

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: 151322  
 Period: From 01/01/2011 To 12/31/2011  
 Worksheet S Parts I-III  
 Date/Time Prepared: 5/8/2012 8:41 am

**PART I - COST REPORT STATUS**

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

Contractor use only  
 5.  Cost Report Status  
 (1) As Submitted  
 (2) Settled without Audit  
 (3) Settled with Audit  
 (4) Reopened  
 (5) Amended

6. Date Received:  
 7. Contractor No.  
 8.  Initial Report for this Provider CCN  
 9.  Final Report for this Provider CCN

10. NPR Date:  
 11. Contractor's Vendor Code: 05  
 12.  If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 5/8/2012 Time: 8:41 am

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

**Encryption Information**

ECR: Date: 5/8/2012 Time: 8:41 am  
 8o.LjqqsgeNTPipXdosqhgUAK7Ft0  
 a4c910xxqizwtH.QxykwtIwrt.Mayk  
 1D9R0xRXAh0Dchjq  
 PI: Date: 5/8/2012 Time: 8:41 am  
 ZgCuSfrFZo2:v0X2rRMPA3jJnAeY50  
 16cnT0Bad1z1BqGwiwrCpyXJsgZ9mb  
 UbzWPahPgM0VcZiZ

(Signed)

*[Signature]*  
 Officer or Administrator of Provider(s)

Title

5-24-12

Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	234,623	492,239	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	98,160	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0	0	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		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0		0	11.00
12.00 CMHC I	0	0	0		0	12.00
200.00 Total	0	332,783	492,239	0	0	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.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet 5 Parts I-III Date/Time Prepared: 5/4/2012 10:10 am
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**PART I - COST REPORT STATUS**

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Date: 5/4/2012 Time: 10:10 am

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(Signed) \_\_\_\_\_  
 Officer or Administrator of Provider(s)

Title \_\_\_\_\_

Date \_\_\_\_\_

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	234,623	492,239	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
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8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	332,783	492,239	0	0	200.00

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Contractor use only 5.  Cost Report Status 6. Date Received:  
 (1) As Submitted 7. Contractor No. 10. NPR Date:  
 (2) Settled without Audit 8.  Initial Report for this Provider CCN 11. Contractor's Vendor Code: 05  
 (3) Settled with Audit 9.  Final Report for this Provider CCN 12.  If line 5, column 1 is 4: Enter number of times reopened = 0-9.  
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 (5) Amended

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ECR: Date: 5/4/2012 Time: 10:10 am  
 o7j6UDHF.Qa0DZLVrAt271iUrUYAW0  
 qBXT30LpQYw2Vgn5NXGyocNfqXXEde  
 FuGR0uwaIk0zAdP1  
 PI: Date: 5/4/2012 Time: 10:10 am  
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 w6JZQ08aMaiQ5huH5bxaU5Gg8OdW6f  
 oKIWPc0mny0Krk5U

(Signed) \_\_\_\_\_  
 Officer or Administrator of Provider(s)  
 \_\_\_\_\_  
 Title  
 \_\_\_\_\_  
 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151322		Period: From 01/01/2011 To 12/31/2011		Worksheet S-2 Part I Date/Time Prepared: 5/4/2012 10:09 am					
1.00		2.00		3.00		4.00					
<b>Hospital and Hospital Health Care Complex Address:</b>											
1.00	Street: ONE HOSPITAL ROAD		PO Box: X		Zip Code: 47856-		County: PERRY		1.00		
2.00	City: TELL CITY		State: IN						2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00	2.00	3.00	4.00	5.00	V	XVIII	XIX		
<b>Hospital and Hospital-Based Component Identification:</b>											
3.00	Hospital	PERRY COUNTY HOSPITAL	151322	15999	1	07/01/2004	N	O	P	3.00	
4.00	Subprovider - IPF									4.00	
5.00	Subprovider - IRF									5.00	
6.00	Subprovider - (Other)									6.00	
7.00	Swing Beds - SNF	PERRY COUNTY HOSPITAL SWING	152322	15999		07/01/2004	N	O	N	7.00	
8.00	Swing Beds - NF						N		N	8.00	
9.00	Hospital-Based SNF									9.00	
10.00	Hospital-Based NF									10.00	
11.00	Hospital-Based OLTC									11.00	
12.00	Hospital-Based HHA	PERRY COUNTY HOSPITAL HHA	157177	15999		06/13/1986	N	P	N	12.00	
13.00	Separately Certified ASC									13.00	
14.00	Hospital-Based Hospice									14.00	
15.00	Hospital-Based Health Clinic - RHC									15.00	
16.00	Hospital-Based Health Clinic - FQHC									16.00	
17.00	Hospital-Based (CMHC) 1									17.00	
18.00	Renal Dialysis									18.00	
19.00	Other									19.00	
						From:	To:				
						1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2011		12/31/2011		20.00	
21.00	Type of Control (see instructions)							9		21.00	
<b>Inpatient PPS Information</b>											
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N		N		22.00	
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.							2		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0			24.00	
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.	0	0	0	0	0	0			25.00	
						Urban/Rural S	Date of Geogr				
						1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.					2					26.00
27.00	For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification (in column 2).					2					27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0					35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/4/2012 10:09 am		
		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		
<b>Prospective Payment System (PPS)-Capital</b>						
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	
<b>Teaching Hospitals</b>						
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)	N	0.00	0.00	61.00	
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
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	
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
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		
<b>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.</b>						
64.00	If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00	
		Program Name 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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

Worksheet S-2  
Part I  
Date/Time Prepared:  
5/4/2012 10:09 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. Use subscripted lines 65.01 through 65.50 for each additional primary care program. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4.			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
<b>Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010</b>							
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
<b>Inpatient Psychiatric Facility PPS</b>							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/4/2012 10:09 am	
		1.00	2.00	3.00	
<b>Inpatient Rehabilitation Facility PPS</b>					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00
		1.00			
<b>Long Term Care Hospital PPS</b>					
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.	N			80.00
<b>TEFRA Providers</b>					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N	86.00
		V	XIX		
		1.00	2.00		
<b>Title V or XIX Inpatient Services</b>					
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		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		97.00
<b>Rural Providers</b>					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		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.	Y	Y	Y	N
		1.00		2.00	
<b>Miscellaneous Cost Reporting Information</b>					
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.	N			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.			0	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.			0	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.	N			N
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
<b>Transplant Center Information</b>					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/4/2012 10:09 am			
		1.00	2.00				
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
<b>All Providers</b>							
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)	1.00	2.00	3.00	Y	140.00	
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	2.00				
144.00	Are provider based physicians' costs included in worksheet A?				Y	144.00	
145.00	If costs for renal services are claimed on worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.				N	145.00	
		1.00	2.00				
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
147.00	was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00	
148.00	was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00	
149.00	was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00	
		Part A	Part B				
		1.00	2.00				
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N			155.00	
156.00	Subprovider - IPF	N	N			156.00	
157.00	Subprovider - IRF	N	N			157.00	
158.00	SUBPROVIDER	N	N			158.00	
159.00	SNF	N	N			159.00	
160.00	HOME HEALTH AGENCY	N	N			160.00	
161.00	CMHC	N	N			161.00	
					1.00		
<b>Multicampus</b>							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
							1.00
<b>Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act</b>							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00169.00

		Y/N	Date	
		1.00	2.00	
<p><b>General Instruction:</b> Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.</p> <p><b>COMPLETED BY ALL HOSPITALS</b></p> <p><b>Provider Organization and Operation</b></p>				
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 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
<b>Financial Data and Reports</b>				
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	C	05/01/2012
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 1.00	Legal Oper. 2.00	
<b>Approved Educational Activities</b>				
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		
<b>Bad Debts</b>				
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
<b>Bed Complement</b>				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		<b>Part A</b>		
		Y/N 1.00	Date 2.00	
<b>PS&amp;R Data</b>				
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	04/03/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet 5-2 Part II Date/Time Prepared: 5/4/2012 10:09 am
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		Part A		
Description		Y/N	Date	
	0	1.00	2.00	
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
				1.00
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>				
<b>Capital Related Cost</b>				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N		23.00
24.00	were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N		25.00
26.00	were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
<b>Interest Expense</b>				
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
<b>Purchased Services</b>				
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/A		33.00
<b>Provider-Based Physicians</b>				
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	
<b>Home Office Costs</b>				
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/A		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/A		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N/A		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N/A		40.00

		Part B		
		Y/N	Date	
		3.00	4.00	
<b>PS&amp;R Data</b>				
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	04/03/2012	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: 151322

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description		Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	
		1.00	2.00	3.00	4.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	21	7,665	92,808.00	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)		21	7,665	92,808.00	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	0.00	8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY	43.00				13.00
14.00	Total (see instructions)		25	9,125	92,808.00	14.00
15.00	CAH visits					15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY	101.00				22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER					26.25
27.00	Total (sum of lines 14-26)		25			27.00
28.00	Observation Bed Days					28.00
29.00	Ambulance Trips					29.00
30.00	Employee discount days (see instruction)					30.00
31.00	Employee discount days - IRF					31.00
32.00	Labor & delivery days (see instructions)					32.00
33.00	LTCH non-covered days					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151322

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description	I/P Days / O/P Visits / Trips				Total All Patients	
	Title V	Title XVIII	Title XIX			
	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	2,661	365	3,867	1.00	
2.00 HMO		0	0		2.00	
3.00 HMO IPF		0	0		3.00	
4.00 HMO IRF		0	0		4.00	
5.00 Hospital Adults & Peds. Swing Bed SNF	0	686	0	686	5.00	
6.00 Hospital Adults & Peds. Swing Bed NF	0		16	16	6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	3,347	381	4,569	7.00	
8.00 INTENSIVE CARE UNIT	0	230	16	363	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		110	163	13.00	
14.00 Total (see instructions)	0	3,577	507	5,095	14.00	
15.00 CAH visits	0	0	0	0	15.00	
16.00 SUBPROVIDER - IPF					16.00	
17.00 SUBPROVIDER - IRF					17.00	
18.00 SUBPROVIDER					18.00	
19.00 SKILLED NURSING FACILITY					19.00	
20.00 NURSING FACILITY					20.00	
21.00 OTHER LONG TERM CARE					21.00	
22.00 HOME HEALTH AGENCY	0	2,916	1,243	4,565	22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00	
24.00 HOSPICE					24.00	
25.00 CMHC - CMHC					25.00	
26.00 RURAL HEALTH CLINIC					26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25	
27.00 Total (sum of lines 14-26)					27.00	
28.00 Observation Bed Days	0		0	409	28.00	
29.00 Ambulance Trips		1,041			29.00	
30.00 Employee discount days (see instruction)				0	30.00	
31.00 Employee discount days - IRF				0	31.00	
32.00 Labor & delivery days (see instructions)			0	0	32.00	
33.00 LTCH non-covered days		0			33.00	

Cost Center Description	Full Time Equivalents			Discharges	Title XVIII	
	Total Interns & Residents	Employees on Payroll	Nonpaid workers	Title V		
	9.00	10.00	11.00	12.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	776	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	241.71	0.00	0	776	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00	6.44	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	248.15	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

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)	144	1,289	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)	144	1,289	14.00
15.00 CAH visits			15.00
16.00 SUBPROVIDER - IPF			16.00
17.00 SUBPROVIDER - IRF			17.00
18.00 SUBPROVIDER			18.00
19.00 SKILLED NURSING FACILITY			19.00
20.00 NURSING FACILITY			20.00
21.00 OTHER LONG TERM CARE			21.00
22.00 HOME HEALTH AGENCY			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)			23.00
24.00 HOSPICE			24.00
25.00 CMHC - CMHC			25.00
26.00 RURAL HEALTH CLINIC			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER			26.25
27.00 Total (sum of lines 14-26)			27.00
28.00 Observation Bed Days			28.00
29.00 Ambulance Trips			29.00
30.00 Employee discount days (see instruction)			30.00
31.00 Employee discount days - IRF			31.00
32.00 Labor & delivery days (see instructions)			32.00
33.00 LTCH non-covered days			33.00

		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	454,368	3.00
4.00	Prior Year Pension Service Cost	0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
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
<b>HEALTH AND INSURANCE COST</b>			
8.00	Health Insurance (Purchased or Self Funded)	2,889,773	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)	26,221	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)	25,125	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'workers' Compensation Insurance	120,287	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
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	816,505	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	33,999	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
<b>OTHER</b>			
21.00	Executive Deferred Compensation	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	10,436	23.00
24.00	<b>Total Wage Related cost (Sum of lines 1 -23)</b>	<b>4,376,714</b>	<b>24.00</b>
25.00	<b>Part B - Other than Core Related Cost</b>		
25.00	<b>OTHER WAGE RELATED COSTS (SPECIFY)</b>	<b>0</b>	<b>25.00</b>

HOME HEALTH AGENCY STATISTICAL DATA	Provider CCN: 151322 Component CCN: 157177	Period: From 01/01/2011 To 12/31/2011	Worksheet S-4 Date/Time Prepared: 5/4/2012 10:09 am
		Home Health Agency I	PPS

0.00	County	1.00				0.00
		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	Other 4.00	Total 5.00

<b>HOME HEALTH AGENCY STATISTICAL DATA</b>							
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	104.00	0.00	55.00	181.00	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	

<b>HOME HEALTH AGENCY - NUMBER OF EMPLOYEES</b>							
3.00	Administrator and Assistant Administrator(s)	0.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			0.00	0.00	0.00	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00

<b>HOME HEALTH AGENCY CBSA CODES</b>							
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).			15999			20.00

Full Episodes						
without outliers		with outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
1.00		2.00	3.00	4.00	5.00	

<b>PPS ACTIVITY DATA</b>							
21.00	Skilled Nursing Visits	972	0	76	19	1,067	21.00
22.00	Skilled Nursing Visit Charges	328,073	0	25,396	6,365	359,834	22.00
23.00	Physical Therapy Visits	924	0	8	30	962	23.00
24.00	Physical Therapy Visit Charges	223,827	0	1,944	7,290	233,061	24.00
25.00	Occupational Therapy Visits	341	0	3	18	362	25.00
26.00	Occupational Therapy Visit Charges	71,912	0	667	3,816	76,395	26.00
27.00	Speech Pathology Visits	16	0	0	0	16	27.00
28.00	Speech Pathology Visit Charges	3,888	0	0	0	3,888	28.00
29.00	Medical Social Service Visits	20	0	0	4	24	29.00
30.00	Medical Social Service Visit Charges	6,029	0	0	1,108	7,137	30.00
31.00	Home Health Aide Visits	471	0	1	13	485	31.00
32.00	Home Health Aide Visit Charges	82,560	0	176	2,288	85,024	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,744	0	88	84	2,916	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)	716,289	0	28,183	20,867	765,339	35.00
36.00	Total Number of Episodes (standard/non outlier)	133	0	29	5	167	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	18,679	0	127	2	18,808	38.00

		1.00	
<b>Uncompensated and indigent care cost computation</b>			
1.00	Cost to charge ratio (worksheet C, Part 1 line 200 column 3 divided by line 200 column 8) Medicaid (see instructions for each line)	0.385511	1.00
2.00	Net revenue from Medicaid	1,396,082	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	759,334	5.00
6.00	Medicaid charges	9,122,926	6.00
7.00	Medicaid cost (line 1 times line 6)	3,516,988	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,361,572	8.00
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>			
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
<b>other state or local government indigent care program (see instructions for each line)</b>			
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
<b>Uncompensated care (see instructions for each line)</b>			
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,361,572	19.00
		Uninsured patients	Insured patients
		1.00	2.00
		Total (col. 1 + col. 2)	
		3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,918,069	0
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	739,437	0
22.00	Partial payment by patients approved for charity care	992,739	0
23.00	Cost of charity care (line 21 minus line 22)	-253,302	0
		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,125,072	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	581,992	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	3,543,080	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	1,365,896	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	1,112,594	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,474,166	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 151322		Period: From 01/01/2011 To 12/31/2011		Worksheet A	
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT		1,112,279	1,112,279	286,115	1,398,394	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		0	0	132,193	132,193	2.00
4.00	EMPLOYEE BENEFITS	127,937	4,058,461	4,186,398	-4,050,887	135,511	4.00
5.00	ADMINISTRATIVE & GENERAL	1,741,145	1,902,836	3,643,981	772,059	4,416,040	5.00
7.00	OPERATION OF PLANT	282,714	956,259	1,238,973	193,278	1,432,251	7.00
8.00	LAUNDRY & LINEN SERVICE	872	94,488	95,360	0	95,360	8.00
9.00	HOUSEKEEPING	215,155	50,104	265,259	206,141	471,400	9.00
10.00	DIETARY	251,296	214,796	466,092	4,590	470,682	10.00
11.00	CAFETERIA	0	0	0	127,221	127,221	11.00
13.00	NURSING ADMINISTRATION	559,285	11,449	570,734	400,282	971,016	13.00
16.00	MEDICAL RECORDS & LIBRARY	174,141	298,575	472,716	50,941	523,657	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	1,570,049	380,152	1,950,201	459,488	2,409,689	30.00
31.00	INTENSIVE CARE UNIT	295,955	14,066	310,021	49,047	359,068	31.00
43.00	NURSERY	38,195	0	38,195	92	38,287	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	505,467	485,137	990,604	42,583	1,033,187	50.00
52.00	DELIVERY ROOM & LABOR ROOM	61,894	143	62,037	82	62,119	52.00
54.00	RADIOLOGY-DIAGNOSTIC	831,869	960,007	1,791,876	243,290	2,035,166	54.00
60.00	LABORATORY	597,877	760,846	1,358,723	148,823	1,507,546	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	11,398	142,090	153,488	-9	153,479	62.00
65.00	RESPIRATORY THERAPY	449,349	278,606	727,955	226,472	954,427	65.00
66.00	PHYSICAL THERAPY	21,842	318,979	340,821	15,426	356,247	66.00
67.00	OCCUPATIONAL THERAPY	0	75,572	75,572	0	75,572	67.00
68.00	SPEECH PATHOLOGY	0	135,760	135,760	0	135,760	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	50,851	340,398	391,249	125,439	516,688	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	23,186	23,186	72.00
73.00	DRUGS CHARGED TO PATIENTS	73,368	2,797,877	2,871,245	24,729	2,895,974	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	201,358	74,064	275,422	107,426	382,848	90.00
91.00	EMERGENCY	803,916	1,626,138	2,430,054	176,473	2,606,527	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	AMBULANCE SERVICES	513,544	353,081	866,625	199,952	1,066,577	95.00
101.00	HOME HEALTH AGENCY	273,432	254,944	528,376	138,242	666,618	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	INTEREST EXPENSE		111,764	111,764	-111,764	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	9,652,909	17,808,871	27,461,780	-9,090	27,452,690	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	1,981,695	1,671,680	3,653,375	31,071	3,684,446	192.00
192.01	MARKETING	33,207	225,900	259,107	-21,981	237,126	192.01
200.00	TOTAL (SUM OF LINES 118-199)	11,667,811	19,706,451	31,374,262	0	31,374,262	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151322

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

Worksheet A

Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	NEW CAP REL COSTS-BLDG & FIXT	-286	1,398,108	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-3,736	128,457	2.00
4.00	EMPLOYEE BENEFITS	0	135,511	4.00
5.00	ADMINISTRATIVE & GENERAL	-69,421	4,346,619	5.00
7.00	OPERATION OF PLANT	-3,526	1,428,725	7.00
8.00	LAUNDRY & LINEN SERVICE	0	95,360	8.00
9.00	HOUSEKEEPING	0	471,400	9.00
10.00	DIETARY	-3,692	466,990	10.00
11.00	CAFETERIA	-46,932	80,289	11.00
13.00	NURSING ADMINISTRATION	0	971,016	13.00
16.00	MEDICAL RECORDS & LIBRARY	-5,009	518,648	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	-211,609	2,198,080	30.00
31.00	INTENSIVE CARE UNIT	0	359,068	31.00
43.00	NURSERY	0	38,287	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	-347,187	686,000	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	62,119	52.00
54.00	RADIOLOGY-DIAGNOSTIC	-110,114	1,925,052	54.00
60.00	LABORATORY	0	1,507,546	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	153,479	62.00
65.00	RESPIRATORY THERAPY	-193,254	761,173	65.00
66.00	PHYSICAL THERAPY	0	356,247	66.00
67.00	OCCUPATIONAL THERAPY	0	75,572	67.00
68.00	SPEECH PATHOLOGY	0	135,760	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	-8,116	508,572	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	23,186	72.00
73.00	DRUGS CHARGED TO PATIENTS	-1,104	2,894,870	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	CLINIC	0	382,848	90.00
91.00	EMERGENCY	-1,323,801	1,282,726	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	AMBULANCE SERVICES	-3,267	1,063,310	95.00
101.00	HOME HEALTH AGENCY	-75,456	591,162	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	INTEREST EXPENSE	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-2,406,510	25,046,180	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	3,684,446	192.00
192.01	MARKETING	0	237,126	192.01
200.00	TOTAL (SUM OF LINES 118-199)	-2,406,510	28,967,752	200.00

		Increases			
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
<b>A - CAFETERIA COST</b>					
1.00	CAFETERIA	11.00	68,592	58,629	1.00
	TOTALS		68,592	58,629	
<b>B - INTEREST EXPENSE</b>					
1.00	NEW CAP REL COSTS-MVBLE	2.00	0	121,691	1.00
	EQUIP				
2.00		0.00	0	0	2.00
	TOTALS		0	121,691	
<b>C - LEASE EXPENSE</b>					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	135,021	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
14.00		0.00	0	0	14.00
	TOTALS		0	135,021	
<b>D - INSURANCE EXPENSE</b>					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	13,808	1.00
2.00	NEW CAP REL COSTS-MVBLE	2.00	0	10,370	2.00
	EQUIP				
	TOTALS		0	24,178	
<b>F - GAIN/LOSS FIXED ASSETS</b>					
1.00	NEW CAP REL COSTS-MVBLE	2.00	0	132	1.00
	EQUIP				
	TOTALS		0	132	
<b>G - DRUGS CHARGED</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	82,452	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	TOTALS		0	82,452	
<b>J - BILLABLE SUPPLIES</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	129,211	1.00
2.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	19,504	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
6.00		0.00	0	0	6.00
8.00		0.00	0	0	8.00
11.00		0.00	0	0	11.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00	AMBULANCE SERVICES	95.00	0	1,394	16.00
17.00		0.00	0	0	17.00
19.00		0.00	0	0	19.00
	TOTALS		0	150,109	
<b>K - PLANT COST</b>					
1.00	OPERATION OF PLANT	7.00	0	78,200	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	78,200	
<b>M - YELLOW PAGES</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	29,458	1.00
	TOTALS		0	29,458	
<b>P - IMPLANTABLE DEVICE</b>					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	3,682	1.00
	TOTALS		0	3,682	
<b>R - PAYROLL</b>					
1.00		0.00	0	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	758,211	2.00
3.00	OPERATION OF PLANT	7.00	0	122,318	3.00
5.00	HOUSEKEEPING	9.00	0	206,141	5.00
6.00	DIETARY	10.00	0	131,811	6.00

Provider CCN: 151322

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

Worksheet A-6

Date/Time Prepared:  
5/4/2012 10:09 am

		Increases			
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
7.00	NURSING ADMINISTRATION	13.00	0	400,282	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	72,779	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	479,718	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	51,171	10.00
11.00	NURSERY	43.00	0	92	11.00
12.00	OPERATING ROOM	50.00	0	149,052	12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	82	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	245,676	14.00
15.00	LABORATORY	60.00	0	148,823	15.00
16.00		0.00	0	0	16.00
17.00	RESPIRATORY THERAPY	65.00	0	249,513	17.00
18.00	PHYSICAL THERAPY	66.00	0	17,403	18.00
20.00		0.00	0	0	20.00
21.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,610	21.00
22.00	CLINIC	90.00	0	108,717	22.00
23.00	EMERGENCY	91.00	0	208,369	23.00
24.00	AMBULANCE SERVICES	95.00	0	215,889	24.00
25.00	HOME HEALTH AGENCY	101.00	0	143,550	25.00
26.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	327,302	26.00
27.00	MARKETING	192.01	0	7,477	27.00
28.00		0.00	0	0	28.00
TOTALS			0	4,050,986	
<b>S - DEPRECIATION</b>					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	137,286	1.00
TOTALS			0	137,286	
500.00	Grand Total: Increases		68,592	4,871,824	500.00

		Decreases				
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
<b>A - CAFETERIA COST</b>						
1.00	DIETARY	10.00	68,592	58,629	0	1.00
	TOTALS		68,592	58,629		
<b>B - INTEREST EXPENSE</b>						
1.00	INTEREST EXPENSE	113.00	0	111,764	10	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	9,927	0	2.00
	TOTALS		0	121,691		
<b>C - LEASE EXPENSE</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,327	9	1.00
2.00	OPERATION OF PLANT	7.00	0	7,240	0	2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	21,838	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	5,040	0	4.00
5.00	OPERATING ROOM	50.00	0	22	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,268	0	6.00
7.00	RESPIRATORY THERAPY	65.00	0	23,041	0	7.00
8.00	PHYSICAL THERAPY	66.00	0	970	0	8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	63,977	0	9.00
11.00	EMERGENCY	91.00	0	487	0	11.00
12.00	HOME HEALTH AGENCY	101.00	0	3,050	0	12.00
14.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3,761	0	14.00
	TOTALS		0	135,021		
<b>D - INSURANCE EXPENSE</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	10,370	9	1.00
2.00	AMBULANCE SERVICES	95.00	0	13,808	10	2.00
	TOTALS		0	24,178		
<b>F - GAIN/LOSS FIXED ASSETS</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	132	10	1.00
	TOTALS		0	132		
<b>G - DRUGS CHARGED</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	781	0	1.00
2.00	OPERATING ROOM	50.00	0	24,827	0	2.00
3.00	EMERGENCY	91.00	0	18,903	0	3.00
4.00	HOME HEALTH AGENCY	101.00	0	186	0	4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	37,755	0	5.00
	TOTALS		0	82,452		
<b>J - BILLABLE SUPPLIES</b>						
1.00		0.00	0	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	15,190	0	3.00
4.00	INTENSIVE CARE UNIT	31.00	0	2,124	0	4.00
6.00	OPERATING ROOM	50.00	0	81,620	0	6.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,118	0	8.00
11.00	PHYSICAL THERAPY	66.00	0	1,007	0	11.00
13.00	DRUGS CHARGED TO PATIENTS	73.00	0	356	0	13.00
14.00	CLINIC	90.00	0	1,291	0	14.00
15.00	EMERGENCY	91.00	0	12,506	0	15.00
16.00		0.00	0	0	0	16.00
17.00	HOME HEALTH AGENCY	101.00	0	2,072	0	17.00
19.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	32,825	0	19.00
	TOTALS		0	150,109		
<b>K - PLANT COST</b>						
1.00	AMBULANCE SERVICES	95.00	0	3,523	0	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	74,677	0	2.00
	TOTALS		0	78,200		
<b>M - YELLOW PAGES</b>						
1.00	MARKETING	192.01	0	29,458	0	1.00
	TOTALS		0	29,458		
<b>P - IMPLANTABLE DEVICE</b>						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,682	0	1.00
	TOTALS		0	3,682		
<b>R - PAYROLL</b>						
1.00		0.00	0	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
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

Provider CCN: 151322

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

Worksheet A-6

Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center	Decreases				wkst. A-7 Ref.	
	Line #	Salary	Other			
6.00	7.00	8.00	9.00	10.00		
14.00	0.00	0	0	0	0	14.00
15.00	0.00	0	0	0	0	15.00
16.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	9	0	0	16.00
17.00		0.00	0	0	0	17.00
18.00		0.00	0	0	0	18.00
20.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	90	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	EMPLOYEE BENEFITS	4.00	4,050,887	0	0	28.00
	TOTALS		4,050,986	0		
<b>S - DEPRECIATION</b>						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	137,286	9	1.00
	TOTALS		0	137,286		
500.00	Grand Total: Decreases		4,119,578	820,838		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151322

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
5/4/2012 10:09 am

	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
	1.00	2.00	3.00	4.00	5.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	2,895,311	50,320	0	50,320	0	1.00
2.00	Land Improvements	1,394,559	100,347	0	100,347	0	2.00
3.00	Buildings and Fixtures	10,329,023	36,831	0	36,831	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	6,989,820	1,671,789	0	1,671,789	353,508	5.00
6.00	Movable Equipment	9,255,773	217,564	0	217,564	45,159	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	30,864,486	2,076,851	0	2,076,851	398,667	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	30,864,486	2,076,851	0	2,076,851	398,667	10.00
<b>SUMMARY OF CAPITAL</b>							
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)		
	9.00	10.00	11.00	12.00	13.00		
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,112,279	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,112,279	0	0	0	0	3.00
<b>COMPUTATION OF RATIOS</b>							
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151322

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
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		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	2,945,631	0		1.00		
2.00	Land Improvements	1,494,906	0		2.00		
3.00	Buildings and Fixtures	10,365,854	0		3.00		
4.00	Building Improvements	0	0		4.00		
5.00	Fixed Equipment	8,308,101	0		5.00		
6.00	Movable Equipment	9,428,178	0		6.00		
7.00	HIT designated Assets	0	0		7.00		
8.00	Subtotal (sum of lines 1-7)	32,542,670	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	32,542,670	0		10.00		
<b>SUMMARY OF CAPITAL</b>							
Cost Center Description		Other Capital-Related costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,112,279		1.00		
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00		
3.00	Total (sum of lines 1-2)	0	1,112,279		3.00		
<b>ALLOCATION OF OTHER CAPITAL</b>							
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	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,398,108	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	-13,826	142,283	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,384,282	142,283	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151322

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

Worksheet A-7  
Parts I-III  
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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		
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,398,108	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	128,457	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,526,565	3.00

1.00	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted	
				Cost Center	Line #
				3.00	4.00
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-33,865	NEW CAP REL COSTS-MVBLE EQUIP	2.00
3.00	Investment income - other (chapter 2)		0		3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		7.00
8.00	Television and radio service (chapter 21)		0		8.00
9.00	Parking lot (chapter 21)		0		9.00
10.00	Provider-based physician adjustment	A-8-2	-2,184,161		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		11.00
12.00	Related organization transactions (chapter 10)	A-8-1	42,151		12.00
13.00	Laundry and linen service		0		13.00
14.00	Cafeteria-employees and guests	B	-46,932	CAFETERIA	11.00
15.00	Rental of quarters to employee and others		0		15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-8,116	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
17.00	Sale of drugs to other than patients	B	-1,104	DRUGS CHARGED TO PATIENTS	73.00
18.00	Sale of medical records and abstracts	B	-5,009	MEDICAL RECORDS & LIBRARY	16.00
19.00	Nursing school (tuition, fees, books, etc.)		0		19.00
20.00	Vending machines		0		20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00
25.00	utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00
29.00	Physicians' assistant		0		29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		32.00
33.00	MISC INCOME	B	-23,097	ADMINISTRATIVE & GENERAL	5.00
34.00	MISC INCOME	B	-3,267	AMBULANCE SERVICES	95.00
35.00	HHA ADVERTISING	A	-526	HOME HEALTH AGENCY	101.00
36.00	RECRUITING	A	-74,930	HOME HEALTH AGENCY	101.00
37.00	SWAP INTEREST	A	-13,826	NEW CAP REL COSTS-MVBLE EQUIP	2.00
38.00	PHONE	A	-10,760	ADMINISTRATIVE & GENERAL	5.00
39.00	PHONE	A	-3,526	OPERATION OF PLANT	7.00
40.00	DIETARY	B	-286	NEW CAP REL COSTS-BLDG & FIXT	1.00
41.00	AHA	A	-3,692	DIETARY	10.00
42.00	NON ALLOWABLE EXPENSE	A	-29,603	ADMINISTRATIVE & GENERAL	5.00
43.00	LOSS REPORTED AS EXP	B	132	ADMINISTRATIVE & GENERAL	5.00
45.00	MISCELLANEOUS EXPENSE	A	-6,093	ADMINISTRATIVE & GENERAL	5.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,406,510		50.00

Provider CCN: 151322

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

Worksheet A-8

Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description	Wkst. A-7	Ref.	
	5.00		
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		10	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 - NEW CAP REL COSTS-BLDG & FIXT		0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	27.00
28.00 Non-physician Anesthetist			28.00
29.00 Physicians' assistant		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)			30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0	32.00
33.00 MISC INCOME		0	33.00
34.00 MISC INCOME		0	34.00
35.00 HHA ADVERTISING		0	35.00
36.00 RECRUITING		0	36.00
37.00 SWAP INTEREST		9	37.00
38.00 PHONE		0	38.00
39.00 PHONE		0	39.00
40.00 DIETARY		9	40.00
41.00 AHA		0	41.00
42.00 NON ALLOWABLE EXPENSE		0	42.00
43.00 LOSS REPORTED AS EXP		0	43.00
45.00 MISCELLANEOUS EXPENSE		0	45.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			50.00

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

Provider CCN: 151322

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

Worksheet A-8-1

Date/Time Prepared:  
5/4/2012 10:09 am

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00		2.00	NEW CAP REL COSTS-MVBLE EQUIP	AMBULANCE DEPRECIATION 1.00
2.00		54.00	RADIOLOGY-DIAGNOSTIC	MOBILE MRI 2.00
3.00		0.00		3.00
4.00		0.00		4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.			5.00

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

	Symbol (1)	Name	Percentage of Ownership
	1.00	2.00	3.00

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

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

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

6.00	G	PERRY CO AMBULA	100.00	6.00
7.00	G	DSSI	100.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:			100.00
		OTHER		

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS  
 Provider CCN: 151322  
 Period: From 01/01/2011 To 12/31/2011  
 Worksheet A-8-1  
 Date/Time Prepared: 5/4/2012 10:09 am

	Amount of Allowable Cost	Amount Included in wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	4.00	5.00	6.00	7.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	43,955	0	43,955	10	1.00
2.00	324,281	326,085	-1,804	0	2.00
3.00	0	0	0	0	3.00
4.00	0	0	0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.	326,085	42,151		5.00

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

Related Organization(s) and/or Home Office		
Name	Percentage of Ownership	Type of Business
4.00	5.00	6.00

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151322

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

Worksheet A-8-2

Date/Time Prepared:  
5/4/2012 10:09 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	50.00	OPERATING ROOM	347,187	347,187	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	108,310	108,310	2.00
3.00	60.00	LABORATORY	18,000	0	3.00
4.00	65.00	RESPIRATORY THERAPY	193,254	193,254	4.00
5.00	91.00	EMERGENCY	1,533,000	1,323,801	5.00
6.00	30.00	ADULTS & PEDIATRICS	211,609	211,609	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			2,411,360	2,184,161	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151322

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

Worksheet A-8-2

Date/Time Prepared:  
5/4/2012 10:09 am

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	18,000	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	209,199	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	227,199					200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151322

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

Worksheet A-8-2

Date/Time Prepared:  
5/4/2012 10:09 am

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151322

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

Worksheet A-8-2

Date/Time Prepared:  
5/4/2012 10:09 am

	RCE Disallowance	Adjustment	
	17.00	18.00	
1.00	0	347,187	1.00
2.00	0	108,310	2.00
3.00	0	0	3.00
4.00	0	193,254	4.00
5.00	0	1,323,801	5.00
6.00	0	211,609	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	2,184,161	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet A-8-3 Par Date/Time Prepared: 5/4/2012 10:09 am
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	Physical Therapy	Cost	
		1.00	

<b>PART I - GENERAL INFORMATION</b>			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52 1.00
2.00	Line 1 multiplied by 15 hours per week		780 2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		358 3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0 4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		312 5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		915 6.00
7.00	Standard travel expense rate	5.50	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

	Supervisors 1.00	Therapists 2.00	Assistants 3.00	Aides 4.00	Trainees 5.00	
9.00	0.00	2,527.00	4,757.00	0.00	0.00	9.00
10.00	0.00	72.00	54.00	0.00	0.00	10.00
11.00	36.00	36.00	27.00			11.00
12.00	0	171	177			12.00
12.01	0	0	0			12.01
13.00	0	2,441	6,942			13.00
13.01	0	0	0			13.01

					1.00	
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<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>			
14.00	Supervisors (column 1, line 9 times column 1, line 10)		0 14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		181,944 15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)		256,878 16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		438,822 17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		0 18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)		0 19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		438,822 20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.			
21.00	weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		0.00 21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		0 22.00
23.00	Total salary equivalency (see instructions)		438,822 23.00

**PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE**

<b>Standard Travel Allowance</b>			
24.00	Therapists (line 3 times column 2, line 11)		12,888 24.00
25.00	Assistants (line 4 times column 3, line 11)		0 25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		12,888 26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		1,969 27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		14,857 28.00

<b>Optional Travel Allowance and Optional Travel Expense</b>			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		12,312 29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		9,558 30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		21,870 31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0 32.00
33.00	Standard travel allowance and standard travel expense (line 28)		0 33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0 34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0 35.00

**Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE**

<b>Standard Travel Expense</b>			
36.00	Therapists (line 5 times column 2, line 11)		11,232 36.00
37.00	Assistants (line 6 times column 3, line 11)		24,705 37.00
38.00	Subtotal (sum of lines 36 and 37)		35,937 38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		6,749 39.00

<b>Optional Travel Allowance and Optional Travel Expense</b>			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0 40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0 41.00
42.00	Subtotal (sum of lines 40 and 41)		0 42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0 43.00
<b>Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.</b>			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0 44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0 45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet A-8-3 Par Date/Time Prepared: 5/4/2012 10:09 am
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		Physical Therapy				Cost	
						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists 1.00	Assistants 2.00	Aides 3.00	Trainees 4.00	Total 5.00	

**PART V - OVERTIME COMPUTATION**

47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00

**CALCULATION OF LIMIT**

50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00

**DETERMINATION OF OVERTIME ALLOWANCE**

52.00	Adjusted hourly salary equivalency amount (see instructions)	72.00	54.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

1.00

**Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT**

57.00	Salary equivalency amount (from line 23)		438,822				57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		0				58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0				59.00
60.00	Overtime allowance (from column 5, line 56)		0				60.00
61.00	Equipment cost (see instructions)		0				61.00
62.00	Supplies (see instructions)		6,449				62.00
63.00	Total allowance (sum of lines 57-62)		445,271				63.00
64.00	Total cost of outside supplier services (from your records)		69,661				64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0				65.00

**LINE 33 CALCULATION**

100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		12,888				100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		1,969				100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		14,857				100.02

**LINE 34 CALCULATION**

101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		1,969				101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		21,870				101.01
101.02	Line 34 = sum of lines 27 and 31		23,839				101.02

**LINE 35 CALCULATION**

102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		21,870				102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0				102.01
102.02	Line 35 = sum of lines 31 and 32		21,870				102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet A-8-3 Par
			Date/Time Prepared: 5/4/2012 10:09 am
		Occupational Therapy	Cost

			1.00	
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**PART I - GENERAL INFORMATION**

1.00	Total number of weeks worked (excluding aides) (see instructions)			52	1.00
2.00	Line 1 multiplied by 15 hours per week			780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)			254	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)			0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)			364	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)			78	6.00
7.00	Standard travel expense rate			5.50	7.00
8.00	Optional travel expense rate per mile			0.00	8.00

	Supervisors	Therapists	Assistants	Aides	Trainees		
	1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	1,486.00	949.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	68.25	51.19	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.13	34.13	25.60			11.00
12.00	Number of travel hours (provider site)	0	18	11			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	3,121	1,090			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

						1.00
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**Part II - SALARY EQUIVALENCY COMPUTATION**

14.00	Supervisors (column 1, line 9 times column 1, line 10)			0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)			101,420	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)			48,579	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)			149,999	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)			0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)			0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)			149,999	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.					
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)			0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)			0	22.00
23.00	Total salary equivalency (see instructions)			149,999	23.00

**PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE**

**Standard Travel Allowance**

24.00	Therapists (line 3 times column 2, line 11)			8,669	24.00
25.00	Assistants (line 4 times column 3, line 11)			0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)			8,669	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)			1,397	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)			10,066	28.00

**Optional Travel Allowance and Optional Travel Expense**

29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)			1,229	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)			563	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)			1,792	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)			0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)			0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)			0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)			0	35.00

**Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE**

**Standard Travel Expense**

36.00	Therapists (line 5 times column 2, line 11)			12,423	36.00
37.00	Assistants (line 6 times column 3, line 11)			1,997	37.00
38.00	Subtotal (sum of lines 36 and 37)			14,420	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)			2,431	39.00

**Optional Travel Allowance and Optional Travel Expense**

40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)			0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)			0	41.00
42.00	Subtotal (sum of lines 40 and 41)			0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)			0	43.00

**Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.**

44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)			0	44.00
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet A-8-3 Par Date/Time Prepared: 5/4/2012 10:09 am
		Occupational Therapy	Cost

45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					1.00	0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						0	46.00
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		

**PART V - OVERTIME COMPUTATION**

47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00

**CALCULATION OF LIMIT**

50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00

**DETERMINATION OF OVERTIME ALLOWANCE**

52.00	Adjusted hourly salary equivalency amount (see instructions)	68.25	51.19	0.00	0.00	0.00	52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0	54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0	55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

1.00

**Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT**

57.00	Salary equivalency amount (from line 23)	149,999	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	651	61.00
62.00	Supplies (see instructions)	1,365	62.00
63.00	Total allowance (sum of lines 57-62)	152,015	63.00
64.00	Total cost of outside supplier services (from your records)	25,124	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00

**LINE 33 CALCULATION**

100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	8,669	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,397	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	10,066	100.02

**LINE 34 CALCULATION**

101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,397	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	1,792	101.01
101.02	Line 34 = sum of lines 27 and 31	3,189	101.02

**LINE 35 CALCULATION**

102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	1,792	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	1,792	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet A-8-3 Par Date/Time Prepared: 5/4/2012 10:09 am
		Speech Pathology	Cost

			1.00
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**PART I - GENERAL INFORMATION**

1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		247	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		28	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.50	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

	Supervisors 1.00	Therapists 2.00	Assistants 3.00	Aides 4.00	Trainees 5.00	
9.00	0.00	2,271.00	0.00	0.00	0.00	9.00
10.00	0.00	59.22	49.20	0.00	0.00	10.00
11.00	29.61	29.61	24.60			11.00
12.00	0	10	0			12.00
12.01	0	0	0			12.01
13.00	0	238	0			13.00
13.01	0	0	0			13.01

					1.00
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**Part II - SALARY EQUIVALENCY COMPUTATION**

14.00	Supervisors (column 1, line 9 times column 1, line 10)		0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		134,489	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)		0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		134,489	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)		0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		134,489	20.00
21.00	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23. Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		0	22.00
23.00	Total salary equivalency (see instructions)		134,489	23.00

**PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE**

**Standard Travel Allowance**

24.00	Therapists (line 3 times column 2, line 11)		7,314	24.00
25.00	Assistants (line 4 times column 3, line 11)		0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		7,314	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		1,359	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		8,673	28.00

**Optional Travel Allowance and Optional Travel Expense**

29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		592	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		592	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0	35.00

**Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE**

**Standard Travel Expense**

36.00	Therapists (line 5 times column 2, line 11)		829	36.00
37.00	Assistants (line 6 times column 3, line 11)		0	37.00
38.00	Subtotal (sum of lines 36 and 37)		829	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		154	39.00

**Optional Travel Allowance and Optional Travel Expense**

40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0	41.00
42.00	Subtotal (sum of lines 40 and 41)		0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0	43.00

**Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.**

44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet A-8-3 Par Date/Time Prepared: 5/4/2012 10:09 am
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	Speech Pathology	Cost	
		1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0	46.00
	Therapists	Assistants	Aides
	1.00	2.00	3.00
	Trainees	Total	
	4.00	5.00	

**PART V - OVERTIME COMPUTATION**

47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00

**CALCULATION OF LIMIT**

50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00

**DETERMINATION OF OVERTIME ALLOWANCE**

52.00	Adjusted hourly salary equivalency amount (see instructions)	59.22	49.20	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

1.00

**PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT**

57.00	Salary equivalency amount (from line 23)	134,489	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	828	62.00
63.00	Total allowance (sum of lines 57-62)	135,317	63.00
64.00	Total cost of outside supplier services (from your records)	1,680	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00

**LINE 33 CALCULATION**

100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	7,314	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,359	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	8,673	100.02

**LINE 34 CALCULATION**

101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,359	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	592	101.01
101.02	Line 34 = sum of lines 27 and 31	1,951	101.02

**LINE 35 CALCULATION**

102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	592	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	592	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151322

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		1.00	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 NEW CAP REL COSTS-BLDG & FIXT	1,398,108	1,398,108				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	128,457		128,457			2.00
4.00 EMPLOYEE BENEFITS	135,511	13,747	1,263	150,521		4.00
5.00 ADMINISTRATIVE & GENERAL	4,346,619	167,179	15,360	22,711	4,551,869	5.00
7.00 OPERATION OF PLANT	1,428,725	143,962	13,227	3,688	1,589,602	7.00
8.00 LAUNDRY & LINEN SERVICE	95,360	19,496	1,791	11	116,658	8.00
9.00 HOUSEKEEPING	471,400	7,222	664	2,806	482,092	9.00
10.00 DIETARY	466,990	93,155	8,559	2,383	571,087	10.00
11.00 CAFETERIA	80,289	0	0	895	81,184	11.00
13.00 NURSING ADMINISTRATION	971,016	12,670	1,164	7,295	992,145	13.00
16.00 MEDICAL RECORDS & LIBRARY	518,648	27,652	2,541	2,271	551,112	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	2,198,080	273,449	25,124	20,480	2,517,133	30.00
31.00 INTENSIVE CARE UNIT	359,068	28,444	2,613	3,860	393,985	31.00
43.00 NURSERY	38,287	5,115	470	498	44,370	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	686,000	88,879	8,166	6,593	789,638	50.00
52.00 DELIVERY ROOM & LABOR ROOM	62,119	10,263	943	807	74,132	52.00
54.00 RADIOLOGY-DIAGNOSTIC	1,925,052	84,255	7,741	10,851	2,027,899	54.00
60.00 LABORATORY	1,507,546	16,772	1,541	7,799	1,533,658	60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	153,479	0	0	149	153,628	62.00
65.00 RESPIRATORY THERAPY	761,173	35,935	3,302	5,861	806,271	65.00
66.00 PHYSICAL THERAPY	356,247	64,395	5,917	285	426,844	66.00
67.00 OCCUPATIONAL THERAPY	75,572	2,597	239	0	78,408	67.00
68.00 SPEECH PATHOLOGY	135,760	2,597	239	0	138,596	68.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	508,572	3,484	320	663	513,039	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	23,186	0	0	0	23,186	72.00
73.00 DRUGS CHARGED TO PATIENTS	2,894,870	17,342	1,593	957	2,914,762	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 CLINIC	382,848	52,438	4,818	2,627	442,731	90.00
91.00 EMERGENCY	1,282,726	53,008	4,870	10,486	1,351,090	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 AMBULANCE SERVICES	1,063,310	90,653	8,329	6,699	1,168,991	95.00
101.00 HOME HEALTH AGENCY	591,162	9,312	856	3,567	604,897	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	25,046,180	1,324,021	121,650	124,242	24,939,007	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,783	1,083	0	12,866	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	3,684,446	62,304	5,724	25,846	3,778,320	192.00
192.01 MARKETING	237,126	0	0	433	237,559	192.01
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	28,967,752	1,398,108	128,457	150,521	28,967,752	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151322

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description		ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	4,551,869					5.00
7.00	OPERATION OF PLANT	296,351	1,885,953				7.00
8.00	LAUNDRY & LINEN SERVICE	21,749	34,260	172,667			8.00
9.00	HOUSEKEEPING	89,877	12,691	11,458	596,118		9.00
10.00	DIETARY	106,468	163,701	0	53,064	894,320	10.00
11.00	CAFETERIA	15,135	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	184,967	22,265	0	7,217	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	102,744	48,593	0	15,751	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	469,272	480,525	77,958	155,763	867,525	30.00
31.00	INTENSIVE CARE UNIT	73,451	49,984	5,015	16,202	26,795	31.00
43.00	NURSERY	8,272	8,989	0	2,914	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	147,213	156,186	8,446	50,628	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	13,821	18,034	0	5,846	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	378,063	148,060	15,371	47,994	0	54.00
60.00	LABORATORY	285,921	29,473	621	9,554	0	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	28,641	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	150,314	63,148	3,819	20,470	0	65.00
66.00	PHYSICAL THERAPY	79,577	113,160	3,866	36,681	0	66.00
67.00	OCCUPATIONAL THERAPY	14,618	4,564	0	1,480	0	67.00
68.00	SPEECH PATHOLOGY	25,839	4,564	0	1,480	0	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	95,646	6,123	0	1,985	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	4,323	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	543,402	30,475	0	9,878	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	82,539	92,148	1,848	29,870	0	90.00
91.00	EMERGENCY	251,885	93,150	43,830	30,195	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	AMBULANCE SERVICES	217,936	159,303	435	51,639	0	95.00
101.00	HOME HEALTH AGENCY	112,772	16,365	0	5,305	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,800,796	1,755,761	172,667	553,916	894,320	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,399	20,706	0	6,712	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	704,386	109,486	0	35,490	0	192.00
192.01	MARKETING	44,288	0	0	0	0	192.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	4,551,869	1,885,953	172,667	596,118	894,320	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151322

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	11.00	13.00	16.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA	96,319					11.00
13.00 NURSING ADMINISTRATION	6,364	1,212,958				13.00
16.00 MEDICAL RECORDS & LIBRARY	3,735	0	721,935			16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	28,648	649,324	195,988	5,442,136	0	30.00
31.00 INTENSIVE CARE UNIT	4,059	92,005	0	661,496	0	31.00
43.00 NURSERY	542	12,290	0	77,377	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	4,345	98,491	0	1,254,947	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	904	20,483	0	133,220	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	11,741	0	148,853	2,777,981	0	54.00
60.00 LABORATORY	10,656	0	146,372	2,016,255	0	60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	181	0	0	182,450	0	62.00
65.00 RESPIRATORY THERAPY	6,830	0	19,847	1,070,699	0	65.00
66.00 PHYSICAL THERAPY	768	0	22,328	683,224	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	99,070	0	67.00
68.00 SPEECH PATHOLOGY	0	0	19,847	190,326	0	68.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	730	0	0	617,523	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	27,509	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	1,800	0	0	3,500,317	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 CLINIC	3,547	80,397	19,847	752,927	0	90.00
91.00 EMERGENCY	11,469	259,968	141,410	2,182,997	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 AMBULANCE SERVICES	0	0	7,443	1,605,747	0	95.00
101.00 HOME HEALTH AGENCY	0	0	0	739,339	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	96,319	1,212,958	721,935	24,015,540	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	42,683	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	4,627,682	0	192.00
192.01 MARKETING	0	0	0	281,847	0	192.01
200.00 Cross Foot Adjustments				0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	96,319	1,212,958	721,935	28,967,752	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151322

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	EMPLOYEE BENEFITS		4.00
5.00	ADMINISTRATIVE & GENERAL		5.00
7.00	OPERATION OF PLANT		7.00
8.00	LAUNDRY & LINEN SERVICE		8.00
9.00	HOUSEKEEPING		9.00
10.00	DIETARY		10.00
11.00	CAFETERIA		11.00
13.00	NURSING ADMINISTRATION		13.00
16.00	MEDICAL RECORDS & LIBRARY		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	ADULTS & PEDIATRICS	5,442,136	30.00
31.00	INTENSIVE CARE UNIT	661,496	31.00
43.00	NURSERY	77,377	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	OPERATING ROOM	1,254,947	50.00
52.00	DELIVERY ROOM & LABOR ROOM	133,220	52.00
54.00	RADIOLOGY-DIAGNOSTIC	2,777,981	54.00
60.00	LABORATORY	2,016,255	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	182,450	62.00
65.00	RESPIRATORY THERAPY	1,070,699	65.00
66.00	PHYSICAL THERAPY	683,224	66.00
67.00	OCCUPATIONAL THERAPY	99,070	67.00
68.00	SPEECH PATHOLOGY	190,326	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	617,523	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	27,509	72.00
73.00	DRUGS CHARGED TO PATIENTS	3,500,317	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	CLINIC	752,927	90.00
91.00	EMERGENCY	2,182,997	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
95.00	AMBULANCE SERVICES	1,605,747	95.00
101.00	HOME HEALTH AGENCY	739,339	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	24,015,540	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	42,683	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	4,627,682	192.00
192.01	MARKETING	281,847	192.01
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	28,967,752	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151322

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	2A	4.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	0	13,747	1,263	15,010	15,010 4.00
5.00	ADMINISTRATIVE & GENERAL	0	167,179	15,360	182,539	2,265 5.00
7.00	OPERATION OF PLANT	0	143,962	13,227	157,189	368 7.00
8.00	LAUNDRY & LINEN SERVICE	0	19,496	1,791	21,287	1 8.00
9.00	HOUSEKEEPING	0	7,222	664	7,886	280 9.00
10.00	DIETARY	0	93,155	8,559	101,714	238 10.00
11.00	CAFETERIA	0	0	0	0	89 11.00
13.00	NURSING ADMINISTRATION	0	12,670	1,164	13,834	728 13.00
16.00	MEDICAL RECORDS & LIBRARY	0	27,652	2,541	30,193	227 16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS	0	273,449	25,124	298,573	2,043 30.00
31.00	INTENSIVE CARE UNIT	0	28,444	2,613	31,057	385 31.00
43.00	NURSERY	0	5,115	470	5,585	50 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	0	88,879	8,166	97,045	658 50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	10,263	943	11,206	81 52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	84,255	7,741	91,996	1,082 54.00
60.00	LABORATORY	0	16,772	1,541	18,313	778 60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	15 62.00
65.00	RESPIRATORY THERAPY	0	35,935	3,302	39,237	585 65.00
66.00	PHYSICAL THERAPY	0	64,395	5,917	70,312	28 66.00
67.00	OCCUPATIONAL THERAPY	0	2,597	239	2,836	0 67.00
68.00	SPEECH PATHOLOGY	0	2,597	239	2,836	0 68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,484	320	3,804	66 71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00	DRUGS CHARGED TO PATIENTS	0	17,342	1,593	18,935	95 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	CLINIC	0	52,438	4,818	57,256	262 90.00
91.00	EMERGENCY	0	53,008	4,870	57,878	1,046 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	AMBULANCE SERVICES	0	90,653	8,329	98,982	668 95.00
101.00	HOME HEALTH AGENCY	0	9,312	856	10,168	356 101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,324,021	121,650	1,445,671	12,394 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,783	1,083	12,866	0 190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	62,304	5,724	68,028	2,573 192.00
192.01	MARKETING	0	0	0	0	43 192.01
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	1,398,108	128,457	1,526,565	15,010 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151322

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description		ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	184,804					5.00
7.00	OPERATION OF PLANT	12,032	169,589				7.00
8.00	LAUNDRY & LINEN SERVICE	883	3,081	25,252			8.00
9.00	HOUSEKEEPING	3,649	1,141	1,676	14,632		9.00
10.00	DIETARY	4,323	14,720	0	1,302	122,297	10.00
11.00	CAFETERIA	614	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	7,510	2,002	0	177	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	4,171	4,370	0	387	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	19,052	43,210	11,401	3,826	118,633	30.00
31.00	INTENSIVE CARE UNIT	2,982	4,495	733	398	3,664	31.00
43.00	NURSERY	336	808	0	72	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	5,977	14,045	1,235	1,243	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	561	1,622	0	143	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	15,349	13,314	2,248	1,178	0	54.00
60.00	LABORATORY	11,608	2,650	91	234	0	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,163	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	6,103	5,678	559	502	0	65.00
66.00	PHYSICAL THERAPY	3,231	10,176	565	900	0	66.00
67.00	OCCUPATIONAL THERAPY	593	410	0	36	0	67.00
68.00	SPEECH PATHOLOGY	1,049	410	0	36	0	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,883	551	0	49	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	175	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	22,062	2,740	0	242	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	3,351	8,286	270	733	0	90.00
91.00	EMERGENCY	10,226	8,376	6,410	741	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	AMBULANCE SERVICES	8,848	14,325	64	1,267	0	95.00
101.00	HOME HEALTH AGENCY	4,578	1,472	0	130	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	154,309	157,882	25,252	13,596	122,297	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	97	1,862	0	165	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	28,600	9,845	0	871	0	192.00
192.01	MARKETING	1,798	0	0	0	0	192.01
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)	184,804	169,589	25,252	14,632	122,297	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151322

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	11.00	13.00	16.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA	703					11.00
13.00 NURSING ADMINISTRATION	46	24,297				13.00
16.00 MEDICAL RECORDS & LIBRARY	27	0	39,375			16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	208	13,008	10,690	520,644	0	30.00
31.00 INTENSIVE CARE UNIT	30	1,843	0	45,587	0	31.00
43.00 NURSERY	4	246	0	7,101	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	32	1,973	0	122,208	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	7	410	0	14,030	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	86	0	8,119	133,372	0	54.00
60.00 LABORATORY	78	0	7,983	41,735	0	60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	1	0	0	1,179	0	62.00
65.00 RESPIRATORY THERAPY	50	0	1,082	53,796	0	65.00
66.00 PHYSICAL THERAPY	6	0	1,218	86,436	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	3,875	0	67.00
68.00 SPEECH PATHOLOGY	0	0	1,082	5,413	0	68.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	5	0	0	8,358	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	175	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	13	0	0	44,087	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 CLINIC	26	1,610	1,082	72,876	0	90.00
91.00 EMERGENCY	84	5,207	7,713	97,681	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 AMBULANCE SERVICES	0	0	406	124,560	0	95.00
101.00 HOME HEALTH AGENCY	0	0	0	16,704	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	703	24,297	39,375	1,399,817	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	14,990	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	109,917	0	192.00
192.01 MARKETING	0	0	0	1,841	0	192.01
200.00 Cross Foot Adjustments				0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	703	24,297	39,375	1,526,565	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151322

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

Worksheet 8  
Part II  
Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	EMPLOYEE BENEFITS		4.00
5.00	ADMINISTRATIVE & GENERAL		5.00
7.00	OPERATION OF PLANT		7.00
8.00	LAUNDRY & LINEN SERVICE		8.00
9.00	HOUSEKEEPING		9.00
10.00	DIETARY		10.00
11.00	CAFETERIA		11.00
13.00	NURSING ADMINISTRATION		13.00
16.00	MEDICAL RECORDS & LIBRARY		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	ADULTS & PEDIATRICS	520,644	30.00
31.00	INTENSIVE CARE UNIT	45,587	31.00
43.00	NURSERY	7,101	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	OPERATING ROOM	122,208	50.00
52.00	DELIVERY ROOM & LABOR ROOM	14,030	52.00
54.00	RADIOLOGY-DIAGNOSTIC	133,372	54.00
60.00	LABORATORY	41,735	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,179	62.00
65.00	RESPIRATORY THERAPY	53,796	65.00
66.00	PHYSICAL THERAPY	86,436	66.00
67.00	OCCUPATIONAL THERAPY	3,875	67.00
68.00	SPEECH PATHOLOGY	5,413	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,358	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	175	72.00
73.00	DRUGS CHARGED TO PATIENTS	44,087	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	CLINIC	72,876	90.00
91.00	EMERGENCY	97,681	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
95.00	AMBULANCE SERVICES	124,560	95.00
101.00	HOME HEALTH AGENCY	16,704	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,399,817	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,990	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	109,917	192.00
192.01	MARKETING	1,841	192.01
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	1,526,565	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151322

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

Worksheet 8-1

Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00	4.00	5A	5.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 NEW CAP REL COSTS-BLDG & FIXT	88,279					1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		88,279				2.00
4.00 EMPLOYEE BENEFITS	868	868	11,539,875			4.00
5.00 ADMINISTRATIVE & GENERAL	10,556	10,556	1,741,145	-4,551,869	24,415,883	5.00
7.00 OPERATION OF PLANT	9,090	9,090	282,714	0	1,589,602	7.00
8.00 LAUNDRY & LINEN SERVICE	1,231	1,231	872	0	116,658	8.00
9.00 HOUSEKEEPING	456	456	215,155	0	482,092	9.00
10.00 DIETARY	5,882	5,882	182,705	0	571,087	10.00
11.00 CAFETERIA	0	0	68,592	0	81,184	11.00
13.00 NURSING ADMINISTRATION	800	800	559,285	0	992,145	13.00
16.00 MEDICAL RECORDS & LIBRARY	1,746	1,746	174,141	0	551,112	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	17,266	17,266	1,570,049	0	2,517,133	30.00
31.00 INTENSIVE CARE UNIT	1,796	1,796	295,955	0	393,985	31.00
43.00 NURSERY	323	323	38,195	0	44,370	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	5,612	5,612	505,467	0	789,638	50.00
52.00 DELIVERY ROOM & LABOR ROOM	648	648	61,894	0	74,132	52.00
54.00 RADIOLOGY-DIAGNOSTIC	5,320	5,320	831,869	0	2,027,899	54.00
60.00 LABORATORY	1,059	1,059	597,877	0	1,533,658	60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	11,398	0	153,628	62.00
65.00 RESPIRATORY THERAPY	2,269	2,269	449,349	0	806,271	65.00
66.00 PHYSICAL THERAPY	4,066	4,066	21,842	0	426,844	66.00
67.00 OCCUPATIONAL THERAPY	164	164	0	0	78,408	67.00
68.00 SPEECH PATHOLOGY	164	164	0	0	138,596	68.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	220	220	50,851	0	513,039	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	23,186	72.00
73.00 DRUGS CHARGED TO PATIENTS	1,095	1,095	73,368	0	2,914,762	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 CLINIC	3,311	3,311	201,358	0	442,731	90.00
91.00 EMERGENCY	3,347	3,347	803,916	0	1,351,090	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 AMBULANCE SERVICES	5,724	5,724	513,544	0	1,168,991	95.00
101.00 HOME HEALTH AGENCY	588	588	273,432	0	604,897	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	83,601	83,601	9,524,973	-4,551,869	20,387,138	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	744	744	0	0	12,866	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	3,934	3,934	1,981,695	0	3,778,320	192.00
192.01 MARKETING	0	0	33,207	0	237,559	192.01
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)	1,398,108	128,457	150,521		4,551,869	202.00
203.00 Unit cost multiplier (wkst. B, Part I)	15.837379	1.455125	0.013044		0.186431	203.00
204.00 Cost to be allocated (per wkst. B, Part II)			15,010		184,804	204.00
205.00 Unit cost multiplier (wkst. B, Part II)			0.001301		0.007569	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151322

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

Worksheet B-1

Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT	67,765					7.00
8.00	LAUNDRY & LINEN SERVICE	1,231	11,121				8.00
9.00	HOUSEKEEPING	456	738	66,078			9.00
10.00	DIETARY	5,882	0	5,882	29,572		10.00
11.00	CAFETERIA	0	0	0	0	12,790	11.00
13.00	NURSING ADMINISTRATION	800	0	800	0	845	13.00
16.00	MEDICAL RECORDS & LIBRARY	1,746	0	1,746	0	496	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	17,266	5,021	17,266	28,686	3,804	30.00
31.00	INTENSIVE CARE UNIT	1,796	323	1,796	886	539	31.00
43.00	NURSERY	323	0	323	0	72	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	5,612	544	5,612	0	577	50.00
52.00	DELIVERY ROOM & LABOR ROOM	648	0	648	0	120	52.00
54.00	RADIOLOGY-DIAGNOSTIC	5,320	990	5,320	0	1,559	54.00
60.00	LABORATORY	1,059	40	1,059	0	1,415	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	24	62.00
65.00	RESPIRATORY THERAPY	2,269	246	2,269	0	907	65.00
66.00	PHYSICAL THERAPY	4,066	249	4,066	0	102	66.00
67.00	OCCUPATIONAL THERAPY	164	0	164	0	0	67.00
68.00	SPEECH PATHOLOGY	164	0	164	0	0	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	220	0	220	0	97	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,095	0	1,095	0	239	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	3,311	119	3,311	0	471	90.00
91.00	EMERGENCY	3,347	2,823	3,347	0	1,523	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	AMBULANCE SERVICES	5,724	28	5,724	0	0	95.00
101.00	HOME HEALTH AGENCY	588	0	588	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	63,087	11,121	61,400	29,572	12,790	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	744	0	744	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	3,934	0	3,934	0	0	192.00
192.01	MARKETING	0	0	0	0	0	192.01
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)	1,885,953	172,667	596,118	894,320	96,319	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	27.830783	15.526212	9.021429	30.242121	7.530805	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	169,589	25,252	14,632	122,297	703	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2.502605	2.270659	0.221435	4.135567	0.054965	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151322

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

Worksheet B-1

Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description		NURSING ADMINISTRATION  (DIRECT NRSING HRS) 13.00	MEDICAL RECORDS & LIBRARY  (TIME SPENT) 16.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	EMPLOYEE BENEFITS			4.00
5.00	ADMINISTRATIVE & GENERAL			5.00
7.00	OPERATION OF PLANT			7.00
8.00	LAUNDRY & LINEN SERVICE			8.00
9.00	HOUSEKEEPING			9.00
10.00	DIETARY			10.00
11.00	CAFETERIA			11.00
13.00	NURSING ADMINISTRATION	7,106		13.00
16.00	MEDICAL RECORDS & LIBRARY	0	291	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	3,804	79	30.00
31.00	INTENSIVE CARE UNIT	539	0	31.00
43.00	NURSERY	72	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	577	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	120	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	60	54.00
60.00	LABORATORY	0	59	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	RESPIRATORY THERAPY	0	8	65.00
66.00	PHYSICAL THERAPY	0	9	66.00
67.00	OCCUPATIONAL THERAPY	0	0	67.00
68.00	SPEECH PATHOLOGY	0	8	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	CLINIC	471	8	90.00
91.00	EMERGENCY	1,523	57	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	AMBULANCE SERVICES	0	3	95.00
101.00	HOME HEALTH AGENCY	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	INTEREST EXPENSE			113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	7,106	291	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	MARKETING	0	0	192.01
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)	1,212,958	721,935	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	170.694906	2,480.876289	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	24,297	39,375	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	3.419223	135.309278	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151322

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Hospital		Cost
			Total Costs	RCE Disallowance	Total Costs		
							3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	5,442,136		5,442,136	0	0	30.00
31.00	INTENSIVE CARE UNIT	661,496		661,496	0	0	31.00
43.00	NURSERY	77,377		77,377	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	1,254,947		1,254,947	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	133,220		133,220	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	2,777,981		2,777,981	0	0	54.00
60.00	LABORATORY	2,016,255		2,016,255	0	0	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	182,450		182,450	0	0	62.00
65.00	RESPIRATORY THERAPY	1,070,699	0	1,070,699	0	0	65.00
66.00	PHYSICAL THERAPY	683,224	0	683,224	0	0	66.00
67.00	OCCUPATIONAL THERAPY	99,070	0	99,070	0	0	67.00
68.00	SPEECH PATHOLOGY	190,326	0	190,326	0	0	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	617,523		617,523	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	27,509		27,509	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	3,500,317		3,500,317	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	752,927		752,927	0	0	90.00
91.00	EMERGENCY	2,182,997		2,182,997	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	448,403		448,403	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	AMBULANCE SERVICES	1,605,747		1,605,747	0	0	95.00
101.00	HOME HEALTH AGENCY	739,339		739,339	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	24,463,943	0	24,463,943	0	0	200.00
201.00	Less Observation Beds	448,403		448,403			201.00
202.00	Total (see instructions)	24,015,540	0	24,015,540	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151322

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description	Title XVIII			Hospital	Cost	
	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		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS	3,254,620		3,254,620		30.00
31.00	INTENSIVE CARE UNIT	1,106,772		1,106,772		31.00
43.00	NURSERY	102,828		102,828		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	719,340	3,488,425	4,207,765	0.298246	50.00
52.00	DELIVERY ROOM & LABOR ROOM	248,958	117,822	366,780	0.363215	52.00
54.00	RADIOLOGY-DIAGNOSTIC	1,916,927	12,245,341	14,162,268	0.196154	54.00
60.00	LABORATORY	1,840,548	6,084,106	7,924,654	0.254428	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	229,994	145,936	375,930	0.485330	62.00
65.00	RESPIRATORY THERAPY	1,607,873	1,674,436	3,282,309	0.326203	65.00
66.00	PHYSICAL THERAPY	363,203	1,063,985	1,427,188	0.478720	66.00
67.00	OCCUPATIONAL THERAPY	142,245	167,476	309,721	0.319869	67.00
68.00	SPEECH PATHOLOGY	81,968	302,809	384,777	0.494640	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,013,077	2,717,250	4,730,327	0.130546	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	29,682	29,682	0.926791	72.00
73.00	DRUGS CHARGED TO PATIENTS	5,633,953	8,988,991	14,622,944	0.239372	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	CLINIC	1,279	604,688	605,967	1.242521	90.00
91.00	EMERGENCY	217,615	3,876,324	4,093,939	0.533227	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	25,572	257,458	283,030	1.584295	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	AMBULANCE SERVICES	0	2,187,052	2,187,052	0.734206	95.00
101.00	HOME HEALTH AGENCY	0	0	0		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	19,506,772	43,951,781	63,458,553		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	19,506,772	43,951,781	63,458,553		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151322

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS				30.00
31.00	INTENSIVE CARE UNIT				31.00
43.00	NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
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
60.00	LABORATORY	0.000000			60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
65.00	RESPIRATORY THERAPY	0.000000			65.00
66.00	PHYSICAL THERAPY	0.000000			66.00
67.00	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	SPEECH PATHOLOGY	0.000000			68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000			73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	CLINIC	0.000000			90.00
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	AMBULANCE SERVICES	0.000000			95.00
101.00	HOME HEALTH AGENCY				101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151322

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description	Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		PPS
			Total Costs	RCE Disallowance	Total Costs		
							Costs
	1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS		5,442,136			5,442,136	30.00
31.00	INTENSIVE CARE UNIT		661,496			661,496	31.00
43.00	NURSERY		77,377			77,377	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM		1,254,947			1,254,947	50.00
52.00	DELIVERY ROOM & LABOR ROOM		133,220			133,220	52.00
54.00	RADIOLOGY-DIAGNOSTIC		2,777,981			2,777,981	54.00
60.00	LABORATORY		2,016,255			2,016,255	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS		182,450			182,450	62.00
65.00	RESPIRATORY THERAPY	0	1,070,699			1,070,699	65.00
66.00	PHYSICAL THERAPY	0	683,224			683,224	66.00
67.00	OCCUPATIONAL THERAPY	0	99,070			99,070	67.00
68.00	SPEECH PATHOLOGY	0	190,326			190,326	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		617,523			617,523	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT		27,509			27,509	72.00
73.00	DRUGS CHARGED TO PATIENTS		3,500,317			3,500,317	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC		752,927			752,927	90.00
91.00	EMERGENCY		2,182,997			2,182,997	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		448,403			448,403	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	AMBULANCE SERVICES		1,605,747			1,605,747	95.00
101.00	HOME HEALTH AGENCY		739,339			739,339	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	0	24,463,943			24,463,943	200.00
201.00	Less Observation Beds		448,403			448,403	201.00
202.00	Total (see instructions)	0	24,015,540			24,015,540	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151322

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description	Charges			Hospital Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	3,254,620		3,254,620			30.00
31.00 INTENSIVE CARE UNIT	1,106,772		1,106,772			31.00
43.00 NURSERY	102,828		102,828			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	719,340	3,488,425	4,207,765	0.298246	0.000000	50.00
52.00 DELIVERY ROOM & LABOR ROOM	248,958	117,822	366,780	0.363215	0.000000	52.00
54.00 RADIOLOGY-DIAGNOSTIC	1,916,927	12,245,341	14,162,268	0.196154	0.000000	54.00
60.00 LABORATORY	1,840,548	6,084,106	7,924,654	0.254428	0.000000	60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	229,994	145,936	375,930	0.485330	0.000000	62.00
65.00 RESPIRATORY THERAPY	1,607,873	1,674,436	3,282,309	0.326203	0.000000	65.00
66.00 PHYSICAL THERAPY	363,203	1,063,985	1,427,188	0.478720	0.000000	66.00
67.00 OCCUPATIONAL THERAPY	142,245	167,476	309,721	0.319869	0.000000	67.00
68.00 SPEECH PATHOLOGY	81,968	302,809	384,777	0.494640	0.000000	68.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,013,077	2,717,250	4,730,327	0.130546	0.000000	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	29,682	29,682	0.926791	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	5,633,953	8,988,991	14,622,944	0.239372	0.000000	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 CLINIC	1,279	604,688	605,967	1.242521	0.000000	90.00
91.00 EMERGENCY	217,615	3,876,324	4,093,939	0.533227	0.000000	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	25,572	257,458	283,030	1.584295	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 AMBULANCE SERVICES	0	2,187,052	2,187,052	0.734206	0.000000	95.00
101.00 HOME HEALTH AGENCY	0	0	0			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	19,506,772	43,951,781	63,458,553			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	19,506,772	43,951,781	63,458,553			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151322

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	PPS
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS				30.00
31.00	INTENSIVE CARE UNIT				31.00
43.00	NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.298246			50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.363215			52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.196154			54.00
60.00	LABORATORY	0.254428			60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.485330			62.00
65.00	RESPIRATORY THERAPY	0.326203			65.00
66.00	PHYSICAL THERAPY	0.478720			66.00
67.00	OCCUPATIONAL THERAPY	0.319869			67.00
68.00	SPEECH PATHOLOGY	0.494640			68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.130546			71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.926791			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.239372			73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	CLINIC	1.242521			90.00
91.00	EMERGENCY	0.533227			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.584295			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	AMBULANCE SERVICES	0.734206			95.00
101.00	HOME HEALTH AGENCY				101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

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

Provider CCN: 151322

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

Worksheet C  
Part II  
Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description	Title XIX			Hospital	PPS	
	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	1,254,947	122,208	1,132,739	0	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	133,220	14,030	119,190	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	2,777,981	133,372	2,644,609	0	0	54.00
60.00 LABORATORY	2,016,255	41,735	1,974,520	0	0	60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	182,450	1,179	181,271	0	0	62.00
65.00 RESPIRATORY THERAPY	1,070,699	53,796	1,016,903	0	0	65.00
66.00 PHYSICAL THERAPY	683,224	86,436	596,788	0	0	66.00
67.00 OCCUPATIONAL THERAPY	99,070	3,875	95,195	0	0	67.00
68.00 SPEECH PATHOLOGY	190,326	5,413	184,913	0	0	68.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	617,523	8,358	609,165	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	27,509	175	27,334	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	3,500,317	44,087	3,456,230	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 CLINIC	752,927	72,876	680,051	0	0	90.00
91.00 EMERGENCY	2,182,997	97,681	2,085,316	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	448,403	0	448,403	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 AMBULANCE SERVICES	1,605,747	124,560	1,481,187	0	0	95.00
101.00 HOME HEALTH AGENCY	739,339	16,704	722,635	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 INTEREST EXPENSE						113.00
200.00 Subtotal (sum of lines 50 thru 199)	18,282,934	826,485	17,456,449	0	0	200.00
201.00 Less Observation Beds	448,403	0	448,403	0	0	201.00
202.00 Total (line 200 minus line 201)	17,834,531	826,485	17,008,046	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part II Date/Time Prepared: 5/4/2012 10:09 am
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Cost Center Description	Cost Net of Capital and Operating Cost Reduction 6.00	Total Charges (Worksheet C, Part I, column 8) 7.00	Outpatient Cost to Charge Ratio (col. 6 / col. 7) 8.00	Title XIX Hospital PPS	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 OPERATING ROOM	1,254,947	4,207,765	0.298246		50.00
52.00 DELIVERY ROOM & LABOR ROOM	133,220	366,780	0.363215		52.00
54.00 RADIOLOGY-DIAGNOSTIC	2,777,981	14,162,268	0.196154		54.00
60.00 LABORATORY	2,016,255	7,924,654	0.254428		60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	182,450	375,930	0.485330		62.00
65.00 RESPIRATORY THERAPY	1,070,699	3,282,309	0.326203		65.00
66.00 PHYSICAL THERAPY	683,224	1,427,188	0.478720		66.00
67.00 OCCUPATIONAL THERAPY	99,070	309,721	0.319869		67.00
68.00 SPEECH PATHOLOGY	190,326	384,777	0.494640		68.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	617,523	4,730,327	0.130546		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	27,509	29,682	0.926791		72.00
73.00 DRUGS CHARGED TO PATIENTS	3,500,317	14,622,944	0.239372		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 CLINIC	752,927	605,967	1.242521		90.00
91.00 EMERGENCY	2,182,997	4,093,939	0.533227		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	448,403	283,030	1.584295		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00 AMBULANCE SERVICES	1,605,747	2,187,052	0.734206		95.00
101.00 HOME HEALTH AGENCY	739,339	0	0.000000		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00 INTEREST EXPENSE					113.00
200.00 Subtotal (sum of lines 50 thru 199)	18,282,934	0			200.00
201.00 Less Observation Beds	448,403	0			201.00
202.00 Total (line 200 minus line 201)	17,834,531	58,994,333			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151322

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

Worksheet D  
Part II  
Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description	Title XVIII			Hospital	Cost	
	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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	122,208	4,207,765	0.029043	190,687	5,538 50.00
52.00	DELIVERY ROOM & LABOR ROOM	14,030	366,780	0.038252	0	0 52.00
54.00	RADIOLOGY-DIAGNOSTIC	133,372	14,162,268	0.009417	866,084	8,156 54.00
60.00	LABORATORY	41,735	7,924,654	0.005266	1,273,345	6,705 60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,179	375,930	0.003136	142,324	446 62.00
65.00	RESPIRATORY THERAPY	53,796	3,282,309	0.016390	1,308,589	21,448 65.00
66.00	PHYSICAL THERAPY	86,436	1,427,188	0.060564	183,492	11,113 66.00
67.00	OCCUPATIONAL THERAPY	3,875	309,721	0.012511	56,152	703 67.00
68.00	SPEECH PATHOLOGY	5,413	384,777	0.014068	61,171	861 68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,358	4,730,327	0.001767	1,201,547	2,123 71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	175	29,682	0.005896	0	0 72.00
73.00	DRUGS CHARGED TO PATIENTS	44,087	14,622,944	0.003015	3,368,918	10,157 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	CLINIC	72,876	605,967	0.120264	0	0 90.00
91.00	EMERGENCY	97,681	4,093,939	0.023860	2,318	55 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	283,030	0.000000	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	685,221	56,807,281		8,654,627	67,305 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151322

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description	Title XVIII				Hospital	Total Cost (sum of col 1 through col. 4) 5.00	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
	1.00	2.00	3.00	4.00			
<b>ANCILLARY SERVICE COST CENTERS</b>							
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
60.00	LABORATORY	0	0	0	0	0	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
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: 151322

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description	Title XVIII			Hospital		
	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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	0	4,207,765	0.000000	0.000000	190,687	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	366,780	0.000000	0.000000	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	14,162,268	0.000000	0.000000	866,084	54.00
60.00 LABORATORY	0	7,924,654	0.000000	0.000000	1,273,345	60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	375,930	0.000000	0.000000	142,324	62.00
65.00 RESPIRATORY THERAPY	0	3,282,309	0.000000	0.000000	1,308,589	65.00
66.00 PHYSICAL THERAPY	0	1,427,188	0.000000	0.000000	183,492	66.00
67.00 OCCUPATIONAL THERAPY	0	309,721	0.000000	0.000000	56,152	67.00
68.00 SPEECH PATHOLOGY	0	384,777	0.000000	0.000000	61,171	68.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,730,327	0.000000	0.000000	1,201,547	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	29,682	0.000000	0.000000	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	14,622,944	0.000000	0.000000	3,368,918	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 CLINIC	0	605,967	0.000000	0.000000	0	90.00
91.00 EMERGENCY	0	4,093,939	0.000000	0.000000	2,318	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	283,030	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	56,807,281			8,654,627	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151322

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description	Title XVIII			Hospital Cost	
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School
	11.00	12.00	13.00	21.00	22.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 OPERATING ROOM	0	0	0	0	0
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
60.00 LABORATORY	0	0	0	0	0
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
65.00 RESPIRATORY THERAPY	0	0	0	0	0
66.00 PHYSICAL THERAPY	0	0	0	0	0
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 SPEECH PATHOLOGY	0	0	0	0	0
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 CLINIC	0	0	0	0	0
91.00 EMERGENCY	0	0	0	0	0
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00 AMBULANCE SERVICES					95.00
200.00 Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/4/2012 10:09 am
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Cost Center Description	Title XVIII		Hospital	Cost
	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
	23.00	24.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 OPERATING ROOM	0	0		50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00 LABORATORY	0	0		60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00 RESPIRATORY THERAPY	0	0		65.00
66.00 PHYSICAL THERAPY	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0		68.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 CLINIC	0	0		90.00
91.00 EMERGENCY	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00 AMBULANCE SERVICES				95.00
200.00 Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151322		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part V Date/Time Prepared: 5/4/2012 10:09 am	
Title XVIII			Hospital		Cost		
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see instructions)	Charges				
			Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)			
	1.00	2.00	3.00	4.00			
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0.298246	0	958,756	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.363215	0	0	0		52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.196154	0	3,910,410	0		54.00
60.00	LABORATORY	0.254428	0	2,316,263	0		60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.485330	0	113,095	0		62.00
65.00	RESPIRATORY THERAPY	0.326203	0	757,099	0		65.00
66.00	PHYSICAL THERAPY	0.478720	0	351,031	0		66.00
67.00	OCCUPATIONAL THERAPY	0.319869	0	37,954	0		67.00
68.00	SPEECH PATHOLOGY	0.494640	0	11,031	0		68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.130546	0	831,859	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.926791	0	28,809	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.239372	0	4,721,622	4,129		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	1.242521	0	40,473	0		90.00
91.00	EMERGENCY	0.533227	0	761,408	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.584295	0	246,360	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	AMBULANCE SERVICES	0.734206	0	0	0		95.00
200.00	Subtotal (see instructions)		0	15,086,170	4,129		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		0	15,086,170	4,129		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/4/2012 10:09 am
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Cost Center Description	Costs			Hospital	Cost
	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		
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 OPERATING ROOM	0	285,945	0		50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	767,043	0		54.00
60.00 LABORATORY	0	589,322	0		60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	54,888	0		62.00
65.00 RESPIRATORY THERAPY	0	246,968	0		65.00
66.00 PHYSICAL THERAPY	0	168,046	0		66.00
67.00 OCCUPATIONAL THERAPY	0	12,140	0		67.00
68.00 SPEECH PATHOLOGY	0	5,456	0		68.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	108,596	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	26,700	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	1,130,224	988		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 CLINIC	0	50,289	0		90.00
91.00 EMERGENCY	0	406,003	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	390,307	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00 AMBULANCE SERVICES		0			95.00
200.00 Subtotal (see instructions)	0	4,241,927	988		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	4,241,927	988		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151322 Component CCN: 15Z322	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/4/2012 10:09 am
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Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Swing Beds - SNF	Cost
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	0.298246	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.363215	0	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.196154	0	0	0	54.00
60.00	LABORATORY	0.254428	0	0	0	60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.485330	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0.326203	0	0	0	65.00
66.00	PHYSICAL THERAPY	0.478720	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0.319869	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0.494640	0	0	0	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.130546	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.926791	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.239372	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	CLINIC	1.242521	0	0	0	90.00
91.00	EMERGENCY	0.533227	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.584295	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	AMBULANCE SERVICES	0.734206		0		95.00
200.00	Subtotal (see instructions)		0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151322 Component CCN: 152322	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/4/2012 10:09 am
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost
	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	
<b>ANCILLARY SERVICE COST CENTERS</b>				
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
60.00 LABORATORY	0	0	0	60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
65.00 RESPIRATORY THERAPY	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	68.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 CLINIC	0	0	0	90.00
91.00 EMERGENCY	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00 AMBULANCE SERVICES		0		95.00
200.00 Subtotal (see instructions)	0	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151322		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part I Date/Time Prepared: 5/4/2012 10:09 am	
Cost Center Description	Title XIX		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		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	520,644	72,153	448,491	4,276	104.89	30.00
31.00	INTENSIVE CARE UNIT	45,587		45,587	363	125.58	31.00
43.00	NURSERY	7,101		7,101	163	43.56	43.00
200.00	Total (lines 30-199)	573,332		501,179	4,802		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part I Date/Time Prepared: 5/4/2012 10:09 am
	Title XIX	Hospital	PPS

Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
	6.00	7.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00 ADULTS & PEDIATRICS	365	38,285	30.00
31.00 INTENSIVE CARE UNIT	16	2,009	31.00
43.00 NURSERY	110	4,792	43.00
200.00 Total (lines 30-199)	491	45,086	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151322

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

Worksheet D  
Part II  
Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description	Title XIX			Hospital	PPS	
	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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	122,208	4,207,765	0.029043	146,813	4,264	50.00
52.00 DELIVERY ROOM & LABOR ROOM	14,030	366,780	0.038252	155,225	5,938	52.00
54.00 RADIOLOGY-DIAGNOSTIC	133,372	14,162,268	0.009417	161,512	1,521	54.00
60.00 LABORATORY	41,735	7,924,654	0.005266	164,815	868	60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	1,179	375,930	0.003136	12,029	38	62.00
65.00 RESPIRATORY THERAPY	53,796	3,282,309	0.016390	152,032	2,492	65.00
66.00 PHYSICAL THERAPY	86,436	1,427,188	0.060564	8,659	524	66.00
67.00 OCCUPATIONAL THERAPY	3,875	309,721	0.012511	1,950	24	67.00
68.00 SPEECH PATHOLOGY	5,413	384,777	0.014068	1,202	17	68.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	8,358	4,730,327	0.001767	137,319	243	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	175	29,682	0.005896	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	44,087	14,622,944	0.003015	426,699	1,286	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 CLINIC	72,876	605,967	0.120264	0	0	90.00
91.00 EMERGENCY	97,681	4,093,939	0.023860	42,899	1,024	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	49,800	283,030	0.175953	22,051	3,880	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	735,021	56,807,281		1,433,205	22,119	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151322		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part III Date/Time Prepared: 5/4/2012 10:09 am	
Cost Center Description	Title XIX			Hospital		PPS	
	Nursing School 1.00	Allied Health Cost 2.00	All Other Medical Education Cost 3.00	Swing-Bed Adjustment Amount (see instructions) 4.00	Total Costs (sum of cols. 1 through 3, minus col. 4) 5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
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: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part III Date/Time Prepared: 5/4/2012 10:09 am
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Cost Center Description	Title XIX		Hospital		PPS	
	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
	6.00	7.00	8.00	9.00	11.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	4,276	0.00	365	0	0	30.00
31.00 INTENSIVE CARE UNIT	363	0.00	16	0	0	31.00
43.00 NURSERY	163	0.00	110	0	0	43.00
200.00 Total (lines 30-199)	4,802		491	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part III Date/Time Prepared: 5/4/2012 10:09 am
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Cost Center Description	Title XIX		Hospital	PPS
	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00 ADULTS & PEDIATRICS	0	0		30.00
31.00 INTENSIVE CARE UNIT	0	0		31.00
43.00 NURSERY	0	0		43.00
200.00 Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151322

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description	Title XIX				Hospital	Total Cost (sum of col 1 through col. 4) 5.00	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All other Medical Education Cost	PPS		
	1.00	2.00	3.00	4.00			
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 OPERATING ROOM	0	0	0	0	0	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00 LABORATORY	0	0	0	0	0	0	60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0	62.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 CLINIC	0	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00 AMBULANCE SERVICES	0	0	0	0	0	0	95.00
200.00 Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151322

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Title XIX		Inpatient Program Charges	
				Hospital	PPS		
	6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 OPERATING ROOM	0	4,207,765	0.000000	0.000000		146,813	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	366,780	0.000000	0.000000		155,225	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	14,162,268	0.000000	0.000000		161,512	54.00
60.00 LABORATORY	0	7,924,654	0.000000	0.000000		164,815	60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	375,930	0.000000	0.000000		12,029	62.00
65.00 RESPIRATORY THERAPY	0	3,282,309	0.000000	0.000000		152,032	65.00
66.00 PHYSICAL THERAPY	0	1,427,188	0.000000	0.000000		8,659	66.00
67.00 OCCUPATIONAL THERAPY	0	309,721	0.000000	0.000000		1,950	67.00
68.00 SPEECH PATHOLOGY	0	384,777	0.000000	0.000000		1,202	68.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,730,327	0.000000	0.000000		137,319	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	29,682	0.000000	0.000000		0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	14,622,944	0.000000	0.000000		426,699	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 CLINIC	0	605,967	0.000000	0.000000		0	90.00
91.00 EMERGENCY	0	4,093,939	0.000000	0.000000		42,899	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	283,030	0.000000	0.000000		22,051	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00 AMBULANCE SERVICES							95.00
200.00 Total (lines 50-199)	0	56,807,281				1,433,205	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151322

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description	Title XIX			Hospital	PPS		
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School		
	11.00	12.00	13.00	21.00	22.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 OPERATING ROOM	0	0	0	0	0	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00 LABORATORY	0	0	0	0	0	0	60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0	62.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 CLINIC	0	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00 AMBULANCE SERVICES							95.00
200.00 Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/4/2012 10:09 am
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Cost Center Description	Title XIX		Hospital	PPS
	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
	23.00	24.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 OPERATING ROOM	0	0		50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00 LABORATORY	0	0		60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00 RESPIRATORY THERAPY	0	0		65.00
66.00 PHYSICAL THERAPY	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0		68.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 CLINIC	0	0		90.00
91.00 EMERGENCY	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00 AMBULANCE SERVICES				95.00
200.00 Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/4/2012 10:09 am
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Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see instructions)	Charges		Hospital	PPS
			Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
			1.00	2.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	0.298246	0	433,943	0		50.00
52.00 DELIVERY ROOM & LABOR ROOM	0.363215	0	73,306	0		52.00
54.00 RADIOLOGY-DIAGNOSTIC	0.196154	0	1,379,480	0		54.00
60.00 LABORATORY	0.254428	0	813,205	0		60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.485330	0	9,056	0		62.00
65.00 RESPIRATORY THERAPY	0.326203	0	163,707	0		65.00
66.00 PHYSICAL THERAPY	0.478720	0	142,487	0		66.00
67.00 OCCUPATIONAL THERAPY	0.319869	0	39,960	0		67.00
68.00 SPEECH PATHOLOGY	0.494640	0	140,464	0		68.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.130546	0	377,396	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.926791	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.239372	0	1,149,487	0		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 CLINIC	1.242521	0	58,330	0		90.00
91.00 EMERGENCY	0.533227	0	774,840	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.584295	0	10,796	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 AMBULANCE SERVICES	0.734206	0	192,358	0		95.00
200.00 Subtotal (see instructions)		0	5,758,815	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00 Net Charges (line 200 +/- line 201)		0	5,758,815	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/4/2012 10:09 am
	Title XIX	Hospital	PPS

Cost Center Description	Costs			Hospital	PPS
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 OPERATING ROOM	0	129,422	0		50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	26,626	0		52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	270,591	0		54.00
60.00 LABORATORY	0	206,902	0		60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	4,395	0		62.00
65.00 RESPIRATORY THERAPY	0	53,402	0		65.00
66.00 PHYSICAL THERAPY	0	68,211	0		66.00
67.00 OCCUPATIONAL THERAPY	0	12,782	0		67.00
68.00 SPEECH PATHOLOGY	0	69,479	0		68.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	49,268	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	275,155	0		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 CLINIC	0	72,476	0		90.00
91.00 EMERGENCY	0	413,166	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	17,104	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00 AMBULANCE SERVICES		141,230			95.00
200.00 Subtotal (see instructions)	0	1,810,209	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	1,810,209	0		202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151322

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

Worksheet D-1

Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description		Title XVIII	Hospital	Cost
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			4,978 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			4,276 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)			4,276 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			686 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			16 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)			2,661 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)			686 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
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		132.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		132.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,442,136	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)		2,112	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)		754,201	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,687,935	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		3,357,448	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		3,357,448	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.396279	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)		785.18	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,687,935	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,096.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,917,361	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)		2,917,361	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151322

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

Worksheet D-1

Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description	Title XVIII				Hospital		Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)			
	1.00	2.00	3.00	4.00	5.00			
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00	
<b>Intensive Care Type Inpatient Hospital Units</b>								
43.00 INTENSIVE CARE UNIT	661,496	363	1,822.30	230	419,129		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)					2,147,251		48.00	
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,483,741		49.00	
<b>PASS THROUGH COST ADJUSTMENTS</b>								
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	
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>								
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	
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>								
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					752,089		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)					752,089		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	
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>								
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	
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>								
87.00 Total observation bed days (see instructions)						409	87.00	
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,096.34	88.00	
89.00 Observation bed cost (line 87 x line 88) (see instructions)						448,403	89.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/4/2012 10:09 am
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Cost Center Description	Title XVIII		Hospital		Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	
	1.00	2.00	3.00	4.00	5.00
<b>COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>					
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: 151322

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

Worksheet D-1

Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description		Title XIX	Hospital	PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			4,978 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			4,276 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)			4,276 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			686 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			16 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)			365 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			16 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)			163 15.00
16.00	Nursery days (title V or XIX only)			110 16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		132.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		132.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,442,136	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)		2,112	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)		754,201	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,687,935	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		3,357,448	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		3,357,448	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.396279	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)		785.18	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,687,935	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,096.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		400,164	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)		400,164	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151322

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

Worksheet D-1

Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description	Title XIX			Hospital	PPS	
	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)	77,377	163	474.71	110	52,218	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>						
43.00 INTENSIVE CARE UNIT	661,496	363	1,822.30	16	29,157	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
<b>Cost Center Description</b>						
					1.00	
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					412,452	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					893,991	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>						
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					45,086	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					22,119	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					67,205	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					826,786	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>						
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>						
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)					2,112	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)					2,112	69.00
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>						
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
87.00 Total observation bed days (see instructions)					409	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,096.34	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					448,403	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/4/2012 10:09 am
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Cost Center Description	Title XIX			Hospital	PPS	
	Cost 1.00	Routine Cost (from line 27) 2.00	column 1 + column 2 3.00	Total Observation Bed Cost (from line 89) 4.00	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) 5.00	
<b>COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
90.00 Capital-related cost	520,644	4,687,935	0.111060	448,403	49,800	90.00
91.00 Nursing School cost	0	4,687,935	0.000000	448,403	0	91.00
92.00 Allied health cost	0	4,687,935	0.000000	448,403	0	92.00
93.00 All other Medical Education	0	4,687,935	0.000000	448,403	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/4/2012 10:09 am
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Cost Center Description	Title XVIII		Hospital	
	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00 ADULTS & PEDIATRICS		2,184,993		30.00
31.00 INTENSIVE CARE UNIT		388,308		31.00
43.00 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 OPERATING ROOM	0.298246	190,687	56,872	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0.363215	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0.196154	866,084	169,886	54.00
60.00 LABORATORY	0.254428	1,273,345	323,975	60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.485330	142,324	69,074	62.00
65.00 RESPIRATORY THERAPY	0.326203	1,308,589	426,866	65.00
66.00 PHYSICAL THERAPY	0.478720	183,492	87,841	66.00
67.00 OCCUPATIONAL THERAPY	0.319869	56,152	17,961	67.00
68.00 SPEECH PATHOLOGY	0.494640	61,171	30,258	68.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.130546	1,201,547	156,857	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.926791	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.239372	3,368,918	806,425	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 CLINIC	1.242521	0	0	90.00
91.00 EMERGENCY	0.533227	2,318	1,236	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.584295	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00 AMBULANCE SERVICES				95.00
200.00 Total (sum of lines 50-94 and 96-98)		8,654,627	2,147,251	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)		8,654,627		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3
		Component CCN: 152322	Date/Time Prepared: 5/4/2012 10:09 am	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS		0	30.00
31.00	INTENSIVE CARE UNIT		0	31.00
43.00	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	0.298246	420	125 50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.363215	0	0 52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.196154	17,029	3,340 54.00
60.00	LABORATORY	0.254428	57,112	14,531 60.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.485330	0	0 62.00
65.00	RESPIRATORY THERAPY	0.326203	84,895	27,693 65.00
66.00	PHYSICAL THERAPY	0.478720	154,956	74,181 66.00
67.00	OCCUPATIONAL THERAPY	0.319869	80,473	25,741 67.00
68.00	SPEECH PATHOLOGY	0.494640	13,035	6,448 68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.130546	146,921	19,180 71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.926791	0	0 72.00
73.00	DRUGS CHARGED TO PATIENTS	0.239372	301,128	72,082 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	CLINIC	1.242521	0	0 90.00
91.00	EMERGENCY	0.533227	0	0 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.584295	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	AMBULANCE SERVICES			95.00
200.00	Total (sum of lines 50-94 and 96-98)		855,969	243,321 200.00
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)		855,969	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/4/2012 10:09 am
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Cost Center Description	Title XIX Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS	
			Inpatient Program Costs (col. 1 x col. 2)	
	1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00 ADULTS & PEDIATRICS		275,160		30.00
31.00 INTENSIVE CARE UNIT		54,046		31.00
43.00 NURSERY		0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 OPERATING ROOM	0.298246	146,813	43,786	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0.363215	155,225	56,380	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0.196154	161,512	31,681	54.00
60.00 LABORATORY	0.254428	164,815	41,934	60.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.485330	12,029	5,838	62.00
65.00 RESPIRATORY THERAPY	0.326203	152,032	49,593	65.00
66.00 PHYSICAL THERAPY	0.478720	8,659	4,145	66.00
67.00 OCCUPATIONAL THERAPY	0.319869	1,950	624	67.00
68.00 SPEECH PATHOLOGY	0.494640	1,202	595	68.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.130546	137,319	17,926	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.926791	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.239372	426,699	102,140	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 CLINIC	1.242521	0	0	90.00
91.00 EMERGENCY	0.533227	42,899	22,875	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.584295	22,051	34,935	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00 AMBULANCE SERVICES				95.00
200.00 Total (sum of lines 50-94 and 96-98)		1,433,205	412,452	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)		1,433,205		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/4/2012 10:09 am
Title XVIII	Hospital	Cost

		1.00	
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**PART B - MEDICAL AND OTHER HEALTH SERVICES**

1.00	Medical and other services (see instructions)	4,242,915	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)	4,242,915	11.00

**COMPUTATION OF LESSER OF COST OR CHARGES**

**Reasonable charges**

12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00

**Customary charges**

15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	4,285,344	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)	46,683	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,532,066	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	1,706,595	27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,706,595	30.00
31.00	Primary payer payments	256	31.00
32.00	Subtotal (line 30 minus line 31)	1,706,339	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)	433,890	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	433,890	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	363,649	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	2,140,229	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	2,140,229	40.00
41.00	Interim payments	1,647,990	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)	492,239	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: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/4/2012 10:09 am
Title XVIII		Hospital	Cost
<b>WORKSHEET OVERRIDE VALUES</b>			Overrides 1.00
112.00 override of Ancillary service charges (line 12)			0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151322

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/4/2012 10:09 am

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,664,556		1,868,002	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
<b>Program to Provider</b>						
3.01	ADJUSTMENTS TO PROVIDER	12/01/2011	550,797		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
<b>Provider to Program</b>						
3.50	ADJUSTMENTS TO PROGRAM	09/26/2011	142,616	09/26/2011	216,065	3.50
3.51		11/14/2011	192,334	11/14/2011	3,947	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)		215,847		-220,012	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)		4,880,403		1,647,990	4.00
<b>TO BE COMPLETED BY CONTRACTOR</b>						
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
<b>Program to Provider</b>						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
<b>Provider to Program</b>						
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		234,623		492,239	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		5,115,026		2,140,229	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: 151322

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/4/2012 10:09 am

		Title XVIII		Swing Beds - SNF	Cost
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider		956,712		0
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
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
<b>Program to Provider</b>					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
<b>Provider to Program</b>					
3.50	ADJUSTMENTS TO PROGRAM	09/26/2011	21,143		0
3.51		11/14/2011	40,676		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-61,819		0
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)		894,893		0
<b>TO BE COMPLETED BY CONTRACTOR</b>					
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
<b>Program to Provider</b>					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
<b>Provider to Program</b>					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER		98,160		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		993,053		0
			0	Contractor Number 1.00	Date (Mo/Day/Yr) 2.00
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151322

Period:

Worksheet E-2

Component CCN: 152322

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

Date/Time Prepared:  
5/4/2012 10:09 am

Title XVIII

Swing Beds - SNF

Cost

		Part A	Part B	
		1.00	2.00	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	759,610	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)	245,754	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	686	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)	1,005,364	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,005,364	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)	1,005,364	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	12,311	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)	993,053	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)	993,053	0	19.00
20.00	Interim payments	894,893	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)	98,160	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part V Date/Time Prepared: 5/4/2012 10:09 am
		Title XVIII	Hospital	Cost

PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHS)				
				1.00
1.00	Inpatient services		5,483,741	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 thru 3)		5,483,741	4.00
5.00	Primary payer payments		1,874	5.00
6.00	Total cost (line 4 less line 5) . For CAH (see instructions)		5,536,704	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		5,536,704	19.00
20.00	Deductibles (exclude professional component)		560,158	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		4,976,546	22.00
23.00	Coinsurance		9,622	23.00
24.00	Subtotal (line 22 minus line 23)		4,966,924	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		148,102	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		148,102	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		106,620	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26)		5,115,026	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		5,115,026	30.00
31.00	Interim payments		4,880,403	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)		234,623	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 151322

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

Worksheet G

Date/Time Prepared:  
5/4/2012 10:09 am

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>					
1.00 Cash on hand in banks	5,485,471	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	9,033,357	0	0	0	4.00
5.00 Other receivable	84,998	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-3,327,637	0	0	0	6.00
7.00 Inventory	700,981	0	0	0	7.00
8.00 Prepaid expenses	775,216	0	0	0	8.00
9.00 Other current assets	8,069,367	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)	20,821,753	0	0	0	11.00
<b>FIXED ASSETS</b>					
12.00 Land	0	0	0	0	12.00
13.00 Land improvements	0	0	0	0	13.00
14.00 Accumulated depreciation	0	0	0	0	14.00
15.00 Buildings	32,542,670	0	0	0	15.00
16.00 Accumulated depreciation	-19,072,772	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	0	0	0	0	23.00
24.00 Accumulated depreciation	0	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	0	0	0	0	27.00
28.00 Accumulated depreciation	0	0	0	0	28.00
29.00 Minor equipment-nondepreciable	0	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	13,469,898	0	0	0	30.00
<b>OTHER ASSETS</b>					
31.00 Investments	0	0	0	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	1,001,226	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	1,001,226	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	35,292,877	0	0	0	36.00
<b>CURRENT LIABILITIES</b>					
37.00 Accounts payable	679,049	0	0	0	37.00
38.00 Salaries, wages, and fees payable	873,214	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	800,090	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	692,670	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	3,045,023	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	1,633,189	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	0	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	1,633,189	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	4,678,212	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>					
52.00 General fund balance	30,614,665	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	30,614,665	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	35,292,877	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151322

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

Worksheet G-1

Date/Time Prepared:  
5/4/2012 10:09 am

	General Fund		Special Purpose Fund		
	1.00	2.00	3.00	4.00	
1.00 Fund balances at beginning of period		30,207,704		0	1.00
2.00 Net income (loss) (from wkst. G-3, line 29)		404,539			2.00
3.00 Total (sum of line 1 and line 2)		30,612,243		0	3.00
4.00 Additions (credit adjustments) (specify)	2,422		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)		2,422		0	10.00
11.00 Subtotal (line 3 plus line 10)		30,614,665		0	11.00
12.00 Deductions (debit adjustments) (specify)	0		0		12.00
13.00	0		0		13.00
14.00	0		0		14.00
15.00	0		0		15.00
16.00	0		0		16.00
17.00	0		0		17.00
18.00 Total deductions (sum of lines 12-17)		0		0	18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		30,614,665		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151322

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

Worksheet G-1

Date/Time Prepared:  
5/4/2012 10:09 am

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151322

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

Worksheet G-2 Parts

Date/Time Prepared:  
5/4/2012 10:09 am

Cost Center Description		Inpatient 1.00	Outpatient 2.00	Total 3.00	
<b>PART I - PATIENT REVENUES</b>					
<b>General Inpatient Routine Services</b>					
1.00	Hospital	3,357,448		3,357,448	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,357,448		3,357,448	10.00
<b>Intensive Care Type Inpatient Hospital Services</b>					
11.00	INTENSIVE CARE UNIT	1,106,772		1,106,772	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)	1,106,772		1,106,772	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,464,220		4,464,220	17.00
18.00	Ancillary services	15,042,552	41,764,729	56,807,281	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,524,528	1,524,528	22.00
23.00	AMBULANCE SERVICES	0	2,187,052	2,187,052	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	161,473	4,088,121	4,249,594	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	19,668,245	49,564,430	69,232,675	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per wkst. A, column 3, line 200)		31,374,262		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	NON-OPERATING EXPENSES	3,695,299			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)		3,695,299		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		27,678,963		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet G-3 Date/Time Prepared: 5/4/2012 10:09 am
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		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	69,232,675	1.00
2.00	Less contractual allowances and discounts on patients' accounts	39,491,412	2.00
3.00	Net patient revenues (line 1 minus line 2)	29,741,263	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	27,678,963	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,062,300	5.00
	<b>OTHER INCOME</b>		
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	156,101	24.00
24.01	NON-OPERATING REVENUE	3,396,421	24.01
25.00	Total other income (sum of lines 6-24)	3,552,522	25.00
26.00	Total (line 5 plus line 25)	5,614,822	26.00
27.00	NON-OPERATING EXPENSE	5,020,860	27.00
27.01	INVESTMENTS	189,423	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	5,210,283	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	404,539	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151322

Period:

Worksheet H

HHA CCN: 157177

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

Date/Time Prepared:  
5/4/2012 10:09 am

		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
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	Capital Related - Bldg. & Fixtures			0		0
2.00	Capital Related - Movable Equipment			0		0
3.00	Plant Operation & Maintenance	0	0	0	0	0
4.00	Transportation	0	0	0	0	0
5.00	Administrative and General	26,867	0	0	0	132,824
<b>HHA REIMBURSABLE SERVICES</b>						
6.00	Skilled Nursing Care	117,579	0	8,570	0	0
7.00	Physical Therapy	0	0	4,977	73,368	0
8.00	Occupational Therapy	0	0	1,622	23,502	0
9.00	Speech Pathology	0	0	0	849	0
10.00	Medical Social Services	4,092	0	304	0	0
11.00	Home Health Aide	50,441	0	6,114	0	0
12.00	Supplies (see instructions)	0	0	0	0	0
13.00	Drugs	0	0	0	0	0
14.00	DME	0	0	0	0	0
<b>HHA NONREIMBURSABLE SERVICES</b>						
15.00	Home Dialysis Aide Services	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0
18.00	Clinic	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0
23.00	All Others (specify)	74,453	0	1,927	887	0
24.00	Total (sum of lines 1-23)	273,432	0	23,514	98,606	132,824

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: 151322  
HHA CCN: 157177

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

Worksheet H  
Date/Time Prepared:  
5/4/2012 10:09 am

		Total (sum of cols. 1 thru 5)	Reclassificati on	Reclassified Trial Balance (col. 6 + col.7)	Home Health Agency I Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
		6.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	159,691	138,242	297,933	-75,456	222,477	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	126,149	0	126,149	0	126,149	6.00
7.00	Physical Therapy	78,345	0	78,345	0	78,345	7.00
8.00	Occupational Therapy	25,124	0	25,124	0	25,124	8.00
9.00	Speech Pathology	849	0	849	0	849	9.00
10.00	Medical Social Services	4,396	0	4,396	0	4,396	10.00
11.00	Home Health Aide	56,555	0	56,555	0	56,555	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
<b>HHA NONREIMBURSABLE SERVICES</b>							
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)	77,267	0	77,267	0	77,267	23.00
24.00	Total (sum of lines 1-23)	528,376	138,242	666,618	-75,456	591,162	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: 151322

Period:

Worksheet H-1

HHA CCN: 157177

From 01/01/2011

Part I

To 12/31/2011

Date/Time Prepared:

5/4/2012 10:09 am

		Capital Related Costs				Home Health Agency I	PPS
		Net Expenses for Cost Allocation (from wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	
		0	1.00	2.00	3.00	4.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	0	0	0	0	0	4.00
5.00	Administrative and General	222,477	0	0	0	0	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	126,149	0	0	0	0	6.00
7.00	Physical Therapy	78,345	0	0	0	0	7.00
8.00	Occupational Therapy	25,124	0	0	0	0	8.00
9.00	Speech Pathology	849	0	0	0	0	9.00
10.00	Medical Social Services	4,396	0	0	0	0	10.00
11.00	Home Health Aide	56,555	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
<b>HHA NONREIMBURSABLE SERVICES</b>							
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)	77,267	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	591,162	0	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 151322  
HHA CCN: 157177

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

Worksheet H-1  
Part I  
Date/Time Prepared:  
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		Subtotal (cols. 0-4) 4A.00	Administrative & General 5.00	Total (cols. 4A + 5) 6.00	Home Health Agency I	PPS
<b>GENERAL SERVICE COST CENTERS</b>						
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	222,477	222,477			5.00
<b>HHA REIMBURSABLE SERVICES</b>						
6.00	Skilled Nursing Care	126,149	76,122	202,271		6.00
7.00	Physical Therapy	78,345	47,276	125,621		7.00
8.00	Occupational Therapy	25,124	15,161	40,285		8.00
9.00	Speech Pathology	849	512	1,361		9.00
10.00	Medical Social Services	4,396	2,653	7,049		10.00
11.00	Home Health Aide	56,555	34,127	90,682		11.00
12.00	Supplies (see instructions)	0	0	0		12.00
13.00	Drugs	0	0	0		13.00
14.00	DME	0	0	0		14.00
<b>HHA NONREIMBURSABLE SERVICES</b>						
15.00	Home Dialysis Aide Services	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0		17.00
18.00	Clinic	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0		19.00
20.00	Day Care Program	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0		21.00
22.00	Homemaker Service	0	0	0		22.00
23.00	All Others (specify)	77,267	46,626	123,893		23.00
24.00	Total (sum of lines 1-23)	368,685		591,162		24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 151322

Period:

Worksheet H-1

HHA CCN: 157177

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

Part II  
Date/Time Prepared:  
5/4/2012 10:09 am

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				
<b>GENERAL SERVICE COST CENTERS</b>							
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	-222,477	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
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
<b>HHA NONREIMBURSABLE SERVICES</b>							
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	-222,477	24.00
25.00	Cost To Be Allocated (per worksheet H-1, Part I)	0	0	0	0	0	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		26.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 151322

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

Worksheet H-1  
Part II  
Date/Time Prepared:  
5/4/2012 10:09 am

HHA CCN: 157177

Home Health  
Agency I

PPS

		Administrative & General (ACCUM. COST)	
		5.00	
<b>GENERAL SERVICE COST CENTERS</b>			
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	368,685	5.00
<b>HHA REIMBURSABLE SERVICES</b>			
6.00	Skilled Nursing Care	126,149	6.00
7.00	Physical Therapy	78,345	7.00
8.00	Occupational Therapy	25,124	8.00
9.00	Speech Pathology	849	9.00
10.00	Medical Social Services	4,396	10.00
11.00	Home Health Aide	56,555	11.00
12.00	Supplies (see instructions)	0	12.00
13.00	Drugs	0	13.00
14.00	DME	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>			
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)	77,267	23.00
24.00	Total (sum of lines 1-23)	368,685	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	222,477	25.00
26.00	Unit Cost Multiplier	0.603434	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151322

Period:

Worksheet H-2

HHA CCN: 157177

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

Part I  
Date/Time Prepared:  
5/4/2012 10:09 am

Home Health  
Agency I

PPS

	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		1.00	2.00			
	0			4.00	4A	
1.00 Administrative and General	0	9,312	856	3,567	13,735	1.00
2.00 Skilled Nursing Care	202,271	0	0	0	202,271	2.00
3.00 Physical Therapy	125,621	0	0	0	125,621	3.00
4.00 Occupational Therapy	40,285	0	0	0	40,285	4.00
5.00 Speech Pathology	1,361	0	0	0	1,361	5.00
6.00 Medical Social Services	7,049	0	0	0	7,049	6.00
7.00 Home Health Aide	90,682	0	0	0	90,682	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)	123,893	0	0	0	123,893	19.00
20.00 Total (sum of lines 1-19) (2)	591,162	9,312	856	3,567	604,897	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: 151322

Period:

Worksheet H-2

HHA CCN: 157177

From 01/01/2011

Part I

To 12/31/2011

Date/Time Prepared:

5/4/2012 10:09 am

				Home Health Agency I		PPS	
		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	2,561	16,365	0	5,305	0	1.00
2.00	Skilled Nursing Care	37,709	0	0	0	0	2.00
3.00	Physical Therapy	23,420	0	0	0	0	3.00
4.00	Occupational Therapy	7,510	0	0	0	0	4.00
5.00	Speech Pathology	254	0	0	0	0	5.00
6.00	Medical Social Services	1,314	0	0	0	0	6.00
7.00	Home Health Aide	16,906	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)	23,098	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	112,772	16,365	0	5,305	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: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet H-2 Part I Date/Time Prepared: 5/4/2012 10:09 am
		HHA CCN: 157177	Home Health Agency I	PPS

	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	11.00	13.00	16.00	24.00	25.00	
1.00	Administrative and General	0	0	0	0	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) (2)	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet H-2 Part I Date/Time Prepared: 5/4/2012 10:09 am
		HHA CCN: 157177	Home Health Agency I	PPS

		Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		26.00	27.00	28.00	
1.00	Administrative and General	37,966			1.00
2.00	Skilled Nursing Care	239,980	12,990	252,970	2.00
3.00	Physical Therapy	149,041	8,068	157,109	3.00
4.00	Occupational Therapy	47,795	2,587	50,382	4.00
5.00	Speech Pathology	1,615	87	1,702	5.00
6.00	Medical Social Services	8,363	453	8,816	6.00
7.00	Home Health Aide	107,588	5,824	113,412	7.00
8.00	Supplies (see instructions)	0	0	0	8.00
9.00	Drugs	0	0	0	9.00
10.00	DME	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	13.00
14.00	Clinic	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	15.00
16.00	Day Care Program	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	17.00
18.00	Homemaker Service	0	0	0	18.00
19.00	All others (specify)	146,991	7,957	154,948	19.00
20.00	Total (sum of lines 1-19) (2)	739,339	37,966	739,339	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.		0.054131		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: 151322 HHA CCN: 157177	Period: From 01/01/2011 To 12/31/2011	Worksheet H-2 Part II Date/Time Prepared: 5/4/2012 10:09 am
		Home Health Agency I	PPS

	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
1.00 Administrative and General	588	588	273,432	SA	0	13,735	1.00
2.00 Skilled Nursing Care	0	0	0		0	202,271	2.00
3.00 Physical Therapy	0	0	0		0	125,621	3.00
4.00 Occupational Therapy	0	0	0		0	40,285	4.00
5.00 Speech Pathology	0	0	0		0	1,361	5.00
6.00 Medical Social Services	0	0	0		0	7,049	6.00
7.00 Home Health Aide	0	0	0		0	90,682	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	123,893	19.00
20.00 Total (sum of lines 1-19)	588	588	273,432			604,897	20.00
21.00 Total cost to be allocated	9,312	856	3,567			112,772	21.00
22.00 Unit cost multiplier	15.836735	1.455782	0.013045			0.186432	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151322  
HHA CCN: 157177

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

Worksheet H-2  
Part II  
Date/Time Prepared:  
5/4/2012 10:09 am

		Home Health Agency I		PPS			
	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)		
	7.00	8.00	9.00	10.00	11.00		
1.00	Administrative and General	588	0	588	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	588	0	588	0	0	20.00
21.00	Total cost to be allocated	16,365	0	5,305	0	0	21.00
22.00	Unit cost multiplier	27.831633	0.000000	9.022109	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 151322	Period: From 01/01/2011 To 12/31/2011	Worksheet H-2 Part II
	HHA CCN: 157177	Home Health Agency I	Date/Time Prepared: 5/4/2012 10:09 am PPS

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151322

Period: From 01/01/2011

Worksheet H-3

HHA CCN: 157177

To 12/31/2011

Parts I-II

Date/Time Prepared: 5/4/2012 10:09 am

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	252,970	0	252,970	1,646	1.00
2.00	Physical Therapy	3.00	157,109	0	157,109	1,186	2.00
3.00	Occupational Therapy	4.00	50,382	0	50,382	408	3.00
4.00	Speech Pathology	5.00	1,702	0	1,702	23	4.00
5.00	Medical Social Services	6.00	8,816	0	8,816	34	5.00
6.00	Home Health Aide	7.00	113,412	0	113,412	1,268	6.00
7.00	Total (sum of lines 1-6)		584,391	0	584,391	4,565	7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits	
				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	15999	648	419	8.00
9.00	Physical Therapy	15999	642	320	9.00
10.00	Occupational Therapy	15999	235	127	10.00
11.00	Speech Pathology	15999	16	0	11.00
12.00	Medical Social Services	15999	10	14	12.00
13.00	Home Health Aide	15999	308	177	13.00
14.00	Total (sum of lines 8-13)		1,859	1,057	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	26,069	15.00
16.00	Cost of Drugs	9.00	0	0	533	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	0.478720	0	0	1.00
2.00	Occupational Therapy	67.00	0.319869	0	0	2.00
3.00	Speech Pathology	68.00	0.494640	0	0	3.00
4.00	Cost of Medical Supplies	71.00	0.130546	0	0	4.00
5.00	Cost of Drugs	73.00	0.239372	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151322

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

Worksheet H-3  
Parts I-II  
Date/Time Prepared:  
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HHA CCN: 157177

Title XVIII

Home Health  
Agency I

PPS

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		
<b>PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR</b>						
<b>BENEFICIARY COST LIMITATION</b>						
<b>Cost Per Visit Computation</b>						
1.00	Skilled Nursing Care	153.69	648	419		1.00
2.00	Physical Therapy	132.47	642	320		2.00
3.00	Occupational Therapy	123.49	235	127		3.00
4.00	Speech Pathology	74.00	16	0		4.00
5.00	Medical Social Services	259.29	10	14		5.00
6.00	Home Health Aide	89.44	308	177		6.00
7.00	Total (sum of lines 1-6)		1,859	1,057		7.00
<b>Cost Center Description</b>						
		5.00	6.00	7.00	8.00	9.00
<b>Limitation Cost Computation</b>						
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
<b>Program Covered Charges</b>						
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		
<b>Supplies and Drugs Cost Computations</b>						
15.00	Cost of Medical Supplies	0.000000	0	18,808	0	15.00
16.00	Cost of Drugs	0.000000	0	0	0	16.00
<b>Cost Center Description</b>						
			Transfer to Part I as Indicated			
			4.00			
<b>PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS</b>						
1.00	Physical Therapy		col. 2, line 2.00			1.00
2.00	Occupational Therapy		col. 2, line 3.00			2.00
3.00	Speech Pathology		col. 2, line 4.00			3.00
4.00	Cost of Medical Supplies		col. 2, line 15.00			4.00
5.00	Cost of Drugs		col. 2, line 16.00			5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151322  
HHA CCN: 157177

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

Worksheet H-3  
Parts I-II  
Date/Time Prepared:  
5/4/2012 10:09 am

Title XVIII

Home Health  
Agency I

PPS

Cost Center Description	Cost of Services			Total Program Cost (sum of cols. 9-10)	
	Part A	Part B			
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
9.00	10.00	11.00	12.00		
<b>PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION</b>					
<b>Cost Per Visit Computation</b>					
1.00	Skilled Nursing Care	99,591	64,396	163,987	1.00
2.00	Physical Therapy	85,046	42,390	127,436	2.00
3.00	Occupational Therapy	29,020	15,683	44,703	3.00
4.00	Speech Pathology	1,184	0	1,184	4.00
5.00	Medical Social Services	2,593	3,630	6,223	5.00
6.00	Home Health Aide	27,548	15,831	43,379	6.00
7.00	Total (sum of lines 1-6)	244,982	141,930	386,912	7.00
Cost Center Description		10.00	11.00	12.00	
<b>Limitation Cost Computation</b>					
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		9.00	10.00	11.00	
<b>Supplies and Drugs Cost Computations</b>					
15.00	Cost of Medical Supplies	0	0	0	15.00
16.00	Cost of Drugs	0	0	0	16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 151322  
HHA CCN: 157177

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

Worksheet H-4  
Part I-II  
Date/Time Prepared:  
5/4/2012 10:09 am

		Title XVIII		Home Health Agency I		PPS	
		Part A	Part B				
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			
		1.00	2.00	3.00			
<b>PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES</b>							
<b>Reasonable Cost of Part A &amp; Part B Services</b>							
1.00	Reasonable cost of services (see instructions)	0	0	0			1.00
2.00	Total charges	495,904	288,243	0			2.00
<b>Customary Charges</b>							
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	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	0			4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000			5.00
6.00	Total customary charges (see instructions)	495,904	288,243	0			6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	495,904	288,243	0			7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0			8.00
9.00	Primary payer amounts	0	0	0			9.00
			<b>Part A Services</b>	<b>Part B Services</b>			
			1.00	2.00			

<b>PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT</b>							
10.00	Total reasonable cost (see instructions)		0	0			10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		268,758	130,535			11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	0			12.00
13.00	Total PPS Reimbursement - LUPA Episodes		7,006	2,472			13.00
14.00	Total PPS Reimbursement - PEP Episodes		2,401	5,681			14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	0			15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0			16.00
17.00	Total Other Payments		0	0			17.00
18.00	DME Payments		0	0			18.00
19.00	Oxygen Payments		0	0			19.00
20.00	Prosthetic and Orthotic Payments		0	0			20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0			21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		278,165	138,688			22.00
23.00	Excess reasonable cost (from line 8)		0	0			23.00
24.00	Subtotal (line 22 minus line 23)		278,165	138,688			24.00
25.00	Coinsurance billed to program patients (from your records)		0	0			25.00
26.00	Net cost (line 24 minus line 25)		278,165	138,688			26.00
27.00	Reimbursable bad debts (from your records)		0	0			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)		278,165	138,688			29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0			30.00
31.00	Subtotal (line 29 plus/minus line 30)		278,165	138,688			31.00
32.00	Interim payments (see instructions)		278,165	138,688			32.00
33.00	Tentative settlement (for contractor use only)		0	0			33.00
34.00	Balance due provider/program (line 31 minus lines 32 and 33)		0	0			34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	0			35.00

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

Provider CCN: 151322  
HHA CCN: 157177

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

Worksheet H-5  
Date/Time Prepared:  
5/4/2012 10:09 am  
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		278,165		138,688	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) <b>Program to Provider</b>					3.00
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
<b>Provider to Program</b>						
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)		278,165		138,688	4.00
<b>TO BE COMPLETED BY CONTRACTOR</b>						
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) <b>Program to Provider</b>					5.00
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
<b>Provider to Program</b>						
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)		278,165		138,688	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00