	0	42.00
43.00 NURSERY	362,021	21,704		84,016	467,741	55,802	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	1,348,407	110,126		430,489	1,889,022	225,360	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	3,991,373	98,268		332,445	4,422,086	527,566	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	1,961,884	31,452		206,467	2,199,803	262,436	60.00
60.01 BLOOD LABORATORY	0	0		0	0	0	60.01
65.00 RESPIRATORY THERAPY	475,794	14,779		109,477	600,050	71,586	65.00
66.00 PHYSICAL THERAPY	813,710	26,721		212,856	1,053,287	125,657	66.00
69.01 CARDIAC REHAB	178,284	13,136		39,760	231,180	27,580	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	29,281	0		0	29,281	3,493	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73.00
74.00 RENAL DIALYSIS	0	0		0	0	0	74.00
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	1,173,866	35,549		274,701	1,484,116	177,055	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	0	0	92.00
93.00 CLINIC	1,628,138	69,054		709,022	2,406,214	287,061	93.00
93.01 BIC	1,936,718	0		252,066	2,188,784	261,122	93.01
93.02 UIC	0	0		0	0	0	93.02
93.03 CIC	0	0		0	0	0	93.03
93.04 RIC	0	0		0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS							
95.00 AMBULANCE SERVICES	720,887	0		150,727	871,614	103,984	95.00
99.10 CORF	0	0		0	0	0	99.10
101.00 HOME HEALTH AGENCY	847,649	11,621		185,724	1,044,994	124,668	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
116.00 HOSPICE	84,170	0		11,813	95,983	11,451	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	40,418,161	1,512,984		5,090,290	39,001,957	4,046,844	118.00
NONREIMBURSABLE COST CENTERS							
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	0	190.00
191.00 RESEARCH	0	0		0	0	0	191.00
191.01 FMH DIAGNOSTIC CENTER	76,375	0		19,629	96,004	11,453	191.01
191.02 WELLNESS	203,845	0		22,434	226,279	26,995	191.02
192.00 PHYSICIANS' PRIVATE OFFICES	3,775,545	65,996		537,684	4,379,225	522,442	192.00
192.01 RFE	4,378	0		0	4,378	522	192.01
192.02 MARKETING	282,034	5,339		13,749	301,122	35,924	192.02
192.03 FOUNDATION	0	1,828		0	1,828	218	192.03
192.04 BROOKVILLE CLINIC	0	0		0	0	0	192.04
192.05 ATOD	0	0		0	0	0	192.05
192.06 HEART CENTER	0	4,154		0	4,154	496	192.06

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150064

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

Worksheet B
Part I
Date/Time Prepared:
2/23/2012 2:34 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
192.07 WVCP	1,767,613	92,876		375,406	2,235,895	266,742	192.07
192.08 OCCUPATIONAL MED	1,888	0		0	1,888	225	192.08
192.09 HOME MEDICAL EQUIPMENT	0	0		0	0	0	192.09
192.10 HOSPITALIST	1,136,125	0		198,721	1,334,846	159,247	192.10
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	78,388		0	78,388	9,352	194.00
200.00 Cross Foot Adjustments					0		200.00
201.00 Negative Cost Centers					0		201.00
202.00 TOTAL (sum lines 118-201)	47,665,964	1,761,565		6,257,913	47,665,964	5,080,460	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150064

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

Worksheet B
Part I
Date/Time Prepared:
2/23/2012 2:34 pm

Cost Center Description	OPERATION OF PLANT	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	7.00	7.01	8.00	9.00	10.00	
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	2,659,744					7.00
7.01 OPERATION OF PLANT	0	964,305				7.01
8.00 LAUNDRY & LINEN SERVICE	4,575	2,684	211,117			8.00
9.00 HOUSEKEEPING	21,246	12,466	0	978,674		9.00
10.00 DIETARY	31,489	18,477	17,751	12,153	557,256	10.00
11.00 CAFETERIA	45,728	26,831	0	17,648	0	11.00
13.00 NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	29,983	17,593	0	11,571	0	14.00
15.00 PHARMACY	29,012	17,023	0	11,197	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	33,654	18,234	0	12,988	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	171,529	100,646	56,083	66,198	303,538	30.00
31.00 INTENSIVE CARE UNIT	103,674	60,831	22,942	40,010	41,461	31.00
40.00 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00 SUBPROVIDER - IRF	106,352	62,403	12,245	41,044	22,219	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	54,978	32,259	0	21,217	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	278,964	163,684	14,016	107,661	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	248,925	146,058	25,047	96,066	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	79,672	46,748	111	30,747	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	37,437	21,966	0	14,448	0	65.00
66.00 PHYSICAL THERAPY	67,688	39,716	15,754	26,122	0	66.00
69.01 CARDIAC REHAB	33,275	19,524	1,829	12,842	0	69.01
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
74.00 RENAL DIALYSIS	0	0	0	0	0	74.00
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	90,050	52,837	34,861	34,752	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00 CLINIC	174,922	0	304	76,528	0	93.00
93.01 BIC	237,153	0	0	91,523	0	93.01
93.02 UIC	0	0	0	0	0	93.02
93.03 CIC	0	0	0	0	0	93.03
93.04 RIC	0	0	0	0	0	93.04
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	29,436	0	8,284	11,360	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
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1,909,742	859,980	209,227	736,075	367,218	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
191.01 FMH DIAGNOSTIC CENTE	0	0	0	0	0	191.01
191.02 WELLNESS	112,155	0	0	35,975	0	191.02
192.00 PHYSICIANS' PRIVATE OFFICES	175,335	87,499	1,890	67,666	0	192.00
192.01 RFE	0	0	0	0	0	192.01
192.02 MARKETING	13,524	7,935	0	5,219	0	192.02
192.03 FOUNDATION	4,631	2,717	0	1,787	0	192.03
192.04 BROOKVILLE CLINIC	0	0	0	0	0	192.04
192.05 ATOD	0	0	0	0	0	192.05
192.06 HEART CENTER	10,523	6,174	0	4,061	0	192.06
192.07 WVCP	235,267	0	0	89,336	190,038	192.07
192.08 OCCUPATIONAL MED	0	0	0	0	0	192.08
192.09 HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.09
192.10 HOSPITALIST	0	0	0	0	0	192.10
194.00 OTHER NONREIMBURSABLE COST CENTERS	198,567	0	0	38,555	0	194.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150064

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

Worksheet B
Part I
Date/Time Prepared:
2/23/2012 2:34 pm

Cost Center Description		OPERATION OF PLANT	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		7.00	7.01	8.00	9.00	10.00	
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)	2,659,744	964,305	211,117	978,674	557,256	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet B Part I Date/Time Prepared: 2/23/2012 2:34 pm
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Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
4.00						4.00
5.00						5.00
7.00						7.00
7.01						7.01
8.00						8.00
9.00						9.00
10.00						10.00
11.00	509,775					11.00
13.00	8,070	575,370				13.00
14.00	3,765	0	1,620,220			14.00
15.00	13,392	26,215	0	2,512,711		15.00
16.00	25,662	0	0	0	1,593,165	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	48,440	94,855	0	0	87,709	30.00
31.00	32,073	62,801	0	0	56,583	31.00
40.00	0	0	0	0	0	40.00
41.00	11,750	23,020	0	0	17,370	41.00
42.00	0	0	0	0	0	42.00
43.00	8,538	16,709	0	0	7,102	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	37,392	73,224	0	0	129,227	50.00
52.00	0	0	0	0	0	52.00
54.00	34,684	19,354	0	0	373,603	54.00
57.00	0	0	0	0	0	57.00
58.00	0	0	0	0	0	58.00
59.00	0	0	0	0	0	59.00
60.00	25,247	0	0	0	247,313	60.00
60.01	0	0	0	0	0	60.01
65.00	15,913	31,165	0	0	69,998	65.00
66.00	19,023	37,241	0	0	42,467	66.00
69.01	4,114	8,066	0	0	4,310	69.01
71.00	0	0	1,620,220	0	55,376	71.00
72.00	0	0	0	0	0	72.00
73.00	0	0	0	2,512,711	143,666	73.00
74.00	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	0	0	0	0	0	88.00
89.00	0	0	0	0	0	89.00
91.00	25,068	49,078	0	0	172,771	91.00
92.00						92.00
93.00	57,190	0	0	0	91,058	93.00
93.01	0	0	0	0	59,206	93.01
93.02	0	0	0	0	0	93.02
93.03	0	0	0	0	0	93.03
93.04	0	0	0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS						
95.00	14,406	49,549	0	0	17,453	95.00
99.10	0	0	0	0	0	99.10
101.00	24,965	48,895	0	0	13,187	101.00
SPECIAL PURPOSE COST CENTERS						
109.00	0	0	0	0	0	109.00
110.00	0	0	0	0	0	110.00
111.00	0	0	0	0	0	111.00
116.00	1,384	2,697	0	0	4,766	116.00
118.00	411,076	542,869	1,620,220	2,512,711	1,593,165	118.00
NONREIMBURSABLE COST CENTERS						
190.00	0	0	0	0	0	190.00
191.00	0	0	0	0	0	191.00
191.01	1,778	0	0	0	0	191.01
191.02	4,592	8,983	0	0	0	191.02
192.00	27,637	7,857	0	0	0	192.00
192.01	0	0	0	0	0	192.01
192.02	1,939	0	0	0	0	192.02
192.03	1,955	0	0	0	0	192.03
192.04	0	0	0	0	0	192.04
192.05	0	0	0	0	0	192.05
192.06	0	0	0	0	0	192.06
192.07	52,793	0	0	0	0	192.07
192.08	0	0	0	0	0	192.08
192.09	0	0	0	0	0	192.09
192.10	8,005	15,661	0	0	0	192.10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150064

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

Worksheet B
Part I
Date/Time Prepared:
2/23/2012 2:34 pm

Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
194.00 OTHER NONREIMBURSABLE COST CENTERS	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)	509,775	575,370	1,620,220	2,512,711	1,593,165	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150064

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

Worksheet B
Part I
Date/Time Prepared:
2/23/2012 2:34 pm

Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	24.00	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
7.01 OPERATION OF PLANT				7.01
8.00 LAUNDRY & LINEN SERVICE				8.00
9.00 HOUSEKEEPING				9.00
10.00 DIETARY				10.00
11.00 CAFETERIA				11.00
13.00 NURSING ADMINISTRATION				13.00
14.00 CENTRAL SERVICES & SUPPLY				14.00
15.00 PHARMACY				15.00
16.00 MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS	3,462,137	0	3,462,137	30.00
31.00 INTENSIVE CARE UNIT	2,101,245	0	2,101,245	31.00
40.00 SUBPROVIDER - IPF	0	0	0	40.00
41.00 SUBPROVIDER - IRF	1,088,829	0	1,088,829	41.00
42.00 SUBPROVIDER	0	0	0	42.00
43.00 NURSERY	664,346	0	664,346	43.00
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	2,918,550	0	2,918,550	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	5,893,389	0	5,893,389	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	2,892,077	0	2,892,077	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
65.00 RESPIRATORY THERAPY	862,563	0	862,563	65.00
66.00 PHYSICAL THERAPY	1,426,955	0	1,426,955	66.00
69.01 CARDIAC REHAB	342,720	0	342,720	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,675,596	0	1,675,596	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	32,774	0	32,774	72.00
73.00 DRUGS CHARGED TO PATIENTS	2,656,377	0	2,656,377	73.00
74.00 RENAL DIALYSIS	0	0	0	74.00
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	2,120,588	0	2,120,588	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00 CLINIC	3,093,277	0	3,093,277	93.00
93.01 BIC	2,837,788	0	2,837,788	93.01
93.02 UCIC	0	0	0	93.02
93.03 CIC	0	0	0	93.03
93.04 RIC	0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS				
95.00 AMBULANCE SERVICES	1,057,006	0	1,057,006	95.00
99.10 CORF	0	0	0	99.10
101.00 HOME HEALTH AGENCY	1,305,789	0	1,305,789	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
116.00 HOSPICE	116,281	0	116,281	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	36,548,287	0	36,548,287	118.00
NONREIMBURSABLE COST CENTERS				
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
191.00 RESEARCH	0	0	0	191.00
191.01 FMH DIAGNOSTIC CENTER	109,235	0	109,235	191.01
191.02 WELLNESS	414,979	0	414,979	191.02
192.00 PHYSICIANS' PRIVATE OFFICES	5,269,551	0	5,269,551	192.00
192.01 RFE	4,900	0	4,900	192.01
192.02 MARKETING	365,663	0	365,663	192.02
192.03 FOUNDATION	13,136	0	13,136	192.03
192.04 BROOKVILLE CLINIC	0	0	0	192.04
192.05 ATOD	0	0	0	192.05
192.06 HEART CENTER	25,408	0	25,408	192.06
192.07 WVCP	3,070,071	0	3,070,071	192.07
192.08 OCCUPATIONAL MED	2,113	0	2,113	192.08

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150064

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

Worksheet B
Part I
Date/Time Prepared:
2/23/2012 2:34 pm

Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	24.00	25.00	26.00	
192.09 HOME MEDICAL EQUIPMENT	0	0	0	192.09
192.10 HOSPITALIST	1,517,759	0	1,517,759	192.10
194.00 OTHER NONREIMBURSABLE COST CENTERS	324,862	0	324,862	194.00
200.00 Cross Foot Adjustments	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	47,665,964	0	47,665,964	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150064

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

Worksheet B
Part II
Date/Time Prepared:
2/23/2012 2:34 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	7,008	7,008	7,008		4.00
5.00	ADMINISTRATIVE & GENERAL	0	146,463	146,463	470	146,933	5.00
7.00	OPERATION OF PLANT	0	699,226	699,226	133	8,198	7.00
7.01	OPERATION OF PLANT	0	0	0	0	2,972	7.01
8.00	LAUNDRY & LINEN SERVICE	0	1,806	1,806	7	628	8.00
9.00	HOUSEKEEPING	0	8,387	8,387	159	2,913	9.00
10.00	DIETARY	0	12,431	12,431	62	1,471	10.00
11.00	CAFETERIA	0	18,052	18,052	85	1,293	11.00
13.00	NURSING ADMINISTRATION	0	0	0	115	1,749	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	11,836	11,836	27	4,800	14.00
15.00	PHARMACY	0	11,453	11,453	137	7,446	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	13,286	13,286	234	4,632	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	67,714	67,714	481	7,808	30.00
31.00	INTENSIVE CARE UNIT	0	40,927	40,927	309	5,181	31.00
40.00	SUBPROVIDER - I/PF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - I/RF	0	41,985	41,985	126	2,442	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	0	21,704	21,704	94	1,614	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	110,126	110,126	483	6,517	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	98,268	98,268	373	15,272	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	31,452	31,452	232	7,589	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	14,779	14,779	123	2,070	65.00
66.00	PHYSICAL THERAPY	0	26,721	26,721	239	3,634	66.00
69.01	CARDIAC REHAB	0	13,136	13,136	45	798	69.01
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	101	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
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	35,549	35,549	308	5,120	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	CLINIC	0	69,054	69,054	784	8,301	93.00
93.01	BIC	0	0	0	283	7,551	93.01
93.02	UCIC	0	0	0	0	0	93.02
93.03	CIC	0	0	0	0	0	93.03
93.04	RIC	0	0	0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	0	0	0	169	3,007	95.00
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	0	11,621	11,621	208	3,605	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
116.00	HOSPICE	0	0	0	13	331	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,512,984	1,512,984	5,699	117,043	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
191.01	FMH DIAGNOSTIC CENTE	0	0	0	22	331	191.01
191.02	WELLNESS	0	0	0	25	781	191.02
192.00	PHYSICIANS' PRIVATE OFFICES	0	65,996	65,996	603	15,108	192.00
192.01	RFE	0	0	0	0	15	192.01
192.02	MARKETING	0	5,339	5,339	15	1,039	192.02
192.03	FOUNDATION	0	1,828	1,828	0	6	192.03
192.04	BROOKVILLE CLINIC	0	0	0	0	0	192.04
192.05	ATOD	0	0	0	0	0	192.05
192.06	HEART CENTER	0	4,154	4,154	0	14	192.06
192.07	WVCP	0	92,876	92,876	421	7,714	192.07

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150064

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

Worksheet B
Part II
Date/Time Prepared:
2/23/2012 2:34 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	
192.08 OCCUPATIONAL MED	0	0	0	0	0	7	192.08
192.09 HOME MEDICAL EQUIPMENT	0	0	0	0	0	0	192.09
192.10 HOSPITALIST	0	0	0	0	223	4,605	192.10
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	78,388	78,388	78,388	0	270	194.00
200.00 Cross Foot Adjustments			0	0			200.00
201.00 Negative Cost Centers			0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	1,761,565	1,761,565	1,761,565	7,008	146,933	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150064		Period: From 10/01/2010 To 09/30/2011		Worksheet B Part II Date/Time Prepared: 2/23/2012 2:34 pm	
Cost Center Description		OPERATION OF PLANT	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		7.00	7.01	8.00	9.00	10.00	
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	707,557					7.00
7.01	OPERATION OF PLANT	0	2,972				7.01
8.00	LAUNDRY & LINEN SERVICE	1,217	8	3,666			8.00
9.00	HOUSEKEEPING	5,652	38	0	17,149		9.00
10.00	DIETARY	8,377	57	308	213	22,919	10.00
11.00	CAFETERIA	12,165	83	0	309	0	11.00
13.00	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	7,976	54	0	203	0	14.00
15.00	PHARMACY	7,718	52	0	196	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	8,953	56	0	228	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	45,631	310	974	1,160	12,484	30.00
31.00	INTENSIVE CARE UNIT	27,580	187	398	701	1,705	31.00
40.00	SUBPROVIDER - I/PF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - I/RF	28,292	192	213	719	914	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	14,626	99	0	372	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	74,211	508	243	1,887	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	66,220	450	435	1,683	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	21,195	144	2	539	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	9,959	68	0	253	0	65.00
66.00	PHYSICAL THERAPY	18,007	122	274	458	0	66.00
69.01	CARDIAC REHAB	8,852	60	32	225	0	69.01
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
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
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	23,955	163	605	609	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	CLINIC	46,533	0	5	1,341	0	93.00
93.01	BIC	63,088	0	0	1,604	0	93.01
93.02	UCIC	0	0	0	0	0	93.02
93.03	CIC	0	0	0	0	0	93.03
93.04	RIC	0	0	0	0	0	93.04
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	7,831	0	144	199	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
116.00	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	508,038	2,651	3,633	12,899	15,103	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
191.01	FMH DIAGNOSTIC CENTE	0	0	0	0	0	191.01
191.02	WELLNESS	29,836	0	0	630	0	191.02
192.00	PHYSICIANS' PRIVATE OFFICES	46,643	270	33	1,186	0	192.00
192.01	RFE	0	0	0	0	0	192.01
192.02	MARKETING	3,598	24	0	91	0	192.02
192.03	FOUNDATION	1,232	8	0	31	0	192.03
192.04	BROOKVILLE CLINIC	0	0	0	0	0	192.04
192.05	ATOD	0	0	0	0	0	192.05
192.06	HEART CENTER	2,799	19	0	71	0	192.06
192.07	WVCP	62,587	0	0	1,565	7,816	192.07
192.08	OCCUPATIONAL MED	0	0	0	0	0	192.08
192.09	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.09
192.10	HOSPITALIST	0	0	0	0	0	192.10
194.00	OTHER NONREIMBURSABLE COST CENTERS	52,824	0	0	676	0	194.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150064			Period: From 10/01/2010 To 09/30/2011		Worksheet B Part II Date/Time Prepared: 2/23/2012 2:34 pm	
Cost Center Description		OPERATION OF PLANT	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		7.00	7.01	8.00	9.00	10.00		
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	707,557	2,972	3,666	17,149	22,919		202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150064		Period: From 10/01/2010 To 09/30/2011		Worksheet B Part II Date/Time Prepared: 2/23/2012 2:34 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
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
7.01	OPERATION OF PLANT						7.01
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	31,987					11.00
13.00	NURSING ADMINISTRATION	506	2,370				13.00
14.00	CENTRAL SERVICES & SUPPLY	236	0	25,132			14.00
15.00	PHARMACY	840	108	0	27,950		15.00
16.00	MEDICAL RECORDS & LIBRARY	1,610	0	0	0	28,999	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,039	391	0	0	1,597	30.00
31.00	INTENSIVE CARE UNIT	2,012	259	0	0	1,030	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	737	95	0	0	316	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	536	69	0	0	129	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	2,346	302	0	0	2,353	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	2,176	80	0	0	6,795	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	1,584	0	0	0	4,503	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	999	128	0	0	1,274	65.00
66.00	PHYSICAL THERAPY	1,194	153	0	0	773	66.00
69.01	CARDIAC REHAB	258	33	0	0	78	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	25,132	0	1,008	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	27,950	2,616	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
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	1,573	202	0	0	3,146	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	CLINIC	3,590	0	0	0	1,658	93.00
93.01	BIC	0	0	0	0	1,078	93.01
93.02	UCIC	0	0	0	0	0	93.02
93.03	CIC	0	0	0	0	0	93.03
93.04	RIC	0	0	0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	904	204	0	0	318	95.00
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	1,566	201	0	0	240	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
116.00	HOSPICE	87	11	0	0	87	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	25,793	2,236	25,132	27,950	28,999	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
191.01	FMH DIAGNOSTIC CENTE	112	0	0	0	0	191.01
191.02	WELLNESS	288	37	0	0	0	191.02
192.00	PHYSICIANS' PRIVATE OFFICES	1,734	32	0	0	0	192.00
192.01	RFE	0	0	0	0	0	192.01
192.02	MARKETING	122	0	0	0	0	192.02
192.03	FOUNDATION	123	0	0	0	0	192.03
192.04	BROOKVILLE CLINIC	0	0	0	0	0	192.04
192.05	ATOD	0	0	0	0	0	192.05
192.06	HEART CENTER	0	0	0	0	0	192.06
192.07	WVCP	3,313	0	0	0	0	192.07
192.08	OCCUPATIONAL MED	0	0	0	0	0	192.08
192.09	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.09
192.10	HOSPITALIST	502	65	0	0	0	192.10

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150064			Period: From 10/01/2010 To 09/30/2011		Worksheet B Part II Date/Time Prepared: 2/23/2012 2:34 pm	
Cost Center Description	CAFETERIA 11.00	NURSING ADMINISTRATION 13.00	CENTRAL SERVICES & SUPPLY 14.00	PHARMACY 15.00	MEDICAL RECORDS & LIBRARY 16.00			
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	0	194.00	
200.00 Cross Foot Adjustments							200.00	
201.00 Negative Cost Centers	0	0	0	0	0	0	201.00	
202.00 TOTAL (sum lines 118-201)	31,987	2,370	25,132	27,950	28,999		202.00	

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150064		Period: From 10/01/2010 To 09/30/2011		Worksheet B Part II Date/Time Prepared: 2/23/2012 2:34 pm	
Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total			
		24.00	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
7.01	OPERATION OF PLANT						7.01
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION						13.00
14.00	CENTRAL SERVICES & SUPPLY						14.00
15.00	PHARMACY						15.00
16.00	MEDICAL RECORDS & LIBRARY						16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	141,589	0	141,589			30.00
31.00	INTENSIVE CARE UNIT	80,289	0	80,289			31.00
40.00	SUBPROVIDER - IPF	0	0	0			40.00
41.00	SUBPROVIDER - IRF	76,031	0	76,031			41.00
42.00	SUBPROVIDER	0	0	0			42.00
43.00	NURSERY	39,243	0	39,243			43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	198,976	0	198,976			50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0			52.00
54.00	RADIOLOGY-DIAGNOSTIC	191,752	0	191,752			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	67,240	0	67,240			60.00
60.01	BLOOD LABORATORY	0	0	0			60.01
65.00	RESPIRATORY THERAPY	29,653	0	29,653			65.00
66.00	PHYSICAL THERAPY	51,575	0	51,575			66.00
69.01	CARDIAC REHAB	23,517	0	23,517			69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,140	0	26,140			71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	101	0	101			72.00
73.00	DRUGS CHARGED TO PATIENTS	30,566	0	30,566			73.00
74.00	RENAL DIALYSIS	0	0	0			74.00
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	71,230	0	71,230			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0			92.00
93.00	CLINIC	131,266	0	131,266			93.00
93.01	BIC	73,604	0	73,604			93.01
93.02	UCIC	0	0	0			93.02
93.03	CIC	0	0	0			93.03
93.04	RIC	0	0	0			93.04
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	4,602	0	4,602			95.00
99.10	CORF	0	0	0			99.10
101.00	HOME HEALTH AGENCY	25,615	0	25,615			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
116.00	HOSPICE	529	0	529			116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,263,518	0	1,263,518			118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
191.00	RESEARCH	0	0	0			191.00
191.01	FMH DIAGNOSTIC CENTER	465	0	465			191.01
191.02	WELLNESS	31,597	0	31,597			191.02
192.00	PHYSICIANS' PRIVATE OFFICES	131,605	0	131,605			192.00
192.01	RFE	15	0	15			192.01
192.02	MARKETING	10,228	0	10,228			192.02
192.03	FOUNDATION	3,228	0	3,228			192.03
192.04	BROOKVILLE CLINIC	0	0	0			192.04
192.05	ATOD	0	0	0			192.05
192.06	HEART CENTER	7,057	0	7,057			192.06
192.07	WVCP	176,292	0	176,292			192.07
192.08	OCCUPATIONAL MED	7	0	7			192.08

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150064

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

Worksheet B
Part II
Date/Time Prepared:
2/23/2012 2:34 pm

Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	24.00	25.00	26.00	
192.09 HOME MEDICAL EQUIPMENT	0	0	0	192.09
192.10 HOSPITALIST	5,395	0	5,395	192.10
194.00 OTHER NONREIMBURSABLE COST CENTERS	132,158	0	132,158	194.00
200.00 Cross Foot Adjustments	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	1,761,565	0	1,761,565	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150064

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

Worksheet B-1
Date/Time Prepared:
2/23/2012 2:34 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCU. 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	399,897					1.00
4.00	EMPLOYEE BENEFITS	1,591	24,279,205				4.00
5.00	ADMINISTRATIVE & GENERAL	33,249	1,627,703	-5,080,460	42,585,504		5.00
7.00	OPERATION OF PLANT	158,733	459,374	0	2,376,257	238,359	7.00
7.01	OPERATION OF PLANT	0	0	0	861,525	0	7.01
8.00	LAUNDRY & LINEN SERVICE	410	23,014	0	182,130	410	8.00
9.00	HOUSEKEEPING	1,904	549,232	0	844,244	1,904	9.00
10.00	DIETARY	2,822	212,987	0	426,504	2,822	10.00
11.00	CAFETERIA	4,098	295,675	0	374,849	4,098	11.00
13.00	NURSING ADMINISTRATION	0	397,479	0	506,835	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	2,687	92,428	0	1,391,323	2,687	14.00
15.00	PHARMACY	2,600	473,483	0	2,158,378	2,600	15.00
16.00	MEDICAL RECORDS & LIBRARY	3,016	808,305	0	1,342,470	3,016	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	15,372	1,664,106	0	2,263,146	15,372	30.00
31.00	INTENSIVE CARE UNIT	9,291	1,070,626	0	1,501,715	9,291	31.00
40.00	SUBPROVIDER - I/PF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - I/RF	9,531	437,104	0	707,966	9,531	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	4,927	325,961	0	467,741	4,927	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	25,000	1,670,194	0	1,889,022	25,000	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	22,308	1,289,808	0	4,422,086	22,308	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	7,140	801,043	0	2,199,803	7,140	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	3,355	424,743	0	600,050	3,355	65.00
66.00	PHYSICAL THERAPY	6,066	825,828	0	1,053,287	6,066	66.00
69.01	CARDIAC REHAB	2,982	154,260	0	231,180	2,982	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	29,281	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
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	8,070	1,065,775	0	1,484,116	8,070	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	CLINIC	15,676	2,750,846	0	2,406,214	15,676	93.00
93.01	BIC	0	977,956	0	2,188,784	21,253	93.01
93.02	UCIC	0	0	0	0	0	93.02
93.03	CIC	0	0	0	0	0	93.03
93.04	RIC	0	0	0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	0	584,785	0	871,614	0	95.00
99.10	CORF	0	0	0	0	0	99.10
101.00	HOME HEALTH AGENCY	2,638	720,564	0	1,044,994	2,638	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
116.00	HOSPICE	0	45,830	0	95,983	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	343,466	19,749,109	-5,080,460	33,921,497	171,146	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
191.01	FMH DIAGNOSTIC CENTE	0	76,155	0	96,004	0	191.01
191.02	WELLNESS	0	87,040	0	226,279	10,051	191.02
192.00	PHYSICIANS' PRIVATE OFFICES	14,982	2,086,084	0	4,379,225	15,713	192.00
192.01	RFE	0	0	0	4,378	0	192.01
192.02	MARKETING	1,212	53,342	0	301,122	1,212	192.02
192.03	FOUNDATION	415	0	0	1,828	415	192.03
192.04	BROOKVILLE CLINIC	0	0	0	0	0	192.04
192.05	ATOD	0	0	0	0	0	192.05
192.06	HEART CENTER	943	0	0	4,154	943	192.06
192.07	WVCP	21,084	1,456,486	0	2,235,895	21,084	192.07

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150064

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

Worksheet B-1

Date/Time Prepared:
2/23/2012 2:34 pm

Cost Center Description	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				
192.08 OCCUPATIONAL MED	0	0	0	1,888	0	192.08
192.09 HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.09
192.10 HOSPITALIST	0	770,989	0	1,334,846	0	192.10
194.00 OTHER NONREIMBURSABLE COST CENTERS	17,795	0	0	78,388	17,795	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)	1,761,565	6,257,913		5,080,460	2,659,744	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	4.405047	0.257748		0.119300	11.158563	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)		7,008		146,933	707,557	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)		0.000289		0.003450	2.968451	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150064

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

Worksheet B-1

Date/Time Prepared:
2/23/2012 2:34 pm

Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	
	7.01	8.00	9.00	10.00	11.00	
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
7.01 OPERATION OF PLANT	147,282					7.01
8.00 LAUNDRY & LINEN SERVICE	410	76,306				8.00
9.00 HOUSEKEEPING	1,904	0	227,262			9.00
10.00 DIETARY	2,822	6,416	2,822	72,807		10.00
11.00 CAFETERIA	4,098	0	4,098	0	792,754	11.00
13.00 NURSING ADMINISTRATION	0	0	0	0	12,550	13.00
14.00 CENTRAL SERVICES & SUPPLY	2,687	0	2,687	0	5,855	14.00
15.00 PHARMACY	2,600	0	2,600	0	20,826	15.00
16.00 MEDICAL RECORDS & LIBRARY	2,785	0	3,016	0	39,907	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	15,372	20,271	15,372	39,658	75,329	30.00
31.00 INTENSIVE CARE UNIT	9,291	8,292	9,291	5,417	49,877	31.00
40.00 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00 SUBPROVIDER - IRF	9,531	4,426	9,531	2,903	18,273	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	4,927	0	4,927	0	13,277	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	25,000	5,066	25,000	0	58,148	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	22,308	9,053	22,308	0	53,938	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	7,140	40	7,140	0	39,261	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	3,355	0	3,355	0	24,747	65.00
66.00 PHYSICAL THERAPY	6,066	5,694	6,066	0	29,583	66.00
69.01 CARDIAC REHAB	2,982	661	2,982	0	6,397	69.01
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
74.00 RENAL DIALYSIS	0	0	0	0	0	74.00
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	8,070	12,600	8,070	0	38,983	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00 CLINIC	0	110	17,771	0	88,939	93.00
93.01 BIC	0	0	21,253	0	0	93.01
93.02 UCIC	0	0	0	0	0	93.02
93.03 CIC	0	0	0	0	0	93.03
93.04 RIC	0	0	0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	0	0	0	0	22,403	95.00
99.10 CORF	0	0	0	0	0	99.10
101.00 HOME HEALTH AGENCY	0	2,994	2,638	0	38,823	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
116.00 HOSPICE	0	0	0	0	2,152	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	131,348	75,623	170,927	47,978	639,268	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
191.01 FMH DIAGNOSTIC CENTE	0	0	0	0	2,765	191.01
191.02 WELLNESS	0	0	8,354	0	7,141	191.02
192.00 PHYSICIANS' PRIVATE OFFICES	13,364	683	15,713	0	42,978	192.00
192.01 RFE	0	0	0	0	0	192.01
192.02 MARKETING	1,212	0	1,212	0	3,016	192.02
192.03 FOUNDATION	415	0	415	0	3,040	192.03
192.04 BROOKVILLE CLINIC	0	0	0	0	0	192.04
192.05 ATOD	0	0	0	0	0	192.05
192.06 HEART CENTER	943	0	943	0	0	192.06
192.07 WVCP	0	0	20,745	24,829	82,098	192.07
192.08 OCCUPATIONAL MED	0	0	0	0	0	192.08
192.09 HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.09

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150064

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

Worksheet B-1

Date/Time Prepared:
2/23/2012 2:34 pm

Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	
	7.01	8.00	9.00	10.00	11.00	
192.10 HOSPITALIST	0	0	0	0	12,448	192.10
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	8,953	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)	964,305	211,117	978,674	557,256	509,775	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	6.547338	2.766716	4.306369	7.653879	0.643043	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	2,972	3,666	17,149	22,919	31,987	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.020179	0.048043	0.075459	0.314791	0.040349	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150064

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

Worksheet B-1
Date/Time Prepared:
2/23/2012 2:34 pm

Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY (100%)	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
	(FTE'S)				
	13.00	14.00	15.00	16.00	
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
7.01 OPERATION OF PLANT					7.01
8.00 LAUNDRY & LINEN SERVICE					8.00
9.00 HOUSEKEEPING					9.00
10.00 DIETARY					10.00
11.00 CAFETERIA					11.00
13.00 NURSING ADMINISTRATION	21,970				13.00
14.00 CENTRAL SERVICES & SUPPLY	0	100			14.00
15.00 PHARMACY	1,001	0	100		15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	0	102,138,790	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS	3,622	0	0	5,623,122	30.00
31.00 INTENSIVE CARE UNIT	2,398	0	0	3,627,586	31.00
40.00 SUBPROVIDER - IPF	0	0	0	0	40.00
41.00 SUBPROVIDER - IRF	879	0	0	1,113,585	41.00
42.00 SUBPROVIDER	0	0	0	0	42.00
43.00 NURSERY	638	0	0	455,340	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	2,796	0	0	8,284,874	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	739	0	0	23,951,643	54.00
57.00 CT SCAN	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	15,855,438	60.00
60.01 BLOOD LABORATORY	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	1,190	0	0	4,487,638	65.00
66.00 PHYSICAL THERAPY	1,422	0	0	2,722,584	66.00
69.01 CARDIAC REHAB	308	0	0	276,342	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	100	0	3,550,183	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	100	9,210,557	73.00
74.00 RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00 EMERGENCY	1,874	0	0	11,076,486	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00 CLINIC	0	0	0	5,837,810	93.00
93.01 BIC	0	0	0	3,795,719	93.01
93.02 UIC	0	0	0	0	93.02
93.03 CIC	0	0	0	0	93.03
93.04 RIC	0	0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES	1,892	0	0	1,118,903	95.00
99.10 CORF	0	0	0	0	99.10
101.00 HOME HEALTH AGENCY	1,867	0	0	845,416	101.00
SPECIAL PURPOSE COST CENTERS					
109.00 PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 ISLET ACQUISITION	0	0	0	0	111.00
116.00 HOSPICE	103	0	0	305,564	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	20,729	100	100	102,138,790	118.00
NONREIMBURSABLE COST CENTERS					
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	191.00
191.01 FMH DIAGNOSTIC CENTER	0	0	0	0	191.01
191.02 WELLNESS	343	0	0	0	191.02
192.00 PHYSICIANS' PRIVATE OFFICES	300	0	0	0	192.00
192.01 RFE	0	0	0	0	192.01
192.02 MARKETING	0	0	0	0	192.02
192.03 FOUNDATION	0	0	0	0	192.03
192.04 BROOKVILLE CLINIC	0	0	0	0	192.04
192.05 ATOD	0	0	0	0	192.05
192.06 HEART CENTER	0	0	0	0	192.06
192.07 WVCP	0	0	0	0	192.07
192.08 OCCUPATIONAL MED	0	0	0	0	192.08

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150064

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

Worksheet B-1

Date/Time Prepared:
2/23/2012 2:34 pm

Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY (100%)	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
	(FTE'S)					
	13.00	14.00	15.00	16.00		
192.09 HOME MEDICAL EQUIPMENT	0	0	0	0		192.09
192.10 HOSPITALIST	598	0	0	0		192.10
194.00 OTHER NONREIMBURSABLE COST CENTERS	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)	575,370	1,620,220	2,512,711	1,593,165		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	26.188894	16,202.200000	25,127.110000	0.015598		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	2,370	25,132	27,950	28,999		204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.107874	251.320000	279.500000	0.000284		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet C Part I Date/Time Prepared: 2/23/2012 2:34 pm		
		Title XVIII	Hospital	PPS		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS		3,462,137	0	3,462,137	30.00
31.00	INTENSIVE CARE UNIT		2,101,245	0	2,101,245	31.00
40.00	SUBPROVIDER - IPF		0	0	0	40.00
41.00	SUBPROVIDER - IRF		1,088,829	0	1,088,829	41.00
42.00	SUBPROVIDER		0	0	0	42.00
43.00	NURSERY		664,346	0	664,346	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM		2,918,550	7,457	2,926,007	50.00
52.00	DELIVERY ROOM & LABOR ROOM		0	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC		5,893,389	0	5,893,389	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		2,892,077	0	2,892,077	60.00
60.01	BLOOD LABORATORY		0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	862,563	0	862,563	65.00
66.00	PHYSICAL THERAPY	0	1,426,955	0	1,426,955	66.00
69.01	CARDIAC REHAB		342,720	0	342,720	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		1,675,596	0	1,675,596	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS		32,774	0	32,774	72.00
73.00	DRUGS CHARGED TO PATIENTS		2,656,377	0	2,656,377	73.00
74.00	RENAL DIALYSIS		0	0	0	74.00
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		2,120,588	0	2,120,588	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		630,630	0	630,630	92.00
93.00	CLINIC		3,093,277	137,810	3,231,087	93.00
93.01	BIC		2,837,788	45,890	2,883,678	93.01
93.02	UCIC		0	0	0	93.02
93.03	CIC		0	0	0	93.03
93.04	RIC		0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES		1,057,006	0	1,057,006	95.00
99.10	CORF		0	0	0	99.10
101.00	HOME HEALTH AGENCY		1,305,789	0	1,305,789	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
116.00	HOSPICE		116,281	0	116,281	116.00
200.00	Subtotal (see instructions)	0	37,178,917	191,157	37,370,074	200.00
201.00	Less Observation Beds		630,630	0	630,630	201.00
202.00	Total (see instructions)	0	36,548,287	191,157	36,739,444	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150064		Period: From 10/01/2010 To 09/30/2011		Worksheet C Part I Date/Time Prepared: 2/23/2012 2:34 pm	
		Title XVIII		Hospital		PPS	
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	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	5,623,122		5,623,122			30.00
31.00	INTENSIVE CARE UNIT	3,627,586		3,627,586			31.00
40.00	SUBPROVIDER - I PF	0		0			40.00
41.00	SUBPROVIDER - I RF	1,113,585		1,113,585			41.00
42.00	SUBPROVIDER	0		0			42.00
43.00	NURSERY	455,340		455,340			43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	2,184,419	6,100,455	8,284,874	0.352275	0.000000	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
54.00	RADIOLOGY-DIAGNOSTIC	2,346,535	21,714,751	24,061,286	0.244932	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	3,707,116	12,148,322	15,855,438	0.182403	0.000000	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	RESPIRATORY THERAPY	2,343,724	2,143,914	4,487,638	0.192209	0.000000	65.00
66.00	PHYSICAL THERAPY	922,444	1,800,140	2,722,584	0.524118	0.000000	66.00
69.01	CARDIAC REHAB	0	276,342	276,342	1.240202	0.000000	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,597,046	1,886,065	3,483,111	0.481063	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	67,072	0	67,072	0.488639	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	4,818,617	4,391,940	9,210,557	0.288406	0.000000	73.00
74.00	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
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	1,740,392	9,336,094	11,076,486	0.191450	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	893,273	893,273	0.705977	0.000000	92.00
93.00	CLINIC	0	5,673,090	5,673,090	0.545254	0.000000	93.00
93.01	BIC	0	3,795,719	3,795,719	0.747629	0.000000	93.01
93.02	UCIC	0	0	0	0.000000	0.000000	93.02
93.03	CIC	0	0	0	0.000000	0.000000	93.03
93.04	RIC	0	0	0	0.000000	0.000000	93.04
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	0	1,118,903	1,118,903	0.944681	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
116.00	HOSPICE	0	0	0			116.00
200.00	Subtotal (see instructions)	30,546,998	71,279,008	101,826,006			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	30,546,998	71,279,008	101,826,006			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet C Part I Date/Time Prepared: 2/23/2012 2:34 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital
		11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS			30.00
31.00	INTENSIVE CARE UNIT			31.00
40.00	SUBPROVIDER - IPF			40.00
41.00	SUBPROVIDER - IRF			41.00
42.00	SUBPROVIDER			42.00
43.00	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.353175		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.244932		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	0.182403		60.00
60.01	BLOOD LABORATORY	0.000000		60.01
65.00	RESPIRATORY THERAPY	0.192209		65.00
66.00	PHYSICAL THERAPY	0.524118		66.00
69.01	CARDIAC REHAB	1.240202		69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.481063		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.488639		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.288406		73.00
74.00	RENAL DIALYSIS	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER			89.00
91.00	EMERGENCY	0.191450		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.705977		92.00
93.00	CLINIC	0.569546		93.00
93.01	BIC	0.759719		93.01
93.02	UCIC	0.000000		93.02
93.03	CIC	0.000000		93.03
93.04	RIC	0.000000		93.04
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	0.944681		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
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: 150064

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

Worksheet C
Part I
Date/Time Prepared:
2/23/2012 2:34 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		3,462,137	0	0	30.00
31.00	INTENSIVE CARE UNIT		2,101,245	0	0	31.00
40.00	SUBPROVIDER - IPF		0	0	0	40.00
41.00	SUBPROVIDER - IRF		1,088,829	0	0	41.00
42.00	SUBPROVIDER		0	0	0	42.00
43.00	NURSERY		664,346	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM		2,918,550	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM		0	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC		5,893,389	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		2,892,077	0	0	60.00
60.01	BLOOD LABORATORY		0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	862,563	0	0	65.00
66.00	PHYSICAL THERAPY	0	1,426,955	0	0	66.00
69.01	CARDIAC REHAB		342,720	0	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		1,675,596	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS		32,774	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS		2,656,377	0	0	73.00
74.00	RENAL DIALYSIS		0	0	0	74.00
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		2,120,588	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		630,630	0	0	92.00
93.00	CLINIC		3,093,277	0	0	93.00
93.01	BIC		2,837,788	0	0	93.01
93.02	UCIC		0	0	0	93.02
93.03	CIC		0	0	0	93.03
93.04	RIC		0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES		1,057,006	0	0	95.00
99.10	CORF		0	0	0	99.10
101.00	HOME HEALTH AGENCY		1,305,789	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
116.00	HOSPICE		116,281	0	0	116.00
200.00	Subtotal (see instructions)	0	37,178,917	0	0	200.00
201.00	Less Observation Beds		630,630	0	0	201.00
202.00	Total (see instructions)	0	36,548,287	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet C Part I Date/Time Prepared: 2/23/2012 2:34 pm	
			Title XIX	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	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	5,623,122		5,623,122		30.00
31.00	INTENSIVE CARE UNIT	3,627,586		3,627,586		31.00
40.00	SUBPROVIDER - I/PF	0		0		40.00
41.00	SUBPROVIDER - I/RF	1,113,585		1,113,585		41.00
42.00	SUBPROVIDER	0		0		42.00
43.00	NURSERY	455,340		455,340		43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	2,184,419	6,100,455	8,284,874	0.352275	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
54.00	RADIOLOGY-DIAGNOSTIC	2,346,535	21,714,751	24,061,286	0.244932	54.00
57.00	CT SCAN	0	0	0	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	LABORATORY	3,707,116	12,148,322	15,855,438	0.182403	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	RESPIRATORY THERAPY	2,343,724	2,143,914	4,487,638	0.192209	65.00
66.00	PHYSICAL THERAPY	922,444	1,800,140	2,722,584	0.524118	66.00
69.01	CARDIAC REHAB	0	276,342	276,342	1.240202	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,597,046	1,886,065	3,483,111	0.481063	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	67,072	0	67,072	0.488639	72.00
73.00	DRUGS CHARGED TO PATIENTS	4,818,617	4,391,940	9,210,557	0.288406	73.00
74.00	RENAL DIALYSIS	0	0	0	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
91.00	EMERGENCY	1,740,392	9,336,094	11,076,486	0.191450	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	893,273	893,273	0.705977	92.00
93.00	CLINIC	0	5,673,090	5,673,090	0.545254	93.00
93.01	BIC	0	3,795,719	3,795,719	0.747629	93.01
93.02	UCIC	0	0	0	0.000000	93.02
93.03	CIC	0	0	0	0.000000	93.03
93.04	RIC	0	0	0	0.000000	93.04
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	1,118,903	1,118,903	0.944681	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
116.00	HOSPICE	0	0	0		116.00
200.00	Subtotal (see instructions)	30,546,998	71,279,008	101,826,006		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	30,546,998	71,279,008	101,826,006		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet C Part I Date/Time Prepared: 2/23/2012 2:34 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
40.00	SUBPROVIDER - IPF			40.00
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
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
65.00	RESPIRATORY THERAPY	0.000000		65.00
66.00	PHYSICAL THERAPY	0.000000		66.00
69.01	CARDIAC REHAB	0.000000		69.01
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
74.00	RENAL DIALYSIS	0.000000		74.00
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
93.00	CLINIC	0.000000		93.00
93.01	BIC	0.000000		93.01
93.02	UCIC	0.000000		93.02
93.03	CIC	0.000000		93.03
93.04	RIC	0.000000		93.04
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
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 ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 150064

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

Worksheet D
Part I
Date/Time Prepared:
2/23/2012 2:34 pm

Cost Center Description		Title XVIII			Hospital	PPS	
		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	141,589	2,087	139,502	4,430	31.49	30.00
31.00	INTENSIVE CARE UNIT	80,289		80,289	2,033	39.49	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	76,031	0	76,031	959	79.28	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	39,243		39,243	495	79.28	43.00
200.00	Total (lines 30-199)	337,152		335,065	7,917		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part I Date/Time Prepared: 2/23/2012 2:34 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
	6.00	7.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS	2,145	67,546		30.00
31.00 INTENSIVE CARE UNIT	1,183	46,717		31.00
40.00 SUBPROVIDER - IPF	0	0		40.00
41.00 SUBPROVIDER - IRF	764	60,570		41.00
42.00 SUBPROVIDER	0	0		42.00
43.00 NURSERY	0	0		43.00
200.00 Total (lines 30-199)	4,092	174,833		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part II Date/Time Prepared: 2/23/2012 2:34 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)	Hospital 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	198,976	8,284,874	0.024017	841,015	20,199	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	191,752	24,061,286	0.007969	1,981,673	15,792	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	67,240	15,855,438	0.004241	2,718,553	11,529	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	29,653	4,487,638	0.006608	1,681,666	11,112	65.00
66.00	PHYSICAL THERAPY	51,575	2,722,584	0.018943	168,606	3,194	66.00
69.01	CARDIAC REHAB	23,517	276,342	0.085101	0	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,140	3,483,111	0.007505	789,465	5,925	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	101	67,072	0.001506	24,459	37	72.00
73.00	DRUGS CHARGED TO PATIENTS	30,566	9,210,557	0.003319	2,608,265	8,657	73.00
74.00	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
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	71,230	11,076,486	0.006431	1,138,097	7,319	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	26,176	893,273	0.029303	0	0	92.00
93.00	CLINIC	131,266	5,673,090	0.023138	0	0	93.00
93.01	BIC	73,604	3,795,719	0.019391	0	0	93.01
93.02	UCIC	0	0	0.000000	0	0	93.02
93.03	CIC	0	0	0.000000	0	0	93.03
93.04	RIC	0	0	0.000000	0	0	93.04
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	921,796	89,887,470		11,951,799	83,764	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150064		Period: From 10/01/2010 To 09/30/2011		Worksheet D Part III Date/Time Prepared: 2/23/2012 2:34 pm	
Cost Center Description		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
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: 150064		Period: From 10/01/2010 To 09/30/2011		Worksheet D Part III Date/Time Prepared: 2/23/2012 2:34 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)	PPS	
		6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	4,430	0.00	2,145	0	30.00	
31.00	INTENSIVE CARE UNIT	2,033	0.00	1,183	0	31.00	
40.00	SUBPROVIDER - IPF	0	0.00	0	0	40.00	
41.00	SUBPROVIDER - IRF	959	0.00	764	0	41.00	
42.00	SUBPROVIDER	0	0.00	0	0	42.00	
43.00	NURSERY	495	0.00	0	0	43.00	
200.00	Total (lines 30-199)	7,917		4,092	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150064

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

Worksheet D
Part IV
Date/Time Prepared:
2/23/2012 2:34 pm

Cost Center Description		Title XVIII				Hospital	PPS
		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
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
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.01	CARDIAC REHAB	0	0	0	0	0	69.01
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
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
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
93.00	CLINIC	0	0	0	0	0	93.00
93.01	BIC	0	0	0	0	0	93.01
93.02	UCIC	0	0	0	0	0	93.02
93.03	CIC	0	0	0	0	0	93.03
93.04	RIC	0	0	0	0	0	93.04
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: 150064

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

Worksheet D
Part IV
Date/Time Prepared:
2/23/2012 2:34 pm

Cost Center Description		Title XVIII			Hospital		PPS
		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	8,284,874	0.000000	0.000000	841,015	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	24,061,286	0.000000	0.000000	1,981,673	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	15,855,438	0.000000	0.000000	2,718,553	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	RESPIRATORY THERAPY	0	4,487,638	0.000000	0.000000	1,681,666	65.00
66.00	PHYSICAL THERAPY	0	2,722,584	0.000000	0.000000	168,606	66.00
69.01	CARDIAC REHAB	0	276,342	0.000000	0.000000	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,483,111	0.000000	0.000000	789,465	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	67,072	0.000000	0.000000	24,459	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	9,210,557	0.000000	0.000000	2,608,265	73.00
74.00	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
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	11,076,486	0.000000	0.000000	1,138,097	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	893,273	0.000000	0.000000	0	92.00
93.00	CLINIC	0	5,673,090	0.000000	0.000000	0	93.00
93.01	BIC	0	3,795,719	0.000000	0.000000	0	93.01
93.02	UCIC	0	0	0.000000	0.000000	0	93.02
93.03	CIC	0	0	0.000000	0.000000	0	93.03
93.04	RIC	0	0	0.000000	0.000000	0	93.04
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	0	89,887,470			11,951,799	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150064

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

Worksheet D
Part IV
Date/Time Prepared:
2/23/2012 2:34 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	PPS
ANCILLARY SERVICE COST CENTERS		11.00	12.00	13.00		
50.00	OPERATING ROOM	0	2,013,707	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	8,480,415	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	472,009	0		60.00
60.01	BLOOD LABORATORY	0	0	0		60.01
65.00	RESPIRATORY THERAPY	0	1,041,203	0		65.00
66.00	PHYSICAL THERAPY	0	188	0		66.00
69.01	CARDIAC REHAB	0	149,972	0		69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	585,041	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,918,770	0		73.00
74.00	RENAL DIALYSIS	0	0	0		74.00
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	2,131,829	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	547,664	0		92.00
93.00	CLINIC	0	596,486	0		93.00
93.01	BIC	0	616,513	0		93.01
93.02	UCIC	0	0	0		93.02
93.03	CIC	0	0	0		93.03
93.04	RIC	0	0	0		93.04
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES					95.00
200.00	Total (Lines 50-199)	0	18,553,797	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 2/23/2012 2:34 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			PPS	
		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	0.352275	2,013,707	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.244932	8,480,415	38	13,083	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	0.182403	472,009	14	0	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0.192209	1,041,203	0	0	65.00
66.00	PHYSICAL THERAPY	0.524118	188	0	0	66.00
69.01	CARDIAC REHAB	1.240202	149,972	0	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.481063	585,041	0	118	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.488639	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.288406	1,918,770	0	14,076	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	0	74.00
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	0.191450	2,131,829	1	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.705977	547,664	0	0	92.00
93.00	CLINIC	0.545254	596,486	6	447	93.00
93.01	BIC	0.747629	616,513	6	102	93.01
93.02	UCIC	0.000000	0	0	0	93.02
93.03	CIC	0.000000	0	0	0	93.03
93.04	RIC	0.000000	0	0	0	93.04
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0.944681		0		95.00
200.00	Subtotal (see instructions)		18,553,797	65	27,826	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		18,553,797	65	27,826	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 2/23/2012 2:34 pm
	Title XVIII	Hospital	PPS

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	709,379	0	0		50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00 RADIOLOGY-DIAGNOSTIC	2,077,125	9	3,204		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	86,096	3	0		60.00
60.01 BLOOD LABORATORY	0	0	0		60.01
65.00 RESPIRATORY THERAPY	200,129	0	0		65.00
66.00 PHYSICAL THERAPY	99	0	0		66.00
69.01 CARDIAC REHAB	185,996	0	0		69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	281,442	0	57		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	553,385	0	4,060		73.00
74.00 RENAL DIALYSIS	0	0	0		74.00
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	408,139	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	386,638	0	0		92.00
93.00 CLINIC	325,236	3	244		93.00
93.01 BIC	460,923	4	76		93.01
93.02 UCIC	0	0	0		93.02
93.03 CIC	0	0	0		93.03
93.04 RIC	0	0	0		93.04
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES		0			95.00
200.00 Subtotal (see instructions)	5,674,587	19	7,641		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	5,674,587	19	7,641		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150064 Component CCN: 15T064		Period: From 10/01/2010 To 09/30/2011		Worksheet D Part II Date/Time Prepared: 2/23/2012 2:34 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	198,976	8,284,874	0.024017	153	4	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	191,752	24,061,286	0.007969	40,634	324	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	67,240	15,855,438	0.004241	63,620	270	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	29,653	4,487,638	0.006608	44,400	293	65.00
66.00	PHYSICAL THERAPY	51,575	2,722,584	0.018943	500,709	9,485	66.00
69.01	CARDIAC REHAB	23,517	276,342	0.085101	0	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,140	3,483,111	0.007505	24,630	185	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	101	67,072	0.001506	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	30,566	9,210,557	0.003319	189,891	630	73.00
74.00	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
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	71,230	11,076,486	0.006431	6,647	43	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	26,176	893,273	0.029303	0	0	92.00
93.00	CLINIC	131,266	5,673,090	0.023138	0	0	93.00
93.01	BIC	73,604	3,795,719	0.019391	0	0	93.01
93.02	UCIC	0	0	0.000000	0	0	93.02
93.03	CIC	0	0	0.000000	0	0	93.03
93.04	RIC	0	0	0.000000	0	0	93.04
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	921,796	89,887,470		870,684	11,234	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150064 Component CCN: 15T064	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part IV Date/Time Prepared: 2/23/2012 2:34 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
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
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.01 CARDIAC REHAB	0	0	0	0	0	69.01
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
74.00 RENAL DIALYSIS	0	0	0	0	0	74.00
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
93.00 CLINIC	0	0	0	0	0	93.00
93.01 BIC	0	0	0	0	0	93.01
93.02 UCIC	0	0	0	0	0	93.02
93.03 CIC	0	0	0	0	0	93.03
93.04 RIC	0	0	0	0	0	93.04
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: 150064 Component CCN: 15T064	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part IV Date/Time Prepared: 2/23/2012 2:34 pm
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	8,284,874	0.000000	0.000000	153	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	24,061,286	0.000000	0.000000	40,634	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	15,855,438	0.000000	0.000000	63,620	60.00
60.01 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00 RESPIRATORY THERAPY	0	4,487,638	0.000000	0.000000	44,400	65.00
66.00 PHYSICAL THERAPY	0	2,722,584	0.000000	0.000000	500,709	66.00
69.01 CARDIAC REHAB	0	276,342	0.000000	0.000000	0	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,483,111	0.000000	0.000000	24,630	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	67,072	0.000000	0.000000	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	9,210,557	0.000000	0.000000	189,891	73.00
74.00 RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
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	11,076,486	0.000000	0.000000	6,647	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	893,273	0.000000	0.000000	0	92.00
93.00 CLINIC	0	5,673,090	0.000000	0.000000	0	93.00
93.01 BIC	0	3,795,719	0.000000	0.000000	0	93.01
93.02 UCIC	0	0	0.000000	0.000000	0	93.02
93.03 CIC	0	0	0.000000	0.000000	0	93.03
93.04 RIC	0	0	0.000000	0.000000	0	93.04
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	89,887,470			870,684	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150064 Component CCN: 15T064	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part IV Date/Time Prepared: 2/23/2012 2:34 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	0	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
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
65.00 RESPIRATORY THERAPY	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	66.00
69.01 CARDIAC REHAB	0	0	0	69.01
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
74.00 RENAL DIALYSIS	0	0	0	74.00
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
93.00 CLINIC	0	0	0	93.00
93.01 BIC	0	0	0	93.01
93.02 UCIC	0	0	0	93.02
93.03 CIC	0	0	0	93.03
93.04 RIC	0	0	0	93.04
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: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 2/23/2012 2:34 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,701	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,430	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,430	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)		271	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,145	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)		58	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)		191	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		184.15	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		188.27	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,462,137	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)		51,021	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		51,021	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,411,116	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		8,944,450	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		8,944,450	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.381367	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)		2,019.06	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,411,116	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)		770.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,651,650	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)		1,651,650	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064		Period: From 10/01/2010 To 09/30/2011		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 2/23/2012 2:34 pm	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	2,101,245	2,033	1,033.57	1,183	1,222,713		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)					3,051,734		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,926,097		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)					114,263		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					83,764		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					198,027		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					5,728,070		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)					10,681		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					35,960		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					46,641		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)					819		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					770.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					630,630		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064		Period: From 10/01/2010 To 09/30/2011		Worksheet D-1 Date/Time Prepared: 2/23/2012 2:34 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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	141,589	3,411,116	0.041508	630,630	26,176	90.00
91.00	Nursing School cost	0	3,411,116	0.000000	630,630	0	91.00
92.00	Allied health cost	0	3,411,116	0.000000	630,630	0	92.00
93.00	All other Medical Education	0	3,411,116	0.000000	630,630	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet D-1
		Component CCN: 15T064		Date/Time Prepared: 2/23/2012 2:34 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		959	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		959	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)		959	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		764	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,088,829	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,088,829	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,113,585	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		1,113,585	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.977769	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,161.19	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,088,829	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)		1,135.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		867,430	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)		867,430	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064		Period: From 10/01/2010 To 09/30/2011		Worksheet D-1	
		Component CCN: 15T064				Date/Time Prepared: 2/23/2012 2:34 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		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)					360,464		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,227,894		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)					60,570		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					11,234		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					71,804		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,156,090		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064		Period: From 10/01/2010 To 09/30/2011		Worksheet D-1	
		Component CCN: 15T064				Date/Time Prepared: 2/23/2012 2:34 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	76,031	1,088,829	0.069828	0	0	90.00
91.00	Nursing School cost	0	1,088,829	0.000000	0	0	91.00
92.00	Allied health cost	0	1,088,829	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,088,829	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 2/23/2012 2:34 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)		4,701	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,430	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,430	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)		271	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		259	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)		495	15.00
16.00	Nursery days (title V or XIX only)		23	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		184.15	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		188.27	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,462,137	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)		51,021	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		51,021	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,411,116	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		8,944,450	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		8,944,450	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.381367	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)		2,019.06	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,411,116	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)		770.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		199,430	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)		199,430	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet D-1 Date/Time Prepared: 2/23/2012 2:34 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)	664,346	495	1,342.11	23	30,869	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	2,101,245	2,033	1,033.57	124	128,163	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)					271,761	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					630,223	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)					819	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					770.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					630,630	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064		Period: From 10/01/2010 To 09/30/2011		Worksheet D-1 Date/Time Prepared: 2/23/2012 2:34 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: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet D-1
		Component CCN: 15T064		Date/Time Prepared: 2/23/2012 2:34 pm
		Title XIX	Subprovider - IRF	
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		959	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		959	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)		959	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		58	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)		495	15.00
16.00	Nursery days (title V or XIX only)		23	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,088,829	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,088,829	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,113,585	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		1,113,585	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.977769	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,161.19	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,088,829	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)		1,135.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		65,852	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)		65,852	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064		Period: From 10/01/2010 To 09/30/2011		Worksheet D-1	
		Component CCN: 15T064				Date/Time Prepared: 2/23/2012 2:34 pm	
		Title XIX		Subprovider - IRF			
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		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)					0		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					65,852		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)					65,852		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064 Component CCN: 15T064		Period: From 10/01/2010 To 09/30/2011		Worksheet D-1 Date/Time Prepared: 2/23/2012 2:34 pm	
		Title XIX		Subprovider - IRF			
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	1,088,829	0.000000	0	0	90.00
91.00	Nursing School cost	0	1,088,829	0.000000	0	0	91.00
92.00	Allied health cost	0	1,088,829	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,088,829	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet D-3 Date/Time Prepared: 2/23/2012 2:34 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		2,513,191		30.00
31.00	INTENSIVE CARE UNIT		2,406,690		31.00
40.00	SUBPROVIDER - IPF		0		40.00
41.00	SUBPROVIDER - IRF		16,577		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.353175	841,015	297,025	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.244932	1,981,673	485,375	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	0.182403	2,718,553	495,872	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0.192209	1,681,666	323,231	65.00
66.00	PHYSICAL THERAPY	0.524118	168,606	88,369	66.00
69.01	CARDIAC REHAB	1.240202	0	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.481063	789,465	379,782	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.488639	24,459	11,952	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.288406	2,608,265	752,239	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	74.00
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	0.191450	1,138,097	217,889	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.705977	0	0	92.00
93.00	CLINIC	0.569546	0	0	93.00
93.01	BIC	0.759719	0	0	93.01
93.02	UCIC	0.000000	0	0	93.02
93.03	CIC	0.000000	0	0	93.03
93.04	RIC	0.000000	0	0	93.04
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		11,951,799	3,051,734	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)		11,951,799		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet D-3	
		Component CCN: 15T064		Date/Time Prepared: 2/23/2012 2:34 pm	
		Title XVIIII	Subprovider - IRF	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		13,113		30.00
31.00	INTENSIVE CARE UNIT		3,367		31.00
40.00	SUBPROVIDER - IPF		0		40.00
41.00	SUBPROVIDER - IRF		871,982		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.353175	153	54	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.244932	40,634	9,953	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	0.182403	63,620	11,604	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0.192209	44,400	8,534	65.00
66.00	PHYSICAL THERAPY	0.524118	500,709	262,431	66.00
69.01	CARDIAC REHAB	1.240202	0	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.481063	24,630	11,849	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.488639	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.288406	189,891	54,766	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	74.00
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	0.191450	6,647	1,273	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.705977	0	0	92.00
93.00	CLINIC	0.569546	0	0	93.00
93.01	BIC	0.759719	0	0	93.01
93.02	UCIC	0.000000	0	0	93.02
93.03	CIC	0.000000	0	0	93.03
93.04	RIC	0.000000	0	0	93.04
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		870,684	360,464	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)		870,684		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet D-3	
		Component CCN: 15U064		Date/Time Prepared: 2/23/2012 2:34 pm	
		Title XVIII	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		499		30.00
31.00	INTENSIVE CARE UNIT		310		31.00
40.00	SUBPROVIDER - IPF		0		40.00
41.00	SUBPROVIDER - IRF		135		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.352275	8	3	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.244932	7,389	1,810	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	0.182403	31,706	5,783	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0.192209	41,912	8,056	65.00
66.00	PHYSICAL THERAPY	0.524118	74,023	38,797	66.00
69.01	CARDIAC REHAB	1.240202	0	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.481063	19,140	9,208	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.488639	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.288406	123,610	35,650	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	74.00
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	0.191450	459	88	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.705977	0	0	92.00
93.00	CLINIC	0.545254	0	0	93.00
93.01	BIC	0.747629	0	0	93.01
93.02	UCIC	0.000000	0	0	93.02
93.03	CIC	0.000000	0	0	93.03
93.04	RIC	0.000000	0	0	93.04
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		298,247	99,395	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)		298,247		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet D-3 Date/Time Prepared: 2/23/2012 2:34 pm	
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		313,764		30.00
31.00	INTENSIVE CARE UNIT		113,655		31.00
40.00	SUBPROVIDER - IPF		0		40.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY		87,302		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.352275	161,336	56,835	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.244932	75,626	18,523	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	0.182403	243,223	44,365	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0.192209	78,188	15,028	65.00
66.00	PHYSICAL THERAPY	0.524118	21,513	11,275	66.00
69.01	CARDIAC REHAB	1.240202	0	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.481063	98,440	47,356	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.488639	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.288406	232,715	67,116	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	74.00
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	0.191450	58,828	11,263	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.705977	0	0	92.00
93.00	CLINIC	0.545254	0	0	93.00
93.01	BIC	0.747629	0	0	93.01
93.02	UCIC	0.000000	0	0	93.02
93.03	CIC	0.000000	0	0	93.03
93.04	RIC	0.000000	0	0	93.04
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		969,869	271,761	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)		969,869		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet D-3
		Component CCN: 15T064	Date/Time Prepared: 2/23/2012 2:34 pm	
		Title XIX	Subprovider - IRF	
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
40.00	SUBPROVIDER - IPF		0	40.00
41.00	SUBPROVIDER - IRF		77,059	41.00
42.00	SUBPROVIDER		0	42.00
43.00	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.000000	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000	0	54.00
57.00	CT SCAN	0.000000	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	LABORATORY	0.000000	1,386	60.00
60.01	BLOOD LABORATORY	0.000000	0	60.01
65.00	RESPIRATORY THERAPY	0.000000	0	65.00
66.00	PHYSICAL THERAPY	0.000000	39,422	66.00
69.01	CARDIAC REHAB	0.000000	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	688	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000	14,376	73.00
74.00	RENAL DIALYSIS	0.000000	0	74.00
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	0.000000	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	92.00
93.00	CLINIC	0.000000	0	93.00
93.01	BIC	0.000000	0	93.01
93.02	UCIC	0.000000	0	93.02
93.03	CIC	0.000000	0	93.03
93.04	RIC	0.000000	0	93.04
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES			95.00
200.00	Total (sum of lines 50-94 and 96-98)		55,872	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)		55,872	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet D-3	
		Component CCN: 15U064		Date/Time Prepared: 2/23/2012 2:34 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
40.00	SUBPROVIDER - IPF		0		40.00
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	0.352275	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.244932	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	0.182403	0	0	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0.192209	0	0	65.00
66.00	PHYSICAL THERAPY	0.524118	0	0	66.00
69.01	CARDIAC REHAB	1.240202	0	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.481063	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.488639	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.288406	0	0	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	74.00
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	0.191450	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.705977	0	0	92.00
93.00	CLINIC	0.545254	0	0	93.00
93.01	BIC	0.747629	0	0	93.01
93.02	UCIC	0.000000	0	0	93.02
93.03	CIC	0.000000	0	0	93.03
93.04	RIC	0.000000	0	0	93.04
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		0		200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part A Date/Time Prepared: 2/23/2012 2:34 pm
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		5,562,426	1.00
2.00	Outlier payments for discharges. (see instructions)		1,121	2.00
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		54.01	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.29	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		23.44	31.00
32.00	Sum of lines 30 and 31		28.73	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00	33.00
34.00	Disproportionate share adjustment (see instructions)		667,491	34.00
Additional payment for high percentage of ESRD beneficiary discharges				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0	46.00
47.00	Subtotal (see instructions)		6,231,038	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		6,231,038	49.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part A Date/Time Prepared: 2/23/2012 2:34 pm
		Title XVIII	Hospital	PPS
		before 1/1	on/after 1/1	
		1.00	1.01	
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)	450,867		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)	0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).	0		52.00
53.00	Nursing and Allied Health Managed Care payment	0		53.00
54.00	Special add-on payments for new technologies	0		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)	0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)	0		56.00
57.00	Routine service other pass through costs	0		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)	0		58.00
59.00	Total (sum of amounts on lines 49 through 58)	6,681,905		59.00
60.00	Primary payer payments	11,569		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	6,670,336		61.00
62.00	Deductibles billed to program beneficiaries	695,140		62.00
63.00	Coinurance billed to program beneficiaries	22,539		63.00
64.00	Allowable bad debts (see instructions)	333,033		64.00
65.00	Adjusted reimbursable bad debts (see instructions)	233,123		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	279,302		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	6,185,780		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)	0		68.00
69.00	Outlier payments reconciliation	0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		70.00
70.95	Recovery of Accelerated Depreciation	0		70.95
70.96	Low Volume Payment-1	425,971		70.96
70.97	Low Volume Payment-2	0		70.97
70.98	Low Volume Payment-3	0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)	6,611,751		71.00
72.00	Interim payments	6,578,047		72.00
73.00	Tentative settlement (for contractor use only)	0		73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)	33,704		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0		75.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Operating outlier amount from Worksheet E, Part A line 2	0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2	0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)	0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)	0		93.00
94.00	The rate used to calculate the Time Value of Money	0.00		94.00
95.00	Time Value of Money for operating expenses(see instructions)	0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)	0		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 2/23/2012 2:34 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			7,660 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			5,674,587 2.00
3.00	PPS payments			4,813,851 3.00
4.00	Outlier payment (see instructions)			1,383 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.761 5.00
6.00	Line 2 times line 5			4,318,361 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)			7,660 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			27,891 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)			27,891 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)			27,891 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			20,231 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)			7,660 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)			4,815,234 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			0 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,211,936 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)			3,610,958 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)			3,610,958 30.00
31.00	Primary payer payments			1,283 31.00
32.00	Subtotal (line 30 minus line 31)			3,609,675 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)			447,565 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			313,296 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			297,459 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			3,922,971 37.00
38.00	MSP-LCC reconciliation amount from PS&R			-83 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			3,923,054 40.00
41.00	Interim payments			3,840,824 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)			82,230 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 2/23/2012 2:34 pm
		Component CCN: 15T064	Title XVIII	Subprovider - IRF
		PPS		
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		0	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		0	40.00
41.00	Interim payments		0	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150064

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

Worksheet E-1
Part I
Date/Time Prepared:
2/23/2012 2:34 pm

Title XVIII

Hospital

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		6,378,628		3,608,866	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	09/30/2011	207,722	09/30/2011	210,878	3.01
3.02			0	05/05/2011	21,080	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	05/05/2011	8,303		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)		199,419		231,958	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)		6,578,047		3,840,824	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		33,704		82,230	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		6,611,751		3,923,054	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: 150064

Period:

Worksheet E-1

Component CCN: 15T064

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

Part I
Date/Time Prepared:
2/23/2012 2:34 pm

Title XVIII

Subprovider -
IRF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
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		1,035,673		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	5,602		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		5,602		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,041,275		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		12,887		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,054,162		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150064

Period:

Worksheet E-1

Component CCN: 15U064

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

Part I
Date/Time Prepared:
2/23/2012 2:34 pm

Title XVIII

Swing Beds - SNF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		84,259		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		84,259		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		1		0	6.02
7.00	Total Medicare program liability (see instructions)		84,258		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet E-1 Part II Date/Time Prepared: 2/23/2012 2:34 pm
		Title XVIII	Hospital	PPS
				1.00
DATA COLLECTION NEEDED FOR THE HIT CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			1,645 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			3,328 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2			402 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			5,644 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			101,826,006 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			0 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			0 8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment(s)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 minus line 30, plus or minus line 31)			0 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet E-2
Component CCN: 15U064		Date/Time Prepared: 2/23/2012 2:34 pm
Title XVIII	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)	87,784	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)			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	249	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)	87,784	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	87,784	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)	87,784	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	3,526	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)	84,258	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)	84,258	0	19.00
20.00	Interim payments	84,259	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)	-1	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet E-2
Component CCN: 15U064		Date/Time Prepared: 2/23/2012 2:34 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. 15-11, section 115.2	0		23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet E-3 Part III Date/Time Prepared: 2/23/2012 2:34 pm
		Component CCN: 15T064	Title XVIII	Subprovider - IRF
				PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)		1,022,355	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0256	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		39,695	3.00
4.00	Outlier Payments		3,619	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		0.00	5.00
6.00	New Teaching program adjustment. (see instructions)		0.00	6.00
7.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)		0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)		0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)		0.00	9.00
10.00	Average Daily Census (see instructions)		2,627,397	10.00
11.00	Medical Education Adjustment Factor $\{((1 + (\text{line 9}/\text{line 10})) \text{ raised to the power of } .6876 - 1)\}$.		0.000000	11.00
12.00	Medical Education Adjustment (line 1 multiplied by line 11).		0	12.00
13.00	Total PPS Payment (sum of lines 1, 3, 4 and 12)		1,065,669	13.00
14.00	Nursing and Allied Health Managed Care payment (see instruction)		0	14.00
15.00	Organ acquisition		0	15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	16.00
17.00	Subtotal (see instructions)		1,065,669	17.00
18.00	Primary payer payments		0	18.00
19.00	Subtotal (line 17 less line 18).		1,065,669	19.00
20.00	Deductibles		10,092	20.00
21.00	Subtotal (line 19 minus line 20)		1,055,577	21.00
22.00	Coinsurance		1,415	22.00
23.00	Subtotal (line 21 minus line 22)		1,054,162	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	26.00
27.00	Subtotal (sum of lines 23 and 25)		1,054,162	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	28.00
29.00	Other pass through costs (see instructions)		0	29.00
30.00	Outlier payments reconciliation		0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	31.00
31.99	Recovery of Accelerated Depreciation		0	31.99
32.00	Total amount payable to the provider (see instructions)		1,054,162	32.00
33.00	Interim payments		1,041,275	33.00
34.00	Tentative settlement (for contractor use only)		0	34.00
35.00	Balance due provider/program (line 32 minus the sum lines 33 and 34)		12,887	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet E-3 Part VII Date/Time Prepared: 2/23/2012 2:34 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		630,223	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)		630,223	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)		630,223	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		525,215	8.00
9.00	Ancillary service charges		969,869	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)		1,495,084	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)		1,495,084	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		864,861	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)		630,223	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.		630,223	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)		630,223	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)		630,223	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		630,223	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)		630,223	40.00
41.00	Interim payments		675,322	41.00
42.00	Balance due provider/program (line 40 minus 41)		-45,099	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet E-3 Part VII Date/Time Prepared: 2/23/2012 2:34 pm
		Component CCN: 15T064	Title XIX	Subprovider - IRF
				1.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0	1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	4.00
5.00	Inpatient primary payer payments		0	5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		77,059	8.00
9.00	Ancillary service charges		55,872	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)		132,931	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)		132,931	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		132,931	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	21.00
PROSPECTIVE PAYMENT AMOUNT				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		0	23.00
24.00	Program capital payments		0	24.00
25.00	Capital exception payments (see instructions)		0	25.00
26.00	Routine and Ancillary service other pass through costs		0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX enter the sum of lines 27 and 21.		0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	31.00
32.00	Deductibles		0	32.00
33.00	Coinurance		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Utilization review		0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	40.00
41.00	Interim payments		40,306	41.00
42.00	Balance due provider/program (line 40 minus 41)		-40,306	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: 150064

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

Worksheet G
Date/Time Prepared:
2/23/2012 2:34 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	814,772	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	18,492,090	0	0	0	4.00
5.00	Other receivable	605,401	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,912,207	0	0	0	6.00
7.00	Inventory	846,247	0	0	0	7.00
8.00	Prepaid expenses	715,804	0	0	0	8.00
9.00	Other current assets	1,070,134	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)	13,632,241	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,244,594	0	0	0	12.00
13.00	Land improvements	535,471	0	0	0	13.00
14.00	Accumulated depreciation	-391,108	0	0	0	14.00
15.00	Buildings	51,747,130	0	0	0	15.00
16.00	Accumulated depreciation	-29,508,919	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	22,102,522	0	0	0	23.00
24.00	Accumulated depreciation	-18,033,857	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)	27,695,833	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	13,934,860	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	1,351,249	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	15,286,109	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	56,614,183	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	917,508	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,051,897	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	5,340,200	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	531,026	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,840,631	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	20,025,092	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	4,313,749	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	24,338,841	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	32,179,472	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	24,434,711				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)	24,434,711	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	56,614,183	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150064

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

Worksheet G-1

Date/Time Prepared:
2/23/2012 2:34 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		27,159,994	
2.00	Net income (loss) (From Wkst. G-3, line 29)		-2,444,074			2.00
3.00	Total (sum of line 1 and line 2)		24,715,920		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)		24,715,920		0	11.00
12.00	INTEREST IN FOUNDATION	281,209		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)		281,209		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		24,434,711		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150064

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

Worksheet G-1

Date/Time Prepared:
2/23/2012 2:34 pm

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
1.00						1.00
			0		0	
2.00						2.00
3.00			0		0	3.00
4.00						4.00
	0			0		
5.00	0			0		5.00
	0			0		
6.00	0			0		6.00
	0			0		
7.00	0			0		7.00
	0			0		
8.00	0			0		8.00
	0			0		
9.00	0			0		9.00
			0		0	
10.00			0		0	10.00
			0		0	
11.00						11.00
12.00	0			0		12.00
	0			0		
13.00	0			0		13.00
	0			0		
14.00	0			0		14.00
	0			0		
15.00	0			0		15.00
	0			0		
16.00	0			0		16.00
	0			0		
17.00	0			0		17.00
			0		0	
18.00			0		0	18.00
			0		0	
19.00			0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150064

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

Worksheet G-2 Parts

Date/Time Prepared:
2/23/2012 2:34 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	6,249,319		6,249,319	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	1,113,585		1,113,585	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)	7,362,904		7,362,904	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,894,662		3,894,662	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)	3,894,662		3,894,662	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11,257,566		11,257,566	17.00
18.00	Ancillary services	20,541,254	71,116,846	91,658,100	18.00
19.00	Outpatient services	0	7,030,378	7,030,378	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		845,416	845,416	22.00
23.00	AMBULANCE SERVICES	0	1,118,903	1,118,903	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	305,564	305,564	26.00
27.00	OTHER (SPECIFY)	4,065,685	0	4,065,685	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	35,864,505	80,417,107	116,281,612	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		52,672,913		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		52,672,913		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150064

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

Worksheet G-3

Date/Time Prepared:
2/23/2012 2:34 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	116,281,612	1.00
2.00	Less contractual allowances and discounts on patients' accounts	61,539,967	2.00
3.00	Net patient revenues (line 1 minus line 2)	54,741,645	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	52,672,913	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,068,732	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	2,174,643	24.00
24.01	CONTRIBUTIONS	289,318	24.01
25.00	Total other income (sum of lines 6-24)	2,463,961	25.00
26.00	Total (line 5 plus line 25)	4,532,693	26.00
27.00	BAD DEBTS	5,367,048	27.00
27.01	LOSS ON DERIVATIVES	338,807	27.01
27.02	UNREALIZED LOSS ON INVESTMENTS	1,077,703	27.02
27.03	LOSS ON DISPOSAL	193,209	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	6,976,767	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,444,074	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 150064

Period:

Worksheet H

HHA CCN: 157097

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

Date/Time Prepared:
2/23/2012 2:34 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	148,167	0	35,203	0	88,105	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	280,730	0	0	0	0	6.00
7.00	Physical Therapy	81,557	0	0	0	0	7.00
8.00	Occupational Therapy	38,382	0	0	0	0	8.00
9.00	Speech Pathology	133	0	0	0	0	9.00
10.00	Medical Social Services	37,974	0	0	0	0	10.00
11.00	Home Health Aide	126,388	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)	713,331	0	35,203	0	88,105	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: 150064

Period: From 10/01/2010

Worksheet H

HHA CCN: 157097

To 09/30/2011

Date/Time Prepared: 2/23/2012 2:34 pm

Home Health Agency I

PPS

		Total (sum of col.s. 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	271,475	11,010	282,485	0	282,485	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	280,730	0	280,730	0	280,730	6.00
7.00	Physical Therapy	81,557	0	81,557	0	81,557	7.00
8.00	Occupational Therapy	38,382	0	38,382	0	38,382	8.00
9.00	Speech Pathology	133	0	133	0	133	9.00
10.00	Medical Social Services	37,974	0	37,974	0	37,974	10.00
11.00	Home Health Aide	126,388	0	126,388	0	126,388	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)	836,639	11,010	847,649	0	847,649	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: 150064	Period: From 10/01/2010	Worksheet H-1 Part I Date/Time Prepared: 2/23/2012 2:34 pm
	HHA CCN: 157097	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	282,485	0	0	0	5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	280,730	0	0	0	6.00
7.00	Physical Therapy	81,557	0	0	0	7.00
8.00	Occupational Therapy	38,382	0	0	0	8.00
9.00	Speech Pathology	133	0	0	0	9.00
10.00	Medical Social Services	37,974	0	0	0	10.00
11.00	Home Health Aide	126,388	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)	847,649	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 150064	Period: From 10/01/2010	Worksheet H-1
		HHA CCN: 157097	To 09/30/2011	Part I
			Home Health Agency I	Date/Time Prepared: 2/23/2012 2:34 pm
				PPS

	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	282,485	282,485	5.00
HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	280,730	140,319	421,049
7.00	Physical Therapy	81,557	40,764	122,321
8.00	Occupational Therapy	38,382	19,184	57,566
9.00	Speech Pathology	133	66	199
10.00	Medical Social Services	37,974	18,980	56,954
11.00	Home Health Aide	126,388	63,172	189,560
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)	565,164		847,649

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 150064
HHA CCN: 157097

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

Worksheet H-1
Part II
Date/Time Prepared:
2/23/2012 2:34 pm

Home Health
Agency I

PPS

		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)				
		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	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	-282,485	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	-282,485	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	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: 150064 HHA CCN: 157097	Period: From 10/01/2010 To 09/30/2011	Worksheet H-1 Part II Date/Time Prepared: 2/23/2012 2:34 pm PPS
		Administrative & General (ACCUM. COST)	Home Health Agency I	
		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	565,164		5.00
HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	280,730		6.00
7.00	Physical Therapy	81,557		7.00
8.00	Occupational Therapy	38,382		8.00
9.00	Speech Pathology	133		9.00
10.00	Medical Social Services	37,974		10.00
11.00	Home Health Aide	126,388		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)	565,164		24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	282,485		25.00
26.00	Unit Cost Multiplier	0.499828		26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150064

Period: From 10/01/2010

Worksheet H-2

HHA CCN: 157097

To 09/30/2011

Part I
Date/Time Prepared:
2/23/2012 2:34 pm

Home Health Agency I

PPS

	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00	4.00		4A	5.00	
1.00 Administrative and General	0	11,621	185,724	197,345	23,543	1.00	
2.00 Skilled Nursing Care	421,049	0	0	421,049	50,230	2.00	
3.00 Physical Therapy	122,321	0	0	122,321	14,593	3.00	
4.00 Occupational Therapy	57,566	0	0	57,566	6,868	4.00	
5.00 Speech Pathology	199	0	0	199	24	5.00	
6.00 Medical Social Services	56,954	0	0	56,954	6,795	6.00	
7.00 Home Health Aide	189,560	0	0	189,560	22,615	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)	847,649	11,621	185,724	1,044,994	124,668	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: 150064

Period:

Worksheet H-2

HHA CCN: 157097

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

Part I
Date/Time Prepared:
2/23/2012 2:34 pm

Home Health
Agency I

PPS

		OPERATION OF PLANT	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		7.00	7.01	8.00	9.00	10.00	
1.00	Administrative and General	29,436	0	8,284	11,360	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)	29,436	0	8,284	11,360	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: 150064

Period:

Worksheet H-2

HHA CCN: 157097

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

Part I
Date/Time Prepared:
2/23/2012 2:34 pm

Home Health
Agency I

PPS

	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
1.00 Administrative and General	24,965	48,895	0	0	13,187	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)	24,965	48,895	0	0	13,187	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: 150064 HHA CCN: 157097		Period: From 10/01/2010 To 09/30/2011		Worksheet H-2 Part I Date/Time Prepared: 2/23/2012 2:34 pm	
				Home Health Agency I		PPS	
		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	357,015	0	357,015			1.00
2.00	Skilled Nursing Care	471,279	0	471,279	177,337	648,616	2.00
3.00	Physical Therapy	136,914	0	136,914	51,520	188,434	3.00
4.00	Occupational Therapy	64,434	0	64,434	24,246	88,680	4.00
5.00	Speech Pathology	223	0	223	84	307	5.00
6.00	Medical Social Services	63,749	0	63,749	23,988	87,737	6.00
7.00	Home Health Aide	212,175	0	212,175	79,840	292,015	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)	1,305,789	0	1,305,789	357,015	1,305,789	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.				0.376291		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: 150064
HHA CCN: 157097

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

Worksheet H-2
Part II
Date/Time Prepared:
2/23/2012 2:34 pm
PPS

	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						
1.00	Administrative and General	2,638	720,564	5A	0	197,345	2,638	1.00
2.00	Skilled Nursing Care	0	0		0	421,049	0	2.00
3.00	Physical Therapy	0	0		0	122,321	0	3.00
4.00	Occupational Therapy	0	0		0	57,566	0	4.00
5.00	Speech Pathology	0	0		0	199	0	5.00
6.00	Medical Social Services	0	0		0	56,954	0	6.00
7.00	Home Health Aide	0	0		0	189,560	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)	2,638	720,564			1,044,994	2,638	20.00
21.00	Total cost to be allocated	11,621	185,724			124,668	29,436	21.00
22.00	Unit cost multiplier	4.405231	0.257748			0.119300	11.158453	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 150064 HHA CCN: 157097	Period: From 10/01/2010 To 09/30/2011	Worksheet H-2 Part II Date/Time Prepared: 2/23/2012 2:34 pm
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		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	
		7.01	8.00	9.00	10.00	11.00	
1.00	Administrative and General	0	2,994	2,638	0	38,823	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	2,994	2,638	0	38,823	20.00
21.00	Total cost to be allocated	0	8,284	11,360	0	24,965	21.00
22.00	Unit cost multiplier	0.000000	2.766867	4.306293	0.000000	0.643047	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 150064 HHA CCN: 157097	Period: From 10/01/2010 To 09/30/2011	Worksheet H-2 Part II Date/Time Prepared: 2/23/2012 2:34 pm PPS
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	NURSING ADMINISTRATION (FTE'S)	CENTRAL SERVICES & SUPPLY (100%)	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
	13.00	14.00	15.00	16.00		
1.00 Administrative and General	1,867	0	0	845,416		1.00
2.00 Skilled Nursing Care	0	0	0	0		2.00
3.00 Physical Therapy	0	0	0	0		3.00
4.00 Occupational Therapy	0	0	0	0		4.00
5.00 Speech Pathology	0	0	0	0		5.00
6.00 Medical Social Services	0	0	0	0		6.00
7.00 Home Health Aide	0	0	0	0		7.00
8.00 Supplies (see instructions)	0	0	0	0		8.00
9.00 Drugs	0	0	0	0		9.00
10.00 DME	0	0	0	0		10.00
11.00 Home Dialysis Aide Services	0	0	0	0		11.00
12.00 Respiratory Therapy	0	0	0	0		12.00
13.00 Private Duty Nursing	0	0	0	0		13.00
14.00 Clinic	0	0	0	0		14.00
15.00 Health Promotion Activities	0	0	0	0		15.00
16.00 Day Care Program	0	0	0	0		16.00
17.00 Home Delivered Meals Program	0	0	0	0		17.00
18.00 Homemaker Service	0	0	0	0		18.00
19.00 All Others (specify)	0	0	0	0		19.00
20.00 Total (sum of lines 1-19)	1,867	0	0	845,416		20.00
21.00 Total cost to be allocated	48,895	0	0	13,187		21.00
22.00 Unit cost multiplier	26.189073	0.000000	0.000000	0.015598		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 150064 HHA CCN: 157097		Period: From 10/01/2010 To 09/30/2011		Worksheet H-3 Parts I-III Date/Time Prepared: 2/23/2012 2:34 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	648,616		648,616	4,417	1.00
2.00	Physical Therapy	3.00	188,434	0	188,434	832	2.00
3.00	Occupational Therapy	4.00	88,680	0	88,680	416	3.00
4.00	Speech Pathology	5.00	307	0	307	28	4.00
5.00	Medical Social Services	6.00	87,737		87,737	39	5.00
6.00	Home Health Aide	7.00	292,015		292,015	11,373	6.00
7.00	Total (sum of lines 1-6)		1,305,789	0	1,305,789	17,105	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	1,262	1,297		8.00
9.00	Physical Therapy		99915	307	170		9.00
10.00	Occupational Therapy		99915	133	114		10.00
11.00	Speech Pathology		99915	0	1		11.00
12.00	Medical Social Services		99915	19	12		12.00
13.00	Home Health Aide		99915	442	1,229		13.00
14.00	Total (sum of lines 8-13)			2,163	2,823		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	0.524118	0	0	1.00
2.00	Occupational Therapy						2.00
3.00	Speech Pathology						3.00
4.00	Cost of Medical Supplies		71.00	0.481063	0	0	4.00
5.00	Cost of Drugs		73.00	0.288406	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 150064 HHA CCN: 157097	Period: From 10/01/2010 To 09/30/2011	Worksheet H-3 Parts I-III Date/Time Prepared: 2/23/2012 2:34 pm PPS	
		Title XVIIII	Home Health Agency I		
Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Part A	Program Visits		
			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	146.85	1,262	1,297	1.00
2.00	Physical Therapy	226.48	307	170	2.00
3.00	Occupational Therapy	213.17	133	114	3.00
4.00	Speech Pathology	10.96	0	1	4.00
5.00	Medical Social Services	2,249.67	19	12	5.00
6.00	Home Health Aide	25.68	442	1,229	6.00
7.00	Total (sum of lines 1-6)		2,163	2,823	7.00
Cost Center Description		5.00	6.00	7.00	8.00
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 Center Description		5.00	6.00	7.00	8.00
Program Covered Charges					
Cost Center Description	Ratio (col. 3 ÷ col. 4)	Part A	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	25,435	15.00
16.00	Cost of Drugs	0.000000	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				2.00
3.00	Speech Pathology				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

APPORTIONMENT OF PATIENT SERVICE COSTS	Provider CCN: 150064	Period: From 10/01/2010	Worksheet H-3 Parts I-III Date/Time Prepared: 2/23/2012 2:34 pm
	HHA CCN: 157097	To 09/30/2011	
	Title XVII I	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	185,325	190,464		375,789	1.00
2.00	Physical Therapy	69,529	38,502		108,031	2.00
3.00	Occupational Therapy	28,352	24,301		52,653	3.00
4.00	Speech Pathology	0	11		11	4.00
5.00	Medical Social Services	42,744	26,996		69,740	5.00
6.00	Home Health Aide	11,351	31,561		42,912	6.00
7.00	Total (sum of lines 1-6)	337,301	311,835		649,136	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	0	15.00
16.00	Cost of Drugs	0	0	0	0	16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 150064 HHA CCN: 157097	Period: From 10/01/2010 To 09/30/2011	Worksheet H-4 Part I-II Date/Time Prepared: 2/23/2012 2:34 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		284,629	267,760
12.00	Total PPS Reimbursement - Full Episodes with Outliers		2,144	7,388
13.00	Total PPS Reimbursement - LUPA Episodes		9,980	7,446
14.00	Total PPS Reimbursement - PEP Episodes		4,059	1,515
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		447	1,893
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)		301,259	286,002
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		301,259	286,002
25.00	Coinsurance billed to program patients (from your records)			0
26.00	Net cost (line 24 minus line 25)		301,259	286,002
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)		301,259	286,002
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		301,259	286,002
32.00	Interim payments (see instructions)		301,259	286,002
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: 150064	Period: From 10/01/2010	Worksheet H-5
	HHA CCN: 157097	To 09/30/2011	Date/Time Prepared: 2/23/2012 2:34 pm
		Home Health Agency I	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		301,259		286,002	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			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		301,259		286,002	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)		301,259		286,002	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: 150064

Period: From 10/01/2010

Worksheet K

Hospice CCN: 151548

To 09/30/2011

Date/Time Prepared: 2/23/2012 2:34 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	0	0	0	0	38,340	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	33,291	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	2,703	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	9,836	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)	45,830	0	0	0	38,340	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150064

Period: From 10/01/2010

Worksheet K

Hospice CCN: 151548

To 09/30/2011

Date/Time Prepared: 2/23/2012 2:34 pm

		Total (col. 6)	Reclassification (col. 7)	Subtotal (col. 8)	Adjustments (col. 9)	Total (col. 10)	
		1-5)	on	6 ± col. 7)		± 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	38,340	0	38,340	0	38,340	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	33,291	0	33,291	0	33,291	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	2,703	0	2,703	0	2,703	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	9,836	0	9,836	0	9,836	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)	84,170	0	84,170	0	84,170	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150064

Period: From 10/01/2010

Worksheet K-1

Hospice CCN: 151548

To 09/30/2011

Date/Time Prepared: 2/23/2012 2:34 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	3.00
4.00	Transportation - Staff	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	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	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	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	2,703	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	0	0	0	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					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	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	0	2,703	0	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150064

Period: From 10/01/2010

Worksheet K-1

Hospice CCN: 151548

To 09/30/2011

Date/Time Prepared: 2/23/2012 2:34 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	0	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	33,291	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	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	2,703	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		9,836	0	9,836	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	9,836	0	45,830	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST		Provider CCN: 150064	Period: From 10/01/2010	Worksheet K-4
		Hospice CCN: 151548	To 09/30/2011	Part I
		Hospice I		Date/Time Prepared: 2/23/2012 2:34 pm

	NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANSPORTATION	
		BUILDINGS & FIXTURES	MOVABLE EQUIPMENT			
		0	1.00			
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	4.00
5.00	Volunteer Service Coordination	0	0	0	0	5.00
6.00	Administrative and General	38,340	0	0	0	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	33,291	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	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	2,703	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	9,836	0	0	0	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)	84,170	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST		Provider CCN: 150064	Period: From 10/01/2010	Worksheet K-4
		Hospice CCN: 151548	To 09/30/2011	Part I
				Date/Time Prepared: 2/23/2012 2:34 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	38,340			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	33,291	27,850	61,141	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	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	2,703	2,261	4,964	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	9,836	8,229	18,065	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	45,830	38,340	84,170	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150064

Period: From 10/01/2010

Worksheet K-4

Hospice CCN: 151548

To 09/30/2011

Part II
Date/Time Prepared:
2/23/2012 2:34 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: 150064

Period: From 10/01/2010

Worksheet K-4

Hospice CCN: 151548

To 09/30/2011

Part II
Date/Time Prepared:
2/23/2012 2:34 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	-38,340	45,830	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	33,291	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	0	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	2,703	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	9,836	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)		38,340	39.00
40.00	Unit Cost Multiplier		0.836570	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150064

Period: From 10/01/2010

Worksheet K-5

Hospice CCN: 151548

To 09/30/2011

Part I
Date/Time Prepared:
2/23/2012 2:34 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	0	0	11,813	11,813	1,409	1.00
2.00 Inpatient - General Care	0	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	0	4.00
5.00 Nursing Care	61,141	0	0	0	61,141	7,295	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	0	9.00
10.00 Medical Social Services	4,964	0	0	0	4,964	592	10.00
11.00 Spiritual Counseling	0	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	18,065	0	0	0	18,065	2,155	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	84,170	0	0	11,813	95,983	11,451	34.00
35.00 Unit Cost Multiplier (see instructions)					0.000000		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150064

Period:

Worksheet K-5

Hospice CCN: 151548

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

Part I
Date/Time Prepared:
2/23/2012 2:34 pm

Cost Center Description		Hospice I					
		OPERATION OF PLANT 7.00	OPERATION OF PLANT 7.01	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
1.00	Administrative and General	0	0	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	0	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150064

Period: From 10/01/2010

Worksheet K-5

Hospice CCN: 151548

To 09/30/2011

Part I
Date/Time Prepared:
2/23/2012 2:34 pm

Cost Center Description		Hospice I					
		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	1,384	2,697	0	0	4,766	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)	1,384	2,697	0	0	4,766	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150064

Period: From 10/01/2010

Worksheet K-5

Hospice CCN: 151548

To 09/30/2011

Part I
Date/Time Prepared:
2/23/2012 2:34 pm

Cost Center Description	Subtotal	Intern &	Subtotal	Allocated	Total Hospice	
	(col.s. 4A-23)	Residents Cost	(col.s. 24 ±	Hospice A&G	Costs (col.s.	
		& Post	25)	(See Part II)	26 ± 27)	
	24.00	Adjustments	26.00	27.00	28.00	
1.00 Administrative and General	22,069					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	68,436	0	68,436	16,032	84,468	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	5,556	0	5,556	1,301	6,857	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	20,220	0	20,220	4,736	24,956	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)	116,281	0	116,281		116,281	34.00
35.00 Unit Cost Multiplier (see instructions)				0.234248		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150064
Hospice CCN: 151548

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

Worksheet K-5
Part II
Date/Time Prepared:
2/23/2012 2:34 pm

Cost Center Description		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	0	45,830	0	11,813	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	61,141	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	4,964	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	18,065	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	45,830		95,983	0	34.00
35.00	Total cost to be allocated	0	11,813		11,451	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.257757		0.119302	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150064

Period:

Worksheet K-5

Hospice CCN: 151548

From 10/01/2010

Part II

To 09/30/2011

Date/Time Prepared:

2/23/2012 2:34 pm

Cost Center Description		Hospice I						
		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)		
		7.01	8.00	9.00	10.00	11.00		
1.00	Administrative and General	0	0	0	0	2,152	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	0	0	0	2,152	34.00	
35.00	Total cost to be allocated	0	0	0	0	1,384	35.00	
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.000000	0.643123	36.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150064

Period:

Worksheet K-5

Hospice CCN: 151548

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

Part II
Date/Time Prepared:
2/23/2012 2:34 pm

Cost Center Description	Hospice I						
	NURSING ADMINISTRATION (FTE'S)	CENTRAL SERVICES & SUPPLY (100%)	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)			
	13.00	14.00	15.00	16.00			
1.00 Administrative and General	103	0	0	305,564		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	0	0	0		5.00	
6.00 Nursing Care-Continuous Home Care	0	0	0	0		6.00	
7.00 Physical Therapy	0	0	0	0		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	0	0	0		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)	103	0	0	305,564		34.00	
35.00 Total cost to be allocated	2,697	0	0	4,766		35.00	
36.00 Unit Cost Multiplier (see instructions)	26.184466	0.000000	0.000000	0.015597		36.00	

COMPUTATION OF TOTAL HOSPICE SHARED COSTS		Provider CCN: 150064	Period: From 10/01/2010	Worksheet K-5
		Hospice CCN: 151548	To 09/30/2011	Part III
		Hospice I		Date/Time Prepared: 2/23/2012 2:34 pm
Cost Center Description	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
ANCI LLARY SERVICE COST CENTERS				
1.00	PHYSICAL THERAPY	66.00	0.524118	0
2.00	OCCUPATIONAL THERAPY	67.00		0
3.00	SPEECH PATHOLOGY	68.00		0
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.288406	0
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00		0
6.00	LABORATORY	60.00	0.182403	0
6.01	BLOOD LABORATORY	60.01	0.000000	0
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.481063	0
8.00	CLINIC	93.00	0.569546	0
8.01	BIC	93.01	0.759719	0
8.02	UCIC	93.02	0.000000	0
8.03	CIC	93.03	0.000000	0
8.04	RIC	93.04	0.000000	0
9.00	RADIOLOGY-THERAPEUTIC	55.00		0
10.00	OTHER ANCI LLARY SERVICE COST CENTERS	76.00		0
11.00	Totals (sum of lines 1-10)			0

CALCULATION OF HOSPICE PER DIEM COST	Provider CCN: 150064	Period: From 10/01/2010	Worksheet K-6
	Hospice CCN: 151548	To 09/30/2011	Date/Time Prepared: 2/23/2012 2:34 pm

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				116,281	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				1,554	2.00
3.00	Average cost per diem (line 1 divided by line 2)				74.83	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	1,554				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	116,286				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		0			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		0			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			0		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			0		13.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150064	Period: From 10/01/2010 To 09/30/2011	Worksheet L Parts I-III Date/Time Prepared: 2/23/2012 2:34 pm
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		450,776	1.00
2.00	Capital DRG outlier payments		91	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		15.46	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		450,867	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00