

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: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet S Parts I-III Date/Time Prepared: 7/23/2013 10:17 am
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**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input checked="" type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input checked="" type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 1/11/2013 Time: 9:16 am
Contractor use only	5. <input checked="" type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input checked="" type="checkbox"/> Initial Report for this Provider CCN 9. <input checked="" type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input checked="" type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification 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 ADAMS MEMORIAL HOSPITAL ( 151330 ) for the cost reporting period beginning 01/01/2011 and ending 12/31/2011 and to the best of my knowledge and belief, this report and statement are true, correct, complete and 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, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(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			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	37,381	35,893	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
200.00 Total	0	37,381	35,893	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: 151330      Period: From 01/01/2011 To 12/31/2011      Worksheet S Parts I-III Date/Time Prepared: 1/11/2013 9:16 am

**PART I - COST REPORT STATUS**

Provider use only      1.  Electronically filed cost report      Date: 1/11/2013      Time: 9:16 am  
 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      6. Date Received:      10. NPR Date:  
 (1) As Submitted      7. Contractor No.      11. Contractor's Vendor Code: 4  
 (2) Settled without Audit      8.  Initial Report for this Provider CCN      12.  If line 5, column 1 is 4: Enter number of times reopened = 0-9.  
 (3) Settled with Audit      9.  Final Report for this Provider CCN  
 (4) Reopened  
 (5) Amended

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Encryption Information  
 ECR: Date: 1/11/2013 Time: 9:16 am  
 SMUUEhE2e.H8DYLD8484t4DV3GZHBO  
 RnX3L0osP6c:XdEcYPBqh9t7hnav63  
 .c4w0voPyg0dXzNr  
 PI: Date: 1/11/2013 Time: 9:16 am  
 3fj T5ph00zj Ql 76BTZI N9cki : gsCk1  
 ex: 4h0E4obfsgx6G8c6Xyg1CuzvNF7  
 bEnWbraxXo0uni Pj

(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			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	37,381	35,893	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
200.00 Total	0	37,381	35,893	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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151330		Period: From 01/01/2011 To 12/31/2011		Worksheet S-2 Part I Date/Time Prepared: 7/23/2013 10:17 am						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 1100 MERCER AVENUE		PO Box:									
2.00	City: DECATUR		State: IN		Zip Code: 46733		County: ADAMS					
		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			
		6.00	7.00	8.00								
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		ADAMS MEMORIAL HOSPITAL	151330	99915	1	11/01/2005	N	O	P	3.00	
4.00	Subprovider - IPF		ADAMS MEMORIAL HOSPITAL	15M330	99915	4	11/01/2005	N	P	P	4.00	
5.00	Subprovider - IRF										5.00	
6.00	Subprovider - (Other)										6.00	
7.00	Swing Beds - SNF		ADAMS MEMORIAL HOSPITAL	15Z330	99915		11/01/2005	N	O	P	7.00	
8.00	Swing Beds - NF										8.00	
9.00	Hospital-Based SNF		ADAMS MEMORIAL HOSPITAL	155316	99915		03/08/1988	N	P	N	9.00	
10.00	Hospital-Based NF										10.00	
11.00	Hospital-Based OLTC										11.00	
12.00	Hospital-Based HHA		ADAMS MEMORIAL HOSPITAL	157172	99915		01/01/1992	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) I										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		
Inpatient PPS Information												
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N				22.00		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2		N		23.00		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days					
		1.00	2.00	3.00	4.00	5.00	6.00					
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 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 col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.					0	0	0	0	0	0	25.00
						Urban/Rural S	Date of Geogr					
						1.00	2.00					
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1				26.00		
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1				27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0				35.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 7/23/2013 10:17 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
		Y/N 1.00	Y/N 2.00			
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.					39.00
		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 additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? 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.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00		0.00	61.00
<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 in column 1. 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	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00		0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151330

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

Worksheet S-2  
Part I  
Date/Time Prepared:  
7/23/2013 10:17 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	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, 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. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

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		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.	Y				70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N		0		71.00
<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 and "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.					86.00
		V	XIX			
		1.00	2.00			
<b>Title V and XIX 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		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	97.00
<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				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	N	N	109.00
				1.00	2.00	3.00
<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. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00

X:\HFSdata\clients\Hospital\Adams\amh11amd.mcrx

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 7/23/2013 10:17 am	
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0		0
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) 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 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
<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
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)		Y	15H060	140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: ADAMS HEALTH NETWORK	Contractor's Name: WPS		Contractor's Number: 08101	
142.00	Street: 1100 MERCER AVE	PO Box:			
143.00	City: DECATUR	State: IN		Zip Code: 46733	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y		144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, 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	Title V	Title XIX
		1.00	2.00	3.00	4.00
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	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151330			Period: From 01/01/2011 To 12/31/2011		Worksheet S-2 Part I Date/Time Prepared: 7/23/2013 10:17 am	
							1.00	
<b>Multi campus</b>								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							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)						0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part II Date/Time Prepared: 7/23/2013 10:17 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
Description		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/04/2012	Y	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		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		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		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		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151330		Period: From 01/01/2011 To 12/31/2011		Worksheet S-2 Part II Date/Time Prepared: 7/23/2013 10:17 am	
	Description	Part A		Part B			
		Y/N	Date	Y/N			
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 relieved for Medicare purposes? If yes, see instructions				N	22.00	
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00	
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00	
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00	
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00	
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00	
<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				Y	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	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.				Y	37.00	
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				N	38.00	
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				Y	39.00	
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				N	40.00	
							1.00 2.00
<b>Cost Report Preparer Contact Information</b>							
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.					41.00	
42.00	Enter the employer/company name of the cost report preparer.					42.00	
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.					43.00	

		Part B	
		Date	
		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)	05/04/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
<b>Cost Report Preparer Contact Information</b>			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HFS Supplemental Information		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part IX Date/Time Prepared: 7/23/2013 10:17 am
		Title V	Title XIX	
		1.00	2.00	
<b>TITLES V AND/OR XIX FOLLOWING MEDICARE</b>				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient	Outpatient	
		1.00	2.00	
<b>CRITICAL ACCESS HOSPITALS</b>				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
<b>RCE DISALLOWANCE</b>				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
<b>PASS THROUGH COST</b>				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151330

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
7/23/2013 10:17 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Visi ts / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	21	7,665	125,712.00	0	1.00
2.00 HMO						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	125,712.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	17,472.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	143,184.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	15	5,475		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		50				27.00
28.00 Observation Bed Days					0	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: 151330

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
7/23/2013 10:17 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	3,199	288	5,238			1.00
2.00 HMO	0	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	120			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	3,199	288	5,358			7.00
8.00 INTENSIVE CARE UNIT	343	41	728			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		31	378			13.00
14.00 Total (see instructions)	3,542	360	6,464	0.00	321.12	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	407	330	2,194	0.00	17.51	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	2,364	0	4,191	0.00	19.12	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	1,315	363	3,180	0.00	5.73	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	0.00	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	363.48	27.00
28.00 Observation Bed Days		0	711			28.00
29.00 Ambulance Trips	999					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151330

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
7/23/2013 10:17 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)			0	744	54	1,576	1.00
2.00 HMO				0			2.00
3.00 HMO IPF Subprovider							3.00
4.00 HMO IRF Subprovider							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	0	744	54	1,576	14.00	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF	0.00	0	53	64	392	16.00	16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY	0.00						19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY	0.00						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE	0.00						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						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

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 151330 Component CCN: 157172		Period: From 01/01/2011 To 12/31/2011		Worksheet S-4 Date/Time Prepared: 7/23/2013 10:17 am	
				Home Health Agency I		PPS	
				1.00			
0.00	County			ADAMS		0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	169	0	506	675	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	87.00	0.00	99.00	186.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		1.28	0.00	1.28	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			1.43	0.00	1.43	5.00
6.00	Direct Nursing Service			2.70	0.00	2.70	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			0.32	0.00	0.32	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
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			23060			20.00
20.01				99915			20.01
				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	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	762	34	37	0	833	21.00
22.00	Skilled Nursing Visit Charges	106,680	4,760	5,180	0	116,620	22.00
23.00	Physical Therapy Visits	188	3	1	0	192	23.00
24.00	Physical Therapy Visit Charges	34,122	545	182	0	34,849	24.00
25.00	Occupational Therapy Visits	45	0	0	0	45	25.00
26.00	Occupational Therapy Visit Charges	9,563	0	0	0	9,563	26.00
27.00	Speech Pathology Visits	48	0	0	0	48	27.00
28.00	Speech Pathology Visit Charges	10,200	0	0	0	10,200	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	197	0	0	0	197	31.00
32.00	Home Health Aide Visit Charges	15,169	0	0	0	15,169	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,240	37	38	0	1,315	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)	175,734	5,305	5,362	0	186,401	35.00
36.00	Total Number of Episodes (standard/non outlier)	100		12	0	112	36.00
37.00	Total Number of Outlier Episodes		1		0	1	37.00
38.00	Total Non-Routine Medical Supply Charges	2,838	34	215	0	3,087	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 151330

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

Worksheet S-7

Date/Time Prepared:  
7/23/2013 10:17 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N		2.00

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
				1.00	2.00
3.00	RUX	0	0	0	3.00
4.00	RUL	0	0	0	4.00
5.00	RVX	0	0	0	5.00
6.00	RVL	0	0	0	6.00
7.00	RHX	43	0	43	7.00
8.00	RHL	29	0	29	8.00
9.00	RMX	40	0	40	9.00
10.00	RML	37	0	37	10.00
11.00	RLX	0	0	0	11.00
12.00	RUC	0	0	0	12.00
13.00	RUB	0	0	0	13.00
14.00	RUA	11	0	11	14.00
15.00	RVC	14	0	14	15.00
16.00	RVB	89	0	89	16.00
17.00	RVA	82	0	82	17.00
18.00	RHC	239	0	239	18.00
19.00	RHB	156	0	156	19.00
20.00	RHA	564	0	564	20.00
21.00	RMC	266	0	266	21.00
22.00	RMB	168	0	168	22.00
23.00	RMA	363	0	363	23.00
24.00	RLB	0	0	0	24.00
25.00	RLA	0	0	0	25.00
26.00	ES3	0	0	0	26.00
27.00	ES2	0	0	0	27.00
28.00	ES1	0	0	0	28.00
29.00	HE2	0	0	0	29.00
30.00	HE1	33	0	33	30.00
31.00	HD2	16	0	16	31.00
32.00	HD1	13	0	13	32.00
33.00	HC2	0	0	0	33.00
34.00	HC1	49	0	49	34.00
35.00	HB2	0	0	0	35.00
36.00	HB1	2	0	2	36.00
37.00	LE2	0	0	0	37.00
38.00	LE1	0	0	0	38.00
39.00	LD2	0	0	0	39.00
40.00	LD1	0	0	0	40.00
41.00	LC2	0	0	0	41.00
42.00	LC1	0	0	0	42.00
43.00	LB2	0	0	0	43.00
44.00	LB1	2	0	2	44.00
45.00	CE2	0	0	0	45.00
46.00	CE1	0	0	0	46.00
47.00	CD2	0	0	0	47.00
48.00	CD1	20	0	20	48.00
49.00	CC2	0	0	0	49.00
50.00	CC1	27	0	27	50.00
51.00	CB2	0	0	0	51.00
52.00	CB1	30	0	30	52.00
53.00	CA2	0	0	0	53.00
54.00	CA1	56	0	56	54.00
55.00	SE3	0	0	0	55.00
56.00	SE2	0	0	0	56.00
57.00	SE1	0	0	0	57.00
58.00	SSC	0	0	0	58.00
59.00	SSB	0	0	0	59.00
60.00	SSA	0	0	0	60.00
61.00	IB2	0	0	0	61.00
62.00	IB1	0	0	0	62.00
63.00	IA2	0	0	0	63.00
64.00	IA1	0	0	0	64.00
65.00	BB2	0	0	0	65.00
66.00	BB1	0	0	0	66.00
67.00	BA2	0	0	0	67.00
68.00	BA1	0	0	0	68.00

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 151330

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

Worksheet S-7

Date/Time Prepared:  
7/23/2013 10:17 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	1	0	1	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	14	0	14	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		2,364	0	2,364	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
SNF SERVICES						
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).			99915	99915	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing			0	0.00	202.00
203.00	Recruitment			0	0.00	203.00
204.00	Retention of employees			0	0.00	204.00
205.00	Training			0	0.00	205.00
206.00	OTHER (SPECIFY)			0	0.00	206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)			1,995,950		207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet S-10 Date/Time Prepared: 7/23/2013 10:17 am
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			1.00	
<b>Uncompensated and indigent care cost computation</b>				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.413796	1.00
<b>Medicaid (see instructions for each line)</b>				
2.00	Net revenue from Medicaid		0	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		0	6.00
7.00	Medicaid cost (line 1 times line 6)		0	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00
<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)		0	19.00
			1.00	
			2.00	
			3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	0	0	0
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	0	0	0
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	0	0	0
			1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		0	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		263,662	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		-263,662	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		-109,102	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		-109,102	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		-109,102	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151330

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

Worksheet A  
Date/Time Prepared:  
7/23/2013 10:17 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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	00100	NEW CAP REL COSTS-BLDG & FIXT		1,322,774	1,322,774	1,770,549	3,093,323	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
2.01	00201	OTHER CAP		1,900,803	1,900,803	-1,756,313	144,490	2.01
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	0	5,926,904	5,926,904	0	5,926,904	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	824,335	5,233,901	6,058,236	-49,357	6,008,879	5.00
7.00	00700	OPERATION OF PLANT	306,628	649,881	956,509	0	956,509	7.00
7.01	00701	BIO-MEDICAL	52,553	104,912	157,465	0	157,465	7.01
7.02	00702	UTILITIES - HOSPITAL	0	520,631	520,631	4,649	525,280	7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	0	103,693	103,693	-4,649	99,044	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	38,235	137,587	175,822	0	175,822	8.00
9.00	00900	HOUSEKEEPING	379,615	89,455	469,070	0	469,070	9.00
10.00	01000	DIETARY	586,857	661,355	1,248,212	-983,628	264,584	10.00
11.00	01100	CAFETERIA	0	0	0	983,628	983,628	11.00
13.00	01300	NURSING ADMINISTRATION	747,517	167,690	915,207	0	915,207	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	669,419	1,651,947	2,321,366	0	2,321,366	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	437,640	179,409	617,049	0	617,049	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	1,233,934	138,894	1,372,828	314,778	1,687,606	30.00
31.00	03100	INTENSIVE CARE UNIT	525,771	11,610	537,381	0	537,381	31.00
40.00	04000	SUBPROVIDER - IPF	997,859	176,890	1,174,749	-217,503	957,246	40.00
43.00	04300	NURSERY	0	0	0	183,640	183,640	43.00
44.00	04400	SKILLED NURSING FACILITY	817,650	41,159	858,809	0	858,809	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	712,029	581,320	1,293,349	0	1,293,349	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	562,572	50,940	613,512	-498,418	115,094	52.00
53.00	05300	ANESTHESIOLOGY	816,697	15,534	832,231	0	832,231	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	825,018	682,703	1,507,721	9,019	1,516,740	54.00
60.00	06000	LABORATORY	897,414	1,406,352	2,303,766	0	2,303,766	60.00
65.00	06500	RESPIRATORY THERAPY	455,524	72,889	528,413	0	528,413	65.00
66.00	06600	PHYSICAL THERAPY	388,255	84,518	472,773	0	472,773	66.00
67.00	06700	OCCUPATIONAL THERAPY	367,607	18,814	386,421	0	386,421	67.00
68.00	06800	SPEECH PATHOLOGY	145,527	10,681	156,208	0	156,208	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	845,267	845,267	0	845,267	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	217,760	217,760	0	217,760	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,534,101	2,534,101	0	2,534,101	73.00
76.00	03020	OP PSYCH	0	0	0	224,323	224,323	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	152,123	28,601	180,724	0	180,724	90.00
90.01	09001	CLINIC - AMO	115,088	6,542	121,630	0	121,630	90.01
91.00	09100	EMERGENCY	1,816,130	285,555	2,101,685	0	2,101,685	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	722,237	130,868	853,105	16,013	869,118	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	4,660	4,660	0	4,660	97.00
101.00	10100	HOME HEALTH AGENCY	335,479	34,762	370,241	0	370,241	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,929,713	26,031,362	41,961,075	-3,269	41,957,806	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	TITLE XX	21,133	4,085	25,218	0	25,218	194.00
194.01	07951	OTHER NRCC	1,295,096	176,795	1,471,891	0	1,471,891	194.01
194.02	07952	OTHER MOBS	0	265,196	265,196	1,507	266,703	194.02
194.03	07953	MONROE	426,207	51,338	477,545	1,762	479,307	194.03
194.04	07954	AMH SURGERY	126,179	-131,345	-5,166	0	-5,166	194.04
194.05	07955	DFM - NON-PROVIDER BASED	189,920	156,693	346,613	0	346,613	194.05
194.06	07956	AMO - NON-PROVIDER BASED	397,660	159,282	556,942	0	556,942	194.06
200.00		TOTAL (SUM OF LINES 118-199)	18,385,908	26,713,406	45,099,314	0	45,099,314	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151330

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

Worksheet A  
Date/Time Prepared:  
7/23/2013 10:17 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-153,594	2,939,729	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
2.01	00201	OTHER CAP	-9,019	135,471	2.01
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	-321,738	5,605,166	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-324,742	5,684,137	5.00
7.00	00700	OPERATION OF PLANT	0	956,509	7.00
7.01	00701	BIO-MEDICAL	0	157,465	7.01
7.02	00702	UTILITIES - HOSPITAL	0	525,280	7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	0	99,044	7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	175,822	8.00
9.00	00900	HOUSEKEEPING	0	469,070	9.00
10.00	01000	DIETARY	0	264,584	10.00
11.00	01100	CAFETERIA	-394,403	589,225	11.00
13.00	01300	NURSING ADMINISTRATION	0	915,207	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	-1,507,699	813,667	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-24,133	592,916	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	0	1,687,606	30.00
31.00	03100	INTENSIVE CARE UNIT	0	537,381	31.00
40.00	04000	SUBPROVIDER - IPF	-52,433	904,813	40.00
43.00	04300	NURSERY	0	183,640	43.00
44.00	04400	SKILLED NURSING FACILITY	0	858,809	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	1,293,349	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	115,094	52.00
53.00	05300	ANESTHESIOLOGY	-832,231	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,516,740	54.00
60.00	06000	LABORATORY	-58,361	2,245,405	60.00
65.00	06500	RESPIRATORY THERAPY	-85,872	442,541	65.00
66.00	06600	PHYSICAL THERAPY	0	472,773	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	386,421	67.00
68.00	06800	SPEECH PATHOLOGY	0	156,208	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	845,267	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	217,760	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-685,791	1,848,310	73.00
76.00	03020	OP PSYCH	0	224,323	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	-120,168	60,556	90.00
90.01	09001	CLINIC - AMO	-104,638	16,992	90.01
91.00	09100	EMERGENCY	-1,020,565	1,081,120	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	0	869,118	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	4,660	97.00
101.00	10100	HOME HEALTH AGENCY	0	370,241	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-5,695,387	36,262,419	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	TITLE XX	0	25,218	194.00
194.01	07951	OTHER NRCC	0	1,471,891	194.01
194.02	07952	OTHER MOBS	0	266,703	194.02
194.03	07953	MONROE	0	479,307	194.03
194.04	07954	AMH SURGERY	0	-5,166	194.04
194.05	07955	DFM - NON-PROVIDER BASED	0	346,613	194.05
194.06	07956	AMO - NON-PROVIDER BASED	0	556,942	194.06
200.00		TOTAL (SUM OF LINES 118-199)	-5,695,387	39,403,927	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 151330

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

Worksheet Non-CMS W  
Date/Time Prepared:  
7/23/2013 10:17 am

Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
	1.00	2.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00 NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	00200		2.00
2.01 OTHER CAP	00201		2.01
3.00 OTHER CAP REL COSTS	00300		3.00
4.00 EMPLOYEE BENEFITS	00400		4.00
5.00 ADMINISTRATIVE & GENERAL	00500		5.00
7.00 OPERATION OF PLANT	00700		7.00
7.01 BIO-MEDICAL	00701		7.01
7.02 UTILITIES - HOSPITAL	00702		7.02
7.03 UTILITIES - OFFSITE BLDGS	00703		7.03
8.00 LAUNDRY & LINEN SERVICE	00800		8.00
9.00 HOUSEKEEPING	00900		9.00
10.00 DIETARY	01000		10.00
11.00 CAFETERIA	01100		11.00
13.00 NURSING ADMINISTRATION	01300		13.00
14.00 CENTRAL SERVICES & SUPPLY	01400		14.00
15.00 PHARMACY	01500		15.00
16.00 MEDICAL RECORDS & LIBRARY	01600		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00 ADULTS & PEDIATRICS	03000		30.00
31.00 INTENSIVE CARE UNIT	03100		31.00
40.00 SUBPROVIDER - IPF	04000		40.00
43.00 NURSERY	04300		43.00
44.00 SKILLED NURSING FACILITY	04400		44.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 OPERATING ROOM	05000		50.00
52.00 DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00 ANESTHESIOLOGY	05300		53.00
54.00 RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00 LABORATORY	06000		60.00
65.00 RESPIRATORY THERAPY	06500		65.00
66.00 PHYSICAL THERAPY	06600		66.00
67.00 OCCUPATIONAL THERAPY	06700		67.00
68.00 SPEECH PATHOLOGY	06800		68.00
69.00 ELECTROCARDIOLOGY	06900		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	07200		72.00
73.00 DRUGS CHARGED TO PATIENTS	07300		73.00
76.00 OP PSYCH	03020		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00 CLINIC	09000		90.00
90.01 CLINIC - AMO	09001		90.01
91.00 EMERGENCY	09100		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
95.00 AMBULANCE SERVICES	09500		95.00
97.00 DURABLE MEDICAL EQUIP-SOLD	09700		97.00
101.00 HOME HEALTH AGENCY	10100		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
116.00 HOSPICE	11600		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)			118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
194.00 TITLE XX	07950		194.00
194.01 OTHER NRCC	07951		194.01
194.02 OTHER MOBS	07952		194.02
194.03 MONROE	07953		194.03
194.04 AMH SURGERY	07954		194.04
194.05 DFM - NON-PROVIDER BASED	07955		194.05
194.06 AMO - NON-PROVIDER BASED	07956		194.06
200.00 TOTAL (SUM OF LINES 118-199)			200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
<b>A - OB, NURSERY &amp; L&amp;D</b>						
1.00	ADULTS & PEDIATRICS	30.00	288,642	26,136	1.00	
2.00	NURSERY	43.00	168,392	15,248	2.00	
	TOTALS		457,034	41,384		
<b>B - INSURANCE</b>						
1.00	NEW CAP REL COSTS-BLDG & FI XT	1.00	0	75,897	1.00	
	TOTALS		0	75,897		
<b>C - CAFETERIA</b>						
1.00	CAFETERIA	11.00	462,461	521,167	1.00	
	TOTALS		462,461	521,167		
<b>D - O/P PSYCH</b>						
1.00	OP PSYCH	76.00	184,752	32,751	1.00	
	TOTALS		184,752	32,751		
<b>E - HOSPITAL USE OF SWISS CITY</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,877	1.00	
2.00	OP PSYCH	76.00	0	6,820	2.00	
3.00	UTILITIES - HOSPITAL	7.02	0	4,649	3.00	
	TOTALS		0	14,346		
<b>F - INTEREST</b>						
1.00	OTHER MOBS	194.02	0	11,204	1.00	
2.00	MONROE	194.03	0	1,762	2.00	
3.00	ADMINISTRATIVE & GENERAL	5.00	0	23,663	3.00	
4.00	NEW CAP REL COSTS-BLDG & FI XT	1.00	0	1,694,652	4.00	
5.00	AMBULANCE SERVICES	95.00	0	16,013	5.00	
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	9,019	6.00	
	TOTALS		0	1,756,313		
500.00	Grand Total: Increases		1,104,247	2,441,858	500.00	

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - OB, NURSERY &amp; L&amp;D</b>							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	457,034	41,384	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		457,034	41,384			
<b>B - INSURANCE</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	75,897	12		1.00
	TOTALS		0	75,897			
<b>C - CAFETERIA</b>							
1.00	DIETARY	10.00	462,461	521,167	0		1.00
	TOTALS		462,461	521,167			
<b>D - O/P PSYCH</b>							
1.00	SUBPROVIDER - IPF	40.00	184,752	32,751	0		1.00
	TOTALS		184,752	32,751			
<b>E - HOSPITAL USE OF SWISS CITY</b>							
1.00	OTHER MOBS	194.02	0	9,697	0		1.00
2.00	UTILITIES - OFFSITE BLDGS	7.03	0	4,649	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	14,346			
<b>F - INTEREST</b>							
1.00	OTHER CAP	2.01	0	1,756,313	11		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	11		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	TOTALS		0	1,756,313			
500.00	Grand Total: Decreases		1,104,247	2,441,858			500.00

Increases			Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary	
2.00	3.00	4.00	6.00	7.00	8.00	
A - OB, NURSERY & L&D						
1.00	ADULTS & PEDIATRICS	30.00	288,642	DELIVERY ROOM & LABOR ROOM	52.00	457,034 1.00
2.00	NURSERY	43.00	168,392		0.00	0 2.00
	TOTALS		457,034	TOTALS		457,034
B - INSURANCE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	ADMINISTRATIVE & GENERAL	5.00	0 1.00
	TOTALS		0	TOTALS		0
C - CAFETERIA						
1.00	CAFETERIA	11.00	462,461	DIETARY	10.00	462,461 1.00
	TOTALS		462,461	TOTALS		462,461
D - O/P PSYCH						
1.00	OP PSYCH	76.00	184,752	SUBPROVIDER - IPF	40.00	184,752 1.00
	TOTALS		184,752	TOTALS		184,752
E - HOSPITAL USE OF SWISS CITY						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	OTHER MOBS	194.02	0 1.00
2.00	OP PSYCH	76.00	0	UTILITIES - OFFSITE BLDGS	7.03	0 2.00
3.00	UTILITIES - HOSPITAL	7.02	0		0.00	0 3.00
	TOTALS		0	TOTALS		0
F - INTEREST						
1.00	OTHER MOBS	194.02	0	OTHER CAP	2.01	0 1.00
2.00	MONROE	194.03	0		0.00	0 2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0		0.00	0 3.00
4.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0		0.00	0 4.00
5.00	AMBULANCE SERVICES	95.00	0		0.00	0 5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0		0.00	0 6.00
	TOTALS		0	TOTALS		0
500.00	Grand Total: Increases		1,104,247	Grand Total: Decreases		1,104,247 500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151330

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
7/23/2013 10:17 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	358,667	0	0	163,076	1.00
2.00	Land Improvements	1,206,356	261,890	0	0	2.00
3.00	Buildings and Fixtures	33,344,312	0	0	2,447,047	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	4,278,072	55,010	0	55,010	5.00
6.00	Movable Equipment	17,681,229	19,529	0	19,529	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	56,868,636	336,429	0	336,429	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	56,868,636	336,429	0	336,429	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	195,591	0			1.00
2.00	Land Improvements	1,468,246	0			2.00
3.00	Buildings and Fixtures	30,897,265	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	4,333,082	0			5.00
6.00	Movable Equipment	17,700,758	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	54,594,942	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	54,594,942	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151330

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
7/23/2013 10:17 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,322,774	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
2.01	OTHER CAP	1,900,803	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	3,223,577	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,322,774				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
2.01	OTHER CAP	0	1,900,803				2.01
3.00	Total (sum of lines 1-2)	0	3,223,577				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151330

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
7/23/2013 10:17 am

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0 1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0 2.00
2.01	OTHER CAP	0	0	0	0.000000	0 2.01
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0 3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,169,180	0 1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0 2.00
2.01	OTHER CAP	0	0	0	1,900,803	0 2.01
3.00	Total (sum of lines 1-2)	0	0	0	3,069,983	0 3.00
Cost Center Description	SUMMARY OF CAPITAL					
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,694,652	75,897	0	0	2,939,729 1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0 2.00
2.01	OTHER CAP	-1,765,332	0	0	0	135,471 2.01
3.00	Total (sum of lines 1-2)	-70,680	75,897	0	0	3,075,200 3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151330

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

Worksheet A-8

Date/Time Prepared:  
7/23/2013 10:17 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-153,594	NEW CAP REL COSTS-BLDG & FIXT		1.00	9	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			NEW CAP REL COSTS-MVBLE EQUIP		2.00	0	2.00
2.01 Investment income - OTHER CAP (chapter 2)			OTHER CAP		2.01	0	2.01
3.00 Investment income - other (chapter 2)		0			0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-3,206	ADMINISTRATIVE & GENERAL		5.00	0	8.00
9.00 Parking lot (chapter 21)		0			0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-1,356,165				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-288,116				0	12.00
13.00 Laundry and linen service		0			0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-394,403	CAFETERIA		11.00	0	14.00
15.00 Rental of quarters to employee and others		0			0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	0	16.00
17.00 Sale of drugs to other than patients	B	-15,838	DRUGS CHARGED TO PATIENTS		73.00	0	17.00
18.00 Sale of medical records and abstracts	B	-24,133	MEDICAL RECORDS & LIBRARY		16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00	0	19.00
20.00 Vending machines		0			0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		RESPIRATORY THERAPY		65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY		66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***		114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT		1.00	0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP		2.00	0	27.00
27.01 Depreciation - OTHER CAP			OTHER CAP		2.01	0	27.01
28.00 Non-physician Anesthetist			*** Cost Center Deleted ***		19.00		28.00
29.00 Physicians' assistant		0			0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY		67.00		30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		SPEECH PATHOLOGY		68.00		31.00

Provider CCN: 151330

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

Worksheet A-8

Date/Time Prepared:  
7/23/2013 10:17 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
	1.00	2.00	3.00	4.00	5.00	
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00 IHA DUES	A	-1,091	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00 AHA DUES	A	-3,432	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00 ANESTHESIOLOGY	A	-832,231	ANESTHESIOLOGY	53.00	0	35.00
36.00 RAD EQUIP INT EXP - UNECESSARY BORRO	A	-9,019	OTHER CAP	2.01	11	36.00
37.00 TRANSPORTATION	B	-1,700	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00 OB RENTALS	B	-282	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00 WORTHMAN FITNESS CENTER	B	-85,872	RESPIRATORY THERAPY	65.00	0	39.00
40.00 MISC INCOME	B	-26,915	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00 ER PHYSICIAN BENEFITS	A	-321,738	EMPLOYEE BENEFITS	4.00	0	41.00
42.00 INSTITUTIONAL PHARMACY	A	-1,507,699	PHARMACY	15.00	0	42.00
43.00 INSTITUTIONAL PHARMACY	A	-669,953	DRUGS CHARGED TO PATIENTS	73.00	0	43.00
44.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	44.00
45.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,695,387				50.00

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

Provider CCN: 151330

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

Worksheet A-8-1

Date/Time Prepared:  
7/23/2013 10:17 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	AHN- CAPITAL	68,218	0
2.00	5.00	ADMINISTRATIVE & GENERAL	AHN- A&G	1,214,824	1,571,158
3.00	0.00			0	0
4.00	0.00			0	0
5.00	0	0		1,283,042	1,571,158

\* 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	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

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

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

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

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

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

Provider CCN: 151330

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

Worksheet A-8-1

Date/Time Prepared:  
7/23/2013 10:17 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	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	68,218	0		1.00
2.00	-356,334	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-288,116			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		
	Type of Business		
	6.00		
<b>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>			

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	MANAGEMENT		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			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: 151330

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

Worksheet A-8-2

Date/Time Prepared:  
7/23/2013 10:17 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	40.00	SUBPROVIDER - IPF	52,433	52,433	0	0	0	1.00
2.00	60.00	LABORATORY	60,000	58,361	1,639	0	0	2.00
3.00	91.00	EMERGENCY	1,232,981	1,020,565	212,416	0	0	3.00
4.00	90.00	CLINIC	120,168	120,168	0	0	0	4.00
5.00	90.01	CLINIC - AMO	104,638	104,638	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,570,220	1,356,165	214,055	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	90.00	CLINIC	0	0	0	0	0	4.00
5.00	90.01	CLINIC - AMO	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	40.00	SUBPROVIDER - IPF	0	0	0	52,433	1.00
2.00	60.00	LABORATORY	0	0	0	58,361	2.00
3.00	91.00	EMERGENCY	0	0	0	1,020,565	3.00
4.00	90.00	CLINIC	0	0	0	120,168	4.00
5.00	90.01	CLINIC - AMO	0	0	0	104,638	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	1,356,165	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151330		Period: From 01/01/2011 To 12/31/2011		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/23/2013 10:17 am	
				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)					54	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					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	83.75	445.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	72.00	54.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.00	36.00	27.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
				1.00			
<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)					6,030	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					24,030	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					30,060	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)					30,060	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)					56.85	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					44,343	22.00
23.00	Total salary equivalency (see instructions)					44,343	23.00
<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>							
<b>Standard Travel Allowance</b>							
24.00	Therapists (line 3 times column 2, line 11)					1,944	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)					1,944	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)					297	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					2,241	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)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					2,241	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					297	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
<b>PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>							
<b>Standard Travel Expense</b>							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
<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
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: 151330				Period: From 01/01/2011 To 12/31/2011		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/23/2013 10:17 am		
							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	Assistants	Aides	Trainees	Total				
		1.00	2.00	3.00	4.00	5.00				
<b>PART V - OVERTIME COMPUTATION</b>										
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			
<b>CALCULATION OF LIMIT</b>										
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			
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>										
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	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			
<b>Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT</b>										
57.00	Salary equivalency amount (from line 23)						44,343	57.00		
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						2,241	58.00		
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00		
60.00	Overtime allowance (from column 5, line 56)						0	60.00		
61.00	Equipment cost (see instructions)						0	61.00		
62.00	Supplies (see instructions)						0	62.00		
63.00	Total allowance (sum of lines 57-62)						46,584	63.00		
64.00	Total cost of outside supplier services (from your records)						29,873	64.00		
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00		
<b>LINE 33 CALCULATION</b>										
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						1,944	100.00		
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						297	100.01		
100.02	Line 33 = line 28 = sum of lines 26 and 27						2,241	100.02		
<b>LINE 34 CALCULATION</b>										
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						297	101.00		
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01		
101.02	Line 34 = sum of lines 27 and 31						297	101.02		
<b>LINE 35 CALCULATION</b>										
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00		
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01		
102.02	Line 35 = sum of lines 31 and 32						0	102.02		

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151330		Period: From 01/01/2011 To 12/31/2011		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/23/2013 10:17 am	
				Occupational 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)					49	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					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	46.00	305.00	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	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
<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)					3,140	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					15,613	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					18,753	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)					18,753	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)					53.43	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					41,675	22.00
23.00	Total salary equivalency (see instructions)					41,675	23.00
<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>							
<b>Standard Travel Allowance</b>							
24.00	Therapists (line 3 times column 2, line 11)					1,672	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)					1,672	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)					270	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					1,942	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)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					1,942	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					270	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
<b>Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>							
<b>Standard Travel Expense</b>							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
<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
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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 7/23/2013 10:17 am
		Occupational Therapy	Cost

						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					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		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)	68.25	51.19	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)					41,675	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					1,942	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					43,617	63.00
64.00	Total cost of outside supplier services (from your records)					4,053	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					1,672	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					270	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					1,942	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					270	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					270	101.02

**LINE 35 CALCULATION**

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151330

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

Worksheet B  
Part I  
Date/Time Prepared:  
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP	OTHER CAP		
	0	1.00	2.00	2.01	4.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	2,939,729	2,939,729			1.00	
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	0			0	2.00	
2.01 00201 OTHER CAP	135,471			0 135,471	2.01	
4.00 00400 EMPLOYEE BENEFITS	5,605,166	0		0	5,605,166 4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	5,684,137	444,306		0 17,850	262,990 5.00	
7.00 00700 OPERATION OF PLANT	956,509	379,834		0 15,262	97,824 7.00	
7.01 00701 BIO-MEDICAL	157,465	8,903		0 358	16,766 7.01	
7.02 00702 UTILITIES - HOSPITAL	525,280	0		0 0	0 7.02	
7.03 00703 UTILITIES - OFFSITE BLDGS	99,044	0		0 0	0 7.03	
8.00 00800 LAUNDRY & LINEN SERVICE	175,822	68,549		0 2,754	12,198 8.00	
9.00 00900 HOUSEKEEPING	469,070	14,773		0 594	121,110 9.00	
10.00 01000 DIETARY	264,584	81,076		0 3,258	39,686 10.00	
11.00 01100 CAFETERIA	589,225	75,108		0 3,018	147,540 11.00	
13.00 01300 NURSING ADMINISTRATION	915,207	4,964		0 199	238,483 13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0		0 0	0 14.00	
15.00 01500 PHARMACY	813,667	29,586		0 1,189	213,567 15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	592,916	63,210		0 2,540	139,622 16.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	1,687,606	400,536		0 16,094	485,752 30.00	
31.00 03100 INTENSIVE CARE UNIT	537,381	78,634		0 3,160	167,738 31.00	
40.00 04000 SUBPROVIDER - I/P	904,813	139,205		0 5,593	259,408 40.00	
43.00 04300 NURSERY	183,640	8,509		0 342	53,723 43.00	
44.00 04400 SKILLED NURSING FACILITY	858,809	216,066		0 8,682	260,857 44.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	1,293,349	219,868		0 8,835	227,161 50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	115,094	0		0 0	33,670 52.00	
53.00 05300 ANESTHESIOLOGY	0	0		0 0	0 53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,516,740	188,962		0 7,593	263,208 54.00	
60.00 06000 LABORATORY	2,245,405	82,731		0 3,324	286,305 60.00	
65.00 06500 RESPIRATORY THERAPY	442,541	29,389		0 1,181	145,327 65.00	
66.00 06600 PHYSICAL THERAPY	472,773	126,244		0 5,073	123,866 66.00	
67.00 06700 OCCUPATIONAL THERAPY	386,421	5,515		0 222	117,279 67.00	
68.00 06800 SPEECH PATHOLOGY	156,208	2,758		0 111	46,428 68.00	
69.00 06900 ELECTROCARDIOLOGY	0	0		0 0	0 69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	845,267	0		0 0	0 71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	217,760	0		0 0	0 72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	1,848,310	0		0 0	0 73.00	
76.00 03020 OP PSYCH	224,323	0		0 0	58,942 76.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	60,556	76,822		0 3,087	48,532 90.00	
90.01 09001 CLINIC - AMO	16,992	4,570		0 184	36,717 90.01	
91.00 09100 EMERGENCY	1,081,120	97,307		0 3,910	579,414 91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES	869,118	0		0 3,422	230,417 95.00	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	4,660	20,643		0 829	0 97.00	
101.00 10100 HOME HEALTH AGENCY	370,241	0		0 8,649	107,029 101.00	
<b>SPECIAL PURPOSE COST CENTERS</b>						
116.00 11600 HOSPICE	0	0		0 0	0 116.00	
118.00 11800 SUBTOTALS (SUM OF LINES 1-117)	36,262,419	2,868,068		0 127,313	4,821,559 118.00	
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22,692		0 912	0 190.00	
194.00 07950 TITLE XX	25,218	0		0 0	6,742 194.00	
194.01 07951 OTHER NRCC	1,471,891	48,969		0 4,972	413,178 194.01	
194.02 07952 OTHER MOBS	266,703	0		0 0	0 194.02	
194.03 07953 MONROE	479,307	0		0 1,357	135,974 194.03	
194.04 07954 AMH SURGERY	-5,166	0		0 0	40,255 194.04	
194.05 07955 DFM - NON-PROVIDER BASED	346,613	0		0 0	60,591 194.05	
194.06 07956 AMO - NON-PROVIDER BASED	556,942	0		0 917	126,867 194.06	
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	TOTAL (sum lines 118-201)	39,403,927	2,939,729		0 135,471	5,605,166 202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet B Part I Date/Time Prepared: 7/23/2013 10:17 am		
Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	BIO-MEDICAL	UTILITIES - HOSPITAL	
	4A	5.00	7.00	7.01	7.02	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01 00201	OTHER CAP					2.01
4.00 00400	EMPLOYEE BENEFITS					4.00
5.00 00500	ADMINISTRATIVE & GENERAL	6,409,283	6,409,283			5.00
7.00 00700	OPERATION OF PLANT	1,449,429	281,554	1,730,983		7.00
7.01 00701	BIO-MEDICAL	183,492	35,644	6,050	225,186	7.01
7.02 00702	UTILITIES - HOSPITAL	525,280	102,037	0	0	627,317
7.03 00703	UTILITIES - OFFSITE BLDGS	99,044	19,239	0	0	0
8.00 00800	LAUNDRY & LINEN SERVICE	259,323	50,374	46,580	0	20,412
9.00 00900	HOUSEKEEPING	605,547	117,629	10,039	0	4,399
10.00 01000	DIETARY	388,604	75,487	55,093	0	24,142
11.00 01100	CAFETERIA	814,891	158,294	51,038	0	22,365
13.00 01300	NURSING ADMINISTRATION	1,158,853	225,110	3,373	0	1,478
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00 01500	PHARMACY	1,058,009	205,520	20,105	0	8,810
16.00 01600	MEDICAL RECORDS & LIBRARY	798,288	155,069	42,953	0	18,822
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	2,589,988	503,110	272,172	37,106	119,270
31.00 03100	INTENSIVE CARE UNIT	786,913	152,859	53,434	900	23,415
40.00 04000	SUBPROVIDER - I/PF	1,309,019	254,280	94,593	89	41,452
43.00 04300	NURSERY	246,214	47,828	5,782	366	2,534
44.00 04400	SKILLED NURSING FACILITY	1,344,414	261,155	146,822	1,277	64,339
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	1,749,213	339,788	149,405	54,041	65,471
52.00 05200	DELIVERY ROOM & LABOR ROOM	148,764	28,898	0	0	0
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,976,503	383,940	128,404	103,966	56,268
60.00 06000	LABORATORY	2,617,765	508,512	56,218	7,145	24,635
65.00 06500	RESPIRATORY THERAPY	618,438	120,133	19,971	12,128	8,751
66.00 06600	PHYSICAL THERAPY	727,956	141,407	85,786	5,415	37,592
67.00 06700	OCCUPATIONAL THERAPY	509,437	98,959	3,748	0	1,642
68.00 06800	SPEECH PATHOLOGY	205,505	39,920	1,874	0	821
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	845,267	164,195	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	217,760	42,300	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	1,848,310	359,038	0	0	0
76.00 03020	OP PSYCH	283,265	55,025	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	188,997	36,713	52,202	115	22,876
90.01 09001	CLINIC - AMO	58,463	11,357	3,105	0	1,361
91.00 09100	EMERGENCY	1,761,751	342,224	66,123	486	28,976
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	1,102,957	214,252	57,864	1,485	0
97.00 09700	DURABLE MEDICAL EQUIP-SOLD	26,132	5,076	14,028	0	6,147
101.00 10100	HOME HEALTH AGENCY	485,919	94,391	146,273	65	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
116.00 11600	HOSPICE	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	35,398,993	5,631,317	1,593,035	224,584	605,978
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	23,604	4,585	15,420	0	6,757
194.00 07950	TITLE XX	31,960	6,208	0	0	0
194.01 07951	OTHER NRCC	1,939,010	376,657	84,086	602	14,582
194.02 07952	OTHER MOBS	266,703	51,808	0	0	0
194.03 07953	MONROE	616,638	119,783	22,942	0	0
194.04 07954	AMH SURGERY	35,089	6,816	0	0	0
194.05 07955	DFM - NON-PROVIDER BASED	407,204	79,100	0	0	0
194.06 07956	AMO - NON-PROVIDER BASED	684,726	133,009	15,500	0	0
200.00	Cross Foot Adjustments	0	0	0	0	0
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118-201)	39,403,927	6,409,283	1,730,983	225,186	627,317

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151330

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

Worksheet B  
Part I  
Date/Time Prepared:  
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Cost Center Description		UTILITIES - OFFSITE BLDGS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.03	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
7.01	00701						7.01
7.02	00702						7.02
7.03	00703						7.03
8.00	00800	118,283					8.00
9.00	00900	0	376,689				9.00
10.00	01000	0	63,541	801,155			10.00
11.00	01100	0	3,501	26,457	573,284		11.00
13.00	01300	0	13,000	24,509	0	1,084,097	13.00
14.00	01400	0	0	1,620	0	49,333	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	0	9,655	0	37,170	16.00
16.00	01600	0	0	20,627	0	32,476	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	59,311	130,704	246,303	136,367	30.00
31.00	03100	0	12,786	25,660	33,466	40,061	31.00
40.00	04000	0	14,632	45,425	100,857	77,462	40.00
43.00	04300	0	0	2,777	0	12,274	43.00
44.00	04400	0	44,799	70,507	192,658	84,594	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	50,178	71,747	0	67,899	50.00
52.00	05200	0	7,548	0	0	7,693	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	21,851	61,662	0	70,608	54.00
60.00	06000	0	184	26,997	0	90,512	60.00
65.00	06500	0	10,885	9,590	0	43,569	65.00
66.00	06600	0	15,832	41,196	0	50,286	66.00
67.00	06700	0	0	1,800	0	21,898	67.00
68.00	06800	0	0	900	0	8,127	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03020	0	3,324	0	0	17,601	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	830	25,068	0	4,857	90.00
90.01	09001	0	21	1,491	0	1,621	90.01
91.00	09100	0	32,303	31,753	0	46,014	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	6,535	20,083	27,787	0	92,693	95.00
97.00	09700	0	0	6,736	0	0	97.00
101.00	10100	0	0	70,243	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	0	0	0	0	0	116.00
118.00		6,535	374,609	734,911	573,284	993,115	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	7,405	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	22,466	1,246	40,379	0	58,685	194.01
194.02	07952	89,282	0	0	0	0	194.02
194.03	07953	0	664	11,017	0	0	194.03
194.04	07954	0	170	0	0	0	194.04
194.05	07955	0	0	0	0	9,914	194.05
194.06	07956	0	0	7,443	0	22,383	194.06
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		118,283	376,689	801,155	573,284	1,084,097	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151330

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

Worksheet B  
Part I  
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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
7.01	00701						7.01
7.02	00702						7.02
7.03	00703						7.03
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	1,439,767					13.00
14.00	01400	0	0				14.00
15.00	01500	0	0	1,339,269			15.00
16.00	01600	0	0	0	1,068,235		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	415,646	0	0	327,080	4,837,057	30.00
31.00	03100	122,106	0	0	48,375	1,299,975	31.00
40.00	04000	236,106	0	0	23,971	2,197,886	40.00
43.00	04300	37,410	0	0	2,406	357,591	43.00
44.00	04400	257,843	0	0	11,344	2,479,752	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	206,958	0	0	66,434	2,821,134	50.00
52.00	05200	23,448	0	0	0	216,351	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	0	9,599	2,812,801	54.00
60.00	06000	0	0	0	0	3,331,968	60.00
65.00	06500	0	0	0	0	843,465	65.00
66.00	06600	0	0	0	0	1,105,470	66.00
67.00	06700	0	0	0	0	637,484	67.00
68.00	06800	0	0	0	0	257,147	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	1,009,462	71.00
72.00	07200	0	0	0	0	260,060	72.00
73.00	07300	0	0	1,339,269	0	3,546,617	73.00
76.00	03020	0	0	0	5,444	364,659	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	331,658	90.00
90.01	09001	0	0	0	0	77,419	90.01
91.00	09100	140,250	0	0	375,041	2,824,921	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	0	0	0	1,523,656	95.00
97.00	09700	0	0	0	0	58,119	97.00
101.00	10100	0	0	0	0	796,891	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	0	0	0	0	0	116.00
118.00		1,439,767	0	1,339,269	869,694	33,991,543	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	57,771	190.00
194.00	07950	0	0	0	0	38,168	194.00
194.01	07951	0	0	0	14,719	2,552,432	194.01
194.02	07952	0	0	0	183,822	591,615	194.02
194.03	07953	0	0	0	0	771,044	194.03
194.04	07954	0	0	0	0	42,075	194.04
194.05	07955	0	0	0	0	496,218	194.05
194.06	07956	0	0	0	0	863,061	194.06
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,439,767	0	1,339,269	1,068,235	39,403,927	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151330

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

Worksheet B  
Part I  
Date/Time Prepared:  
7/23/2013 10:17 am

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
2.01	00201	OTHER CAP		2.01
4.00	00400	EMPLOYEE BENEFITS		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
7.01	00701	BIO-MEDICAL		7.01
7.02	00702	UTILITIES - HOSPITAL		7.02
7.03	00703	UTILITIES - OFFSITE BLDGS		7.03
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	0	4,837,057
31.00	03100	INTENSIVE CARE UNIT	0	1,299,975
40.00	04000	SUBPROVIDER - IPF	0	2,197,886
43.00	04300	NURSERY	0	357,591
44.00	04400	SKILLED NURSING FACILITY	0	2,479,752
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	0	2,821,134
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	216,351
53.00	05300	ANESTHESIOLOGY	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,812,801
60.00	06000	LABORATORY	0	3,331,968
65.00	06500	RESPIRATORY THERAPY	0	843,465
66.00	06600	PHYSICAL THERAPY	0	1,105,470
67.00	06700	OCCUPATIONAL THERAPY	0	637,484
68.00	06800	SPEECH PATHOLOGY	0	257,147
69.00	06900	ELECTROCARDIOLOGY	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,009,462
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	260,060
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,546,617
76.00	03020	OP PSYCH	0	364,659
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000	CLINIC	0	331,658
90.01	09001	CLINIC - AMO	0	77,419
91.00	09100	EMERGENCY	0	2,824,921
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500	AMBULANCE SERVICES	0	1,523,656
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	58,119
101.00	10100	HOME HEALTH AGENCY	0	796,891
<b>SPECIAL PURPOSE COST CENTERS</b>				
116.00	11600	HOSPICE	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	33,991,543
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	57,771
194.00	07950	TITLE XX	0	38,168
194.01	07951	OTHER NRCC	0	2,552,432
194.02	07952	OTHER MOBS	0	591,615
194.03	07953	MONROE	0	771,044
194.04	07954	AMH SURGERY	0	42,075
194.05	07955	DFM - NON-PROVIDER BASED	0	496,218
194.06	07956	AMO - NON-PROVIDER BASED	0	863,061
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	39,403,927

COST ALLOCATION STATISTICS

Provider CCN: 151330

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

Worksheet Non-CMS W  
Date/Time Prepared:  
7/23/2013 10:17 am

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
2.01	OTHER CAP	30	SQUARE FEET	2.01
4.00	EMPLOYEE BENEFITS	4	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	30	SQUARE FEET	7.00
7.01	BIO-MEDICAL	32	COST	7.01
7.02	UTILITIES - HOSPITAL	1	SQUARE FEET	7.02
7.03	UTILITIES - OFFSITE BLDGS	33	COST	7.03
8.00	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	30	SQUARE FEET	9.00
10.00	DIETARY	10	MEALS SERVED	10.00
11.00	CAFETERIA	11	MEALS SERVED	11.00
13.00	NURSING ADMINISTRATION	13	DIRECT NURS. HRS.	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	14.00
15.00	PHARMACY	15	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	16	TIME SPENT	16.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151330

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

Worksheet B  
Part II  
Date/Time Prepared:  
7/23/2013 10:17 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP	OTHER CAP		
		1.00	2.00	2.01		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01 00201	OTHER CAP					2.01
4.00 00400	EMPLOYEE BENEFITS	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	444,306	0	17,850	462,156
7.00 00700	OPERATION OF PLANT	0	379,834	0	15,262	395,096
7.01 00701	BIO-MEDICAL	0	8,903	0	358	9,261
7.02 00702	UTILITIES - HOSPITAL	0	0	0	0	7.02
7.03 00703	UTILITIES - OFFSITE BLDGS	0	0	0	0	7.03
8.00 00800	LAUNDRY & LINEN SERVICE	0	68,549	0	2,754	71,303
9.00 00900	HOUSEKEEPING	0	14,773	0	594	15,367
10.00 01000	DIETARY	0	81,076	0	3,258	84,334
11.00 01100	CAFETERIA	0	75,108	0	3,018	78,126
13.00 01300	NURSING ADMINISTRATION	0	4,964	0	199	5,163
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	29,586	0	1,189	30,775
16.00 01600	MEDICAL RECORDS & LIBRARY	0	63,210	0	2,540	65,750
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	400,536	0	16,094	416,630
31.00 03100	INTENSIVE CARE UNIT	0	78,634	0	3,160	81,794
40.00 04000	SUBPROVIDER - IPF	0	139,205	0	5,593	144,798
43.00 04300	NURSERY	0	8,509	0	342	8,851
44.00 04400	SKILLED NURSING FACILITY	0	216,066	0	8,682	224,748
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	219,868	0	8,835	228,703
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	188,962	0	7,593	196,555
60.00 06000	LABORATORY	0	82,731	0	3,324	86,055
65.00 06500	RESPIRATORY THERAPY	0	29,389	0	1,181	30,570
66.00 06600	PHYSICAL THERAPY	0	126,244	0	5,073	131,317
67.00 06700	OCCUPATIONAL THERAPY	0	5,515	0	222	5,737
68.00 06800	SPEECH PATHOLOGY	0	2,758	0	111	2,869
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03020	OP PSYCH	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	76,822	0	3,087	79,909
90.01 09001	CLINIC - AMO	0	4,570	0	184	4,754
91.00 09100	EMERGENCY	0	97,307	0	3,910	101,217
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	0	0	3,422	3,422
97.00 09700	DURABLE MEDICAL EQUIP-SOLD	0	20,643	0	829	21,472
101.00 10100	HOME HEALTH AGENCY	0	0	0	8,649	8,649
<b>SPECIAL PURPOSE COST CENTERS</b>						
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,868,068	0	127,313	2,995,381
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22,692	0	912	23,604
194.00 07950	TITLE XX	0	0	0	0	194.00
194.01 07951	OTHER NRCC	0	48,969	0	4,972	53,941
194.02 07952	OTHER MOBS	0	0	0	0	194.02
194.03 07953	MONROE	0	0	0	1,357	1,357
194.04 07954	AMH SURGERY	0	0	0	0	194.04
194.05 07955	DFM - NON-PROVIDER BASED	0	0	0	0	194.05
194.06 07956	AMO - NON-PROVIDER BASED	0	0	0	917	917
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	2,939,729	0	135,471	3,075,200

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151330

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

Worksheet B Part II Date/Time Prepared: 7/23/2013 10:17 am

Cost Center Description		EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	BIO-MEDICAL	UTILITIES - HOSPITAL	
		4.00	5.00	7.00	7.01	7.02	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	OTHER CAP					2.01
4.00	00400	EMPLOYEE BENEFITS	0				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	462,156			5.00
7.00	00700	OPERATION OF PLANT	0	20,302	415,398		7.00
7.01	00701	BIO-MEDICAL	0	2,570	1,452	13,283	7.01
7.02	00702	UTILITIES - HOSPITAL	0	7,358	0	0	7,358
7.03	00703	UTILITIES - OFFSITE BLDGS	0	1,387	0	0	0
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,632	11,178	0	239
9.00	00900	HOUSEKEEPING	0	8,482	2,409	0	52
10.00	01000	DIETARY	0	5,443	13,221	0	283
11.00	01100	CAFETERIA	0	11,414	12,248	0	262
13.00	01300	NURSING ADMINISTRATION	0	16,232	809	0	17
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	0	14,820	4,825	0	103
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,182	10,308	0	221
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	36,278	65,316	2,189	1,399
31.00	03100	INTENSIVE CARE UNIT	0	11,022	12,823	53	275
40.00	04000	SUBPROVIDER - I/PF	0	18,335	22,700	5	486
43.00	04300	NURSERY	0	3,449	1,388	22	30
44.00	04400	SKILLED NURSING FACILITY	0	18,831	35,234	75	755
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	24,501	35,854	3,189	768
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,084	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	27,685	30,814	6,129	660
60.00	06000	LABORATORY	0	36,667	13,491	422	289
65.00	06500	RESPIRATORY THERAPY	0	8,662	4,793	716	103
66.00	06600	PHYSICAL THERAPY	0	10,196	20,587	319	441
67.00	06700	OCCUPATIONAL THERAPY	0	7,136	899	0	19
68.00	06800	SPEECH PATHOLOGY	0	2,879	450	0	10
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,840	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,050	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,889	0	0	0
76.00	03020	OP PSYCH	0	3,968	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	2,647	12,527	7	268
90.01	09001	CLINIC - AMO	0	819	745	0	16
91.00	09100	EMERGENCY	0	24,677	15,868	29	340
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	15,449	13,886	88	0
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	366	3,366	0	72
101.00	10100	HOME HEALTH AGENCY	0	6,806	35,102	4	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	406,058	382,293	13,247	7,108
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	331	3,700	0	79
194.00	07950	TITLE XX	0	448	0	0	0
194.01	07951	OTHER NRCC	0	27,160	20,179	36	171
194.02	07952	OTHER MOBS	0	3,736	0	0	0
194.03	07953	MONROE	0	8,637	5,506	0	0
194.04	07954	AMH SURGERY	0	491	0	0	0
194.05	07955	DFM - NON-PROVIDER BASED	0	5,704	0	0	0
194.06	07956	AMO - NON-PROVIDER BASED	0	9,591	3,720	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	0	462,156	415,398	13,283	7,358

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet B Part II Date/Time Prepared: 7/23/2013 10:17 am			
Cost Center Description		UTILITIES - OFFSITE BLDGS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.03	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	OTHER CAP					2.01
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	BIO-MEDICAL					7.01
7.02	00702	UTILITIES - HOSPITAL					7.02
7.03	00703	UTILITIES - OFFSITE BLDGS	1,387				7.03
8.00	00800	LAUNDRY & LINEN SERVICE	0	86,352			8.00
9.00	00900	HOUSEKEEPING	0	14,567	40,877		9.00
10.00	01000	DIETARY	0	803	1,350	105,434	10.00
11.00	01100	CAFETERIA	0	2,980	1,251	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	83	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	493	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,052	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	13,596	6,668	45,298	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,931	1,309	6,155	31.00
40.00	04000	SUBPROVIDER - I PF	0	3,354	2,318	18,549	40.00
43.00	04300	NURSERY	0	0	142	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	10,270	3,597	35,432	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	11,503	3,661	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,730	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,009	3,146	0	54.00
60.00	06000	LABORATORY	0	42	1,377	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,495	489	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,629	2,102	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	92	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	46	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	OP PSYCH	0	762	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	190	1,279	0	90.00
90.01	09001	CLINIC - AMO	0	5	76	0	90.01
91.00	09100	EMERGENCY	0	7,405	1,620	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	4,511	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	77	4,604	1,418	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	344	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	3,584	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	77	85,875	37,497	105,434	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	378	0	190.00
194.00	07950	TITLE XX	0	0	0	0	194.00
194.01	07951	OTHER NRCC	263	286	2,060	0	194.01
194.02	07952	OTHER MOBS	1,047	0	0	0	194.02
194.03	07953	MONROE	0	152	562	0	194.03
194.04	07954	AMH SURGERY	0	39	0	0	194.04
194.05	07955	DFM - NON-PROVIDER BASED	0	0	0	972	194.05
194.06	07956	AMO - NON-PROVIDER BASED	0	0	380	2,194	194.06
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,387	86,352	40,877	105,434	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151330

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

Worksheet B Part II Date/Time Prepared: 7/23/2013 10:17 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal		
		13.00	14.00	15.00	16.00	24.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00	
2.01	00201	OTHER CAP					2.01	
4.00	00400	EMPLOYEE BENEFITS					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT					7.00	
7.01	00701	BIO-MEDICAL					7.01	
7.02	00702	UTILITIES - HOSPITAL					7.02	
7.03	00703	UTILITIES - OFFSITE BLDGS					7.03	
8.00	00800	LAUNDRY & LINEN SERVICE					8.00	
9.00	00900	HOUSEKEEPING					9.00	
10.00	01000	DIETARY					10.00	
11.00	01100	CAFETERIA					11.00	
13.00	01300	NURSING ADMINISTRATION	27,140				13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0			14.00	
15.00	01500	PHARMACY	0	0	54,660		15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	91,697	16.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	7,835	0	0	28,077	636,656	30.00
31.00	03100	INTENSIVE CARE UNIT	2,302	0	0	4,153	126,744	31.00
40.00	04000	SUBPROVIDER - IPF	4,451	0	0	2,058	224,648	40.00
43.00	04300	NURSERY	705	0	0	207	15,997	43.00
44.00	04400	SKILLED NURSING FACILITY	4,860	0	0	974	343,069	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	3,901	0	0	5,703	324,440	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	442	0	0	0	5,010	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	824	277,744	54.00
60.00	06000	LABORATORY	0	0	0	0	147,217	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	52,099	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	173,521	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	16,030	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	7,051	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	11,840	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	3,050	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	54,660	0	80,549	73.00
76.00	03020	OP PSYCH	0	0	0	467	6,923	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	97,303	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	6,574	90.01
91.00	09100	EMERGENCY	2,644	0	0	32,192	190,503	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	48,031	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	25,620	97.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	54,145	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,140	0	54,660	74,655	2,874,764	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	28,092	190.00
194.00	07950	TITLE XX	0	0	0	0	448	194.00
194.01	07951	OTHER NRCC	0	0	0	1,263	111,112	194.01
194.02	07952	OTHER MOBS	0	0	0	15,779	20,562	194.02
194.03	07953	MONROE	0	0	0	0	16,214	194.03
194.04	07954	AMH SURGERY	0	0	0	0	530	194.04
194.05	07955	DFM - NON-PROVIDER BASED	0	0	0	0	6,676	194.05
194.06	07956	AMO - NON-PROVIDER BASED	0	0	0	0	16,802	194.06
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	27,140	0	54,660	91,697	3,075,200	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet B Part II Date/Time Prepared: 7/23/2013 10:17 am
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
2.01	00201	OTHER CAP		2.01
4.00	00400	EMPLOYEE BENEFITS		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
7.01	00701	BIO-MEDICAL		7.01
7.02	00702	UTILITIES - HOSPITAL		7.02
7.03	00703	UTILITIES - OFFSITE BLDGS		7.03
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03020	OP PSYCH	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000	CLINIC	0	90.00
90.01	09001	CLINIC - AMO	0	90.01
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500	AMBULANCE SERVICES	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
116.00	11600	HOSPICE	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
194.00	07950	TITLE XX	0	194.00
194.01	07951	OTHER NRCC	0	194.01
194.02	07952	OTHER MOBS	0	194.02
194.03	07953	MONROE	0	194.03
194.04	07954	AMH SURGERY	0	194.04
194.05	07955	DFM - NON-PROVIDER BASED	0	194.05
194.06	07956	AMO - NON-PROVIDER BASED	0	194.06
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118-201)	0	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151330

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

Worksheet B-1

Date/Time Prepared:  
7/23/2013 10:17 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	OTHER CAP (SQUARE FEET)			
	1.00	2.00	2.01			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	149,241				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		0			2.00
2.01 00201	OTHER CAP		0	171,160		2.01
4.00 00400	EMPLOYEE BENEFITS	0	0	0	17,569,211	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	22,556	0	22,556	824,335	-6,409,283
7.00 00700	OPERATION OF PLANT	19,283	0	19,283	306,628	0
7.01 00701	BIO-MEDICAL	452	0	452	52,553	0
7.02 00702	UTILITIES - HOSPITAL	0	0	0	0	0
7.03 00703	UTILITIES - OFFSITE BLDGS	0	0	0	0	0
8.00 00800	LAUNDRY & LINEN SERVICE	3,480	0	3,480	38,235	0
9.00 00900	HOUSEKEEPING	750	0	750	379,615	0
10.00 01000	DIETARY	4,116	0	4,116	124,396	0
11.00 01100	CAFETERIA	3,813	0	3,813	462,461	0
13.00 01300	NURSING ADMINISTRATION	252	0	252	747,517	0
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00 01500	PHARMACY	1,502	0	1,502	669,419	0
16.00 01600	MEDICAL RECORDS & LIBRARY	3,209	0	3,209	437,640	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	20,334	0	20,334	1,522,576	0
31.00 03100	INTENSIVE CARE UNIT	3,992	0	3,992	525,771	0
40.00 04000	SUBPROVIDER - IPF	7,067	0	7,067	813,107	0
43.00 04300	NURSERY	432	0	432	168,392	0
44.00 04400	SKILLED NURSING FACILITY	10,969	0	10,969	817,650	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	11,162	0	11,162	712,029	0
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	105,538	0
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	9,593	0	9,593	825,018	0
60.00 06000	LABORATORY	4,200	0	4,200	897,414	0
65.00 06500	RESPIRATORY THERAPY	1,492	0	1,492	455,524	0
66.00 06600	PHYSICAL THERAPY	6,409	0	6,409	388,255	0
67.00 06700	OCCUPATIONAL THERAPY	280	0	280	367,607	0
68.00 06800	SPEECH PATHOLOGY	140	0	140	145,527	0
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00 03020	OP PSYCH	0	0	0	184,752	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	3,900	0	3,900	152,123	0
90.01 09001	CLINIC - AMO	232	0	232	115,088	0
91.00 09100	EMERGENCY	4,940	0	4,940	1,816,130	0
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	0	4,323	722,237	0
97.00 09700	DURABLE MEDICAL EQUIP-SOLD	1,048	0	1,048	0	0
101.00 10100	HOME HEALTH AGENCY	0	0	10,928	335,479	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
116.00 11600	HOSPICE	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	145,603	0	160,854	15,113,016	-6,409,283
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,152	0	1,152	0	0
194.00 07950	TITLE XX	0	0	0	21,133	0
194.01 07951	OTHER NRCC	2,486	0	6,282	1,295,096	0
194.02 07952	OTHER MOBS	0	0	0	0	0
194.03 07953	MONROE	0	0	1,714	426,207	0
194.04 07954	AMH SURGERY	0	0	0	126,179	0
194.05 07955	DFM - NON-PROVIDER BASED	0	0	0	189,920	0
194.06 07956	AMO - NON-PROVIDER BASED	0	0	1,158	397,660	0
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)	2,939,729	0	135,471	5,605,166	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	19.697865	0.000000	0.791487	0.319033	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)				0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)				0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151330

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

Worksheet B-1

Date/Time Prepared:  
7/23/2013 10:17 am

Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	BIO-MEDICAL (COST)	UTILITIES - HOSPITAL (SQUARE FEET)	UTILITIES - OFFSITE BLDGS (COST)	
		5.00	7.00	7.01	7.02	7.03	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 OTHER CAP						2.01
4.00	00400 EMPLOYEE BENEFITS						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	32,994,644					5.00
7.00	00700 OPERATION OF PLANT	1,449,429	129,321				7.00
7.01	00701 BIO-MEDICAL	183,492	452	10,881,768			7.01
7.02	00702 UTILITIES - HOSPITAL	525,280	0	0	106,950		7.02
7.03	00703 UTILITIES - OFFSITE BLDGS	99,044	0	0	0	103,229	7.03
8.00	00800 LAUNDRY & LINEN SERVICE	259,323	3,480	0	3,480	0	8.00
9.00	00900 HOUSEKEEPING	605,547	750	0	750	0	9.00
10.00	01000 DIETARY	388,604	4,116	0	4,116	0	10.00
11.00	01100 CAFETERIA	814,891	3,813	0	3,813	0	11.00
13.00	01300 NURSING ADMINISTRATION	1,158,853	252	0	252	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500 PHARMACY	1,058,009	1,502	0	1,502	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	798,288	3,209	0	3,209	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	2,589,988	20,334	1,793,090	20,334	0	30.00
31.00	03100 INTENSIVE CARE UNIT	786,913	3,992	43,469	3,992	0	31.00
40.00	04000 SUBPROVIDER - IPF	1,309,019	7,067	4,306	7,067	0	40.00
43.00	04300 NURSERY	246,214	432	17,701	432	0	43.00
44.00	04400 SKILLED NURSING FACILITY	1,344,414	10,969	61,732	10,969	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	1,749,213	11,162	2,611,451	11,162	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	148,764	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,976,503	9,593	5,024,043	9,593	0	54.00
60.00	06000 LABORATORY	2,617,765	4,200	345,272	4,200	0	60.00
65.00	06500 RESPIRATORY THERAPY	618,438	1,492	586,042	1,492	0	65.00
66.00	06600 PHYSICAL THERAPY	727,956	6,409	261,650	6,409	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	509,437	280	0	280	0	67.00
68.00	06800 SPEECH PATHOLOGY	205,505	140	0	140	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	845,267	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	217,760	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,848,310	0	0	0	0	73.00
76.00	03020 OP PSYCH	283,265	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	188,997	3,900	5,551	3,900	0	90.00
90.01	09001 CLINIC - AMO	58,463	232	0	232	0	90.01
91.00	09100 EMERGENCY	1,761,751	4,940	23,487	4,940	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	1,102,957	4,323	71,747	0	5,703	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	26,132	1,048	0	1,048	0	97.00
101.00	10100 HOME HEALTH AGENCY	485,919	10,928	3,131	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600 HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	28,989,710	119,015	10,852,672	103,312	5,703	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	23,604	1,152	0	1,152	0	190.00
194.00	07950 TITLE XX	31,960	0	0	0	0	194.00
194.01	07951 OTHER NRCC	1,939,010	6,282	29,096	2,486	19,607	194.01
194.02	07952 OTHER MOBS	266,703	0	0	0	77,919	194.02
194.03	07953 MONROE	616,638	1,714	0	0	0	194.03
194.04	07954 AMH SURGERY	35,089	0	0	0	0	194.04
194.05	07955 DFM - NON-PROVIDER BASED	407,204	0	0	0	0	194.05
194.06	07956 AMO - NON-PROVIDER BASED	684,726	1,158	0	0	0	194.06
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)	6,409,283	1,730,983	225,186	627,317	118,283	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.194252	13.385166	0.020694	5.865517	1.145831	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	462,156	415,398	13,283	7,358	1,387	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.014007	3.212147	0.001221	0.068799	0.013436	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151330

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

Worksheet B-1

Date/Time Prepared:  
7/23/2013 10:17 am

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		8.00	9.00	10.00	11.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
7.01	00701						7.01
7.02	00702						7.02
7.03	00703						7.03
8.00	00800	237,048					8.00
9.00	00900	39,985	124,639				9.00
10.00	01000	2,203	4,116	37,413			10.00
11.00	01100	8,181	3,813	0	509,563		11.00
13.00	01300	0	252	0	23,188	222,027	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	1,502	0	17,471	0	15.00
16.00	01600	0	3,209	0	15,265	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	37,324	20,334	16,074	64,097	64,097	30.00
31.00	03100	8,046	3,992	2,184	18,830	18,830	31.00
40.00	04000	9,208	7,067	6,582	36,410	36,410	40.00
43.00	04300	0	432	0	5,769	5,769	43.00
44.00	04400	28,192	10,969	12,573	39,762	39,762	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	31,577	11,162	0	31,915	31,915	50.00
52.00	05200	4,750	0	0	3,616	3,616	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	13,751	9,593	0	33,188	0	54.00
60.00	06000	116	4,200	0	42,544	0	60.00
65.00	06500	6,850	1,492	0	20,479	0	65.00
66.00	06600	9,963	6,409	0	23,636	0	66.00
67.00	06700	0	280	0	10,293	0	67.00
68.00	06800	0	140	0	3,820	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03020	2,092	0	0	8,273	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	522	3,900	0	2,283	0	90.00
90.01	09001	13	232	0	762	0	90.01
91.00	09100	20,328	4,940	0	21,628	21,628	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	12,638	4,323	0	43,569	0	95.00
97.00	09700	0	1,048	0	0	0	97.00
101.00	10100	0	10,928	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	0	0	0	0	0	116.00
118.00		235,739	114,333	37,413	466,798	222,027	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	1,152	0	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	784	6,282	0	27,584	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	418	1,714	0	0	0	194.03
194.04	07954	107	0	0	0	0	194.04
194.05	07955	0	0	0	4,660	0	194.05
194.06	07956	0	1,158	0	10,521	0	194.06
200.00							200.00
201.00							201.00
202.00		376,689	801,155	573,284	1,084,097	1,439,767	202.00
203.00		1.589083	6.427803	15.323123	2.127503	6.484648	203.00
204.00		86,352	40,877	105,434	106,281	27,140	204.00
205.00		0.364281	0.327963	2.818111	0.208573	0.122237	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151330

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

Worksheet B-1

Date/Time Prepared:  
7/23/2013 10:17 am

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201 OTHER CAP				2.01
4.00	00400 EMPLOYEE BENEFITS				4.00
5.00	00500 ADMINISTRATIVE & GENERAL				5.00
7.00	00700 OPERATION OF PLANT				7.00
7.01	00701 BIO-MEDICAL				7.01
7.02	00702 UTILITIES - HOSPITAL				7.02
7.03	00703 UTILITIES - OFFSITE BLDGS				7.03
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00	00900 HOUSEKEEPING				9.00
10.00	01000 DIETARY				10.00
11.00	01100 CAFETERIA				11.00
13.00	01300 NURSING ADMINISTRATION				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	1,063,027			14.00
15.00	01500 PHARMACY	0	100		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	846,674	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS	0	0	259,241	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	38,342	31.00
40.00	04000 SUBPROVIDER - IPF	0	0	18,999	40.00
43.00	04300 NURSERY	0	0	1,907	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	8,991	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0	0	52,655	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	7,608	54.00
60.00	06000 LABORATORY	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	845,267	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	217,760	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	100	0	73.00
76.00	03020 OP PSYCH	0	0	4,315	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 CLINIC - AMO	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	297,254	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES	0	0	0	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	97.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
116.00	11600 HOSPICE	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,063,027	100	689,312	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
194.00	07950 TITLE XX	0	0	0	194.00
194.01	07951 OTHER NRCC	0	0	11,666	194.01
194.02	07952 OTHER MOBS	0	0	145,696	194.02
194.03	07953 MONROE	0	0	0	194.03
194.04	07954 AMH SURGERY	0	0	0	194.04
194.05	07955 DFM - NON-PROVIDER BASED	0	0	0	194.05
194.06	07956 AMO - NON-PROVIDER BASED	0	0	0	194.06
200.00	Cross Foot Adjustments				200.00
201.00	Negative Cost Centers				201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	1,339,269	1,068,235	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	13,392.690000	1.261684	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	54,660	91,697	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	546.600000	0.108303	205.00

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COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 7/23/2013 10:17 am
		Title XVIII	Hospital	Cost

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		4,837,057	0	4,837,057	30.00
31.00	03100 INTENSIVE CARE UNIT		1,299,975	0	1,299,975	31.00
40.00	04000 SUBPROVIDER - I/PF		2,197,886	0	2,197,886	40.00
43.00	04300 NURSERY		357,591	0	357,591	43.00
44.00	04400 SKILLED NURSING FACILITY		2,479,752	0	2,479,752	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		2,821,134	0	2,821,134	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		216,351	0	216,351	52.00
53.00	05300 ANESTHESIOLOGY		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		2,812,801	0	2,812,801	54.00
60.00	06000 LABORATORY		3,331,968	0	3,331,968	60.00
65.00	06500 RESPIRATORY THERAPY	0	843,465	0	843,465	65.00
66.00	06600 PHYSICAL THERAPY	0	1,105,470	0	1,105,470	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	637,484	0	637,484	67.00
68.00	06800 SPEECH PATHOLOGY	0	257,147	0	257,147	68.00
69.00	06900 ELECTROCARDIOLOGY		0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1,009,462	0	1,009,462	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		260,060	0	260,060	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		3,546,617	0	3,546,617	73.00
76.00	03020 OP PSYCH		364,659	0	364,659	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC		331,658	0	331,658	90.00
90.01	09001 CLINIC - AMO		77,419	0	77,419	90.01
91.00	09100 EMERGENCY		2,824,921	0	2,824,921	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		578,107		578,107	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES		1,523,656	0	1,523,656	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD		58,119	0	58,119	97.00
101.00	10100 HOME HEALTH AGENCY		796,891		796,891	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
116.00	11600 HOSPICE		0		0	116.00
200.00	Subtotal (see instructions)		34,569,650	0	34,569,650	200.00
201.00	Less Observation Beds		578,107		578,107	201.00
202.00	Total (see instructions)		33,991,543	0	33,991,543	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151330

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

Worksheet C  
Part I  
Date/Time Prepared:  
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		Title XVIIII			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	5,793,203		5,793,203		30.00
31.00	03100	INTENSIVE CARE UNIT	1,527,085		1,527,085		31.00
40.00	04000	SUBPROVIDER - IPF	3,057,108		3,057,108		40.00
43.00	04300	NURSERY	254,256		254,256		43.00
44.00	04400	SKILLED NURSING FACILITY	1,995,950		1,995,950		44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	1,476,159	4,549,149	6,025,308	0.468214	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	111,279	48,073	159,352	1.357692	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,834,608	14,772,864	16,607,472	0.169370	54.00
60.00	06000	LABORATORY	2,939,462	12,912,424	15,851,886	0.210194	60.00
65.00	06500	RESPIRATORY THERAPY	3,745,503	1,738,447	5,483,950	0.153806	65.00
66.00	06600	PHYSICAL THERAPY	930,478	1,131,502	2,061,980	0.536121	66.00
67.00	06700	OCCUPATIONAL THERAPY	574,548	1,259,146	1,833,694	0.347650	67.00
68.00	06800	SPEECH PATHOLOGY	124,705	492,996	617,701	0.416297	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,015,602	291,166	2,306,768	0.437609	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	701,629	319,089	1,020,718	0.254781	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,245,954	4,105,714	9,351,668	0.379250	73.00
76.00	03020	OP PSYCH	0	694,629	694,629	0.524969	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	15,797	207,702	223,499	1.483935	90.00
90.01	09001	CLINIC - AMO	0	417,956	417,956	0.185232	90.01
91.00	09100	EMERGENCY	77,094	2,793,327	2,870,421	0.984149	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,079,558	1,079,558	0.535503	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	75	2,623,896	2,623,971	0.580668	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	217	217	267.829493	97.00
101.00	10100	HOME HEALTH AGENCY	0	287,345	287,345		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	HOSPICE	0	0	0		116.00
200.00		Subtotal (see instructions)	32,420,495	49,725,200	82,145,695		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	32,420,495	49,725,200	82,145,695		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 7/23/2013 10:17 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital Cost
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.468214		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.357692		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.169370		54.00
60.00	06000 LABORATORY	0.210194		60.00
65.00	06500 RESPIRATORY THERAPY	0.153806		65.00
66.00	06600 PHYSICAL THERAPY	0.536121		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.347650		67.00
68.00	06800 SPEECH PATHOLOGY	0.416297		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.437609		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.254781		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.379250		73.00
76.00	03020 OP PSYCH	0.524969		76.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	1.483935		90.00
90.01	09001 CLINIC - AMO	0.185232		90.01
91.00	09100 EMERGENCY	0.984149		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.535503		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0.580668		95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	267.829493		97.00
101.00	10100 HOME HEALTH AGENCY			101.00
	SPECIAL PURPOSE COST CENTERS			
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 7/23/2013 10:17 am
		Title XIX	Hospital	PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		4,837,057	0	4,837,057	30.00
31.00	03100 INTENSIVE CARE UNIT		1,299,975	0	1,299,975	31.00
40.00	04000 SUBPROVIDER - I/PF		2,197,886	0	2,197,886	40.00
43.00	04300 NURSERY		357,591	0	357,591	43.00
44.00	04400 SKILLED NURSING FACILITY		2,479,752	0	2,479,752	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		2,821,134	0	2,821,134	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		216,351	0	216,351	52.00
53.00	05300 ANESTHESIOLOGY		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		2,812,801	0	2,812,801	54.00
60.00	06000 LABORATORY		3,331,968	0	3,331,968	60.00
65.00	06500 RESPIRATORY THERAPY	0	843,465	0	843,465	65.00
66.00	06600 PHYSICAL THERAPY	0	1,105,470	0	1,105,470	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	637,484	0	637,484	67.00
68.00	06800 SPEECH PATHOLOGY	0	257,147	0	257,147	68.00
69.00	06900 ELECTROCARDIOLOGY		0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1,009,462	0	1,009,462	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		260,060	0	260,060	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		3,546,617	0	3,546,617	73.00
76.00	03020 OP PSYCH		364,659	0	364,659	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC		331,658	0	331,658	90.00
90.01	09001 CLINIC - AMO		77,419	0	77,419	90.01
91.00	09100 EMERGENCY		2,824,921	0	2,824,921	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		578,107		578,107	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES		1,523,656	0	1,523,656	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD		58,119	0	58,119	97.00
101.00	10100 HOME HEALTH AGENCY		796,891		796,891	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
116.00	11600 HOSPICE		0		0	116.00
200.00	Subtotal (see instructions)		34,569,650	0	34,569,650	200.00
201.00	Less Observation Beds		578,107		578,107	201.00
202.00	Total (see instructions)		33,991,543	0	33,991,543	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151330

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

Worksheet C  
Part I  
Date/Time Prepared:  
7/23/2013 10:17 am

		Title XIX			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	5,793,203		5,793,203		30.00
31.00	03100	INTENSIVE CARE UNIT	1,527,085		1,527,085		31.00
40.00	04000	SUBPROVIDER - IPF	3,057,108		3,057,108		40.00
43.00	04300	NURSERY	254,256		254,256		43.00
44.00	04400	SKILLED NURSING FACILITY	1,995,950		1,995,950		44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	1,476,159	4,549,149	6,025,308	0.468214	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	111,279	48,073	159,352	1.357692	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,834,608	14,772,864	16,607,472	0.169370	54.00
60.00	06000	LABORATORY	2,939,462	12,912,424	15,851,886	0.210194	60.00
65.00	06500	RESPIRATORY THERAPY	3,745,503	1,738,447	5,483,950	0.153806	65.00
66.00	06600	PHYSICAL THERAPY	930,478	1,131,502	2,061,980	0.536121	66.00
67.00	06700	OCCUPATIONAL THERAPY	574,548	1,259,146	1,833,694	0.347650	67.00
68.00	06800	SPEECH PATHOLOGY	124,705	492,996	617,701	0.416297	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,015,602	291,166	2,306,768	0.437609	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	701,629	319,089	1,020,718	0.254781	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,245,954	4,105,714	9,351,668	0.379250	73.00
76.00	03020	OP PSYCH	0	694,629	694,629	0.524969	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	15,797	207,702	223,499	1.483935	90.00
90.01	09001	CLINIC - AMO	0	417,956	417,956	0.185232	90.01
91.00	09100	EMERGENCY	77,094	2,793,327	2,870,421	0.984149	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,079,558	1,079,558	0.535503	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	75	2,623,896	2,623,971	0.580668	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	217	217	267.829493	97.00
101.00	10100	HOME HEALTH AGENCY	0	287,345	287,345		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	HOSPICE	0	0	0		116.00
200.00		Subtotal (see instructions)	32,420,495	49,725,200	82,145,695		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	32,420,495	49,725,200	82,145,695		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 7/23/2013 10:17 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.468214		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.357692		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.169370		54.00
60.00	06000 LABORATORY	0.210194		60.00
65.00	06500 RESPIRATORY THERAPY	0.153806		65.00
66.00	06600 PHYSICAL THERAPY	0.536121		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.347650		67.00
68.00	06800 SPEECH PATHOLOGY	0.416297		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.437609		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.254781		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.379250		73.00
76.00	03020 OP PSYCH	0.524969		76.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	1.483935		90.00
90.01	09001 CLINIC - AMO	0.185232		90.01
91.00	09100 EMERGENCY	0.984149		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.535503		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0.580668		95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	267.829493		97.00
101.00	10100 HOME HEALTH AGENCY			101.00
	SPECIAL PURPOSE COST CENTERS			
116.00	11600 HOSPICE			116.00
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: 151330

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

Worksheet C Part II Date/Time Prepared: 7/23/2013 10:17 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	05000 OPERATING ROOM	2,821,134	324,440	2,496,694	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	216,351	5,010	211,341	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,812,801	277,744	2,535,057	0	0	54.00
60.00	06000 LABORATORY	3,331,968	147,217	3,184,751	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	843,465	52,099	791,366	0	0	65.00
66.00	06600 PHYSICAL THERAPY	1,105,470	173,521	931,949	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	637,484	16,030	621,454	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	257,147	7,051	250,096	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,009,462	11,840	997,622	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	260,060	3,050	257,010	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,546,617	80,549	3,466,068	0	0	73.00
76.00	03020 OP PSYCH	364,659	6,923	357,736	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	331,658	97,303	234,355	0	0	90.00
90.01	09001 CLINIC - AMO	77,419	6,574	70,845	0	0	90.01
91.00	09100 EMERGENCY	2,824,921	190,503	2,634,418	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	578,107	0	578,107	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	1,523,656	48,031	1,475,625	0	0	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	58,119	25,620	32,499	0	0	97.00
101.00	10100 HOME HEALTH AGENCY	796,891	54,145	742,746	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600 HOSPICE	0	0	0	0	0	116.00
200.00	Subtotal (sum of lines 50 thru 199)	23,397,389	1,527,650	21,869,739	0	0	200.00
201.00	Less Observation Beds	578,107	0	578,107	0	0	201.00
202.00	Total (line 200 minus line 201)	22,819,282	1,527,650	21,291,632	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part II Date/Time Prepared: 7/23/2013 10:17 am
		Title XIX		Hospital
				PPS

Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
	6.00	7.00	8.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	2,821,134	6,025,308	0.468214	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	216,351	159,352	1.357692	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	2,812,801	16,607,472	0.169370	54.00
60.00 06000 LABORATORY	3,331,968	15,851,886	0.210194	60.00
65.00 06500 RESPIRATORY THERAPY	843,465	5,483,950	0.153806	65.00
66.00 06600 PHYSICAL THERAPY	1,105,470	2,061,980	0.536121	66.00
67.00 06700 OCCUPATIONAL THERAPY	637,484	1,833,694	0.347650	67.00
68.00 06800 SPEECH PATHOLOGY	257,147	617,701	0.416297	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,009,462	2,306,768	0.437609	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	260,060	1,020,718	0.254781	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3,546,617	9,351,668	0.379250	73.00
76.00 03020 OP PSYCH	364,659	694,629	0.524969	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	331,658	223,499	1.483935	90.00
90.01 09001 CLINIC - AMO	77,419	417,956	0.185232	90.01
91.00 09100 EMERGENCY	2,824,921	2,870,421	0.984149	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	578,107	1,079,558	0.535503	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00 09500 AMBULANCE SERVICES	1,523,656	2,623,971	0.580668	95.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	58,119	217	267.829493	97.00
101.00 10100 HOME HEALTH AGENCY	796,891	287,345	2.773290	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
116.00 11600 HOSPICE	0	0	0.000000	116.00
200.00	Subtotal (sum of lines 50 thru 199)	23,397,389	69,518,093	200.00
201.00	Less Observation Beds	578,107	0	201.00
202.00	Total (line 200 minus line 201)	22,819,282	69,518,093	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151330

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

Worksheet D  
Part II  
Date/Time Prepared:  
7/23/2013 10:17 am

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	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	05000 OPERATING ROOM	324,440	6,025,308	0.053846	225,718	12,154	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	5,010	159,352	0.031440	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	277,744	16,607,472	0.016724	600,479	10,042	54.00
60.00	06000 LABORATORY	147,217	15,851,886	0.009287	1,151,297	10,692	60.00
65.00	06500 RESPIRATORY THERAPY	52,099	5,483,950	0.009500	972,112	9,235	65.00
66.00	06600 PHYSICAL THERAPY	173,521	2,061,980	0.084153	118,706	9,989	66.00
67.00	06700 OCCUPATIONAL THERAPY	16,030	1,833,694	0.008742	48,697	426	67.00
68.00	06800 SPEECH PATHOLOGY	7,051	617,701	0.011415	42,706	487	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11,840	2,306,768	0.005133	1,568,002	8,049	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	3,050	1,020,718	0.002988	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	80,549	9,351,668	0.008613	1,891,098	16,288	73.00
76.00	03020 OP PSYCH	6,923	694,629	0.009966	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	97,303	223,499	0.435362	0	0	90.00
90.01	09001 CLINIC - AMO	6,574	417,956	0.015729	0	0	90.01
91.00	09100 EMERGENCY	190,503	2,870,421	0.066368	2,805	186	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,079,558	0.000000	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	25,620	217	118.064516	0	0	97.00
200.00	Total (lines 50-199)	1,425,474	66,606,777		6,621,620	77,548	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330

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

Worksheet D  
Part IV  
Date/Time Prepared:  
7/23/2013 10:17 am

Cost Center Description		Title XVIII				Hospital		Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost			
		1.00	2.00	3.00	4.00	5.00			
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00	03020	OP PSYCH	0	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>									
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	0	97.00
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: 151330

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

Worksheet D  
Part IV  
Date/Time Prepared:  
7/23/2013 10:17 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Cost
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	6,025,308	0.000000	0.000000	225,718	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	159,352	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	16,607,472	0.000000	0.000000	600,479	54.00
60.00	06000 LABORATORY	0	15,851,886	0.000000	0.000000	1,151,297	60.00
65.00	06500 RESPIRATORY THERAPY	0	5,483,950	0.000000	0.000000	972,112	65.00
66.00	06600 PHYSICAL THERAPY	0	2,061,980	0.000000	0.000000	118,706	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,833,694	0.000000	0.000000	48,697	67.00
68.00	06800 SPEECH PATHOLOGY	0	617,701	0.000000	0.000000	42,706	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,306,768	0.000000	0.000000	1,568,002	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	1,020,718	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	9,351,668	0.000000	0.000000	1,891,098	73.00
76.00	03020 OP PSYCH	0	694,629	0.000000	0.000000	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	223,499	0.000000	0.000000	0	90.00
90.01	09001 CLINIC - AMO	0	417,956	0.000000	0.000000	0	90.01
91.00	09100 EMERGENCY	0	2,870,421	0.000000	0.000000	2,805	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,079,558	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	217	0.000000	0.000000	0	97.00
200.00	Total (lines 50-199)	0	66,606,777			6,621,620	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330

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

Worksheet D  
Part IV  
Date/Time Prepared:  
7/23/2013 10:17 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	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OP PSYCH	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
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: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 7/23/2013 10:17 am
	Title XVIII	Hospital	Cost

Cost Center Description	PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost		
	23.00	24.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00 06000 LABORATORY	0	0		60.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00 03020 OP PSYCH	0	0		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 CLINIC - AMO	0	0		90.01
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00 09500 AMBULANCE SERVICES				95.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00 Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 7/23/2013 10:17 am
	Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0.468214	0	1,105,246	0	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	1.357692	0	166	0	0
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.169370	0	3,399,363	0	0
60.00 06000 LABORATORY	0.210194	0	1,380,443	0	0
65.00 06500 RESPIRATORY THERAPY	0.153806	0	1,097,840	0	0
66.00 06600 PHYSICAL THERAPY	0.536121	0	567,130	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.347650	0	208,514	0	0
68.00 06800 SPEECH PATHOLOGY	0.416297	0	59,654	0	0
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.437609	0	501,902	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.254781	0	56,202	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.379250	0	1,358,342	1,942	0
76.00 03020 OP PSYCH	0.524969	0	89,003	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000 CLINIC	1.483935	0	0	0	0
90.01 09001 CLINIC - AMO	0.185232	0	29,757	1,435	0
91.00 09100 EMERGENCY	0.984149	0	687,315	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.535503	0	426,206	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00 09500 AMBULANCE SERVICES	0.580668	0	0	0	0
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	267.829493	0	0	0	0
200.00 Subtotal (see instructions)		0	10,967,083	3,377	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00 Net Charges (line 200 +/- line 201)		0	10,967,083	3,377	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 7/23/2013 10:17 am
		Title XVIII	Hospital	Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	517,492	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	225	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	575,750	0	54.00
60.00	06000 LABORATORY	290,161	0	60.00
65.00	06500 RESPIRATORY THERAPY	168,854	0	65.00
66.00	06600 PHYSICAL THERAPY	304,050	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	72,490	0	67.00
68.00	06800 SPEECH PATHOLOGY	24,834	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	219,637	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	14,319	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	515,151	737	73.00
76.00	03020 OP PSYCH	46,724	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0	0	90.00
90.01	09001 CLINIC - AMO	5,512	266	90.01
91.00	09100 EMERGENCY	676,420	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	228,235	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
200.00	Subtotal (see instructions)	3,659,854	1,003	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	3,659,854	1,003	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151330		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part II Date/Time Prepared: 7/23/2013 10:17 am	
		Component CCN: 15M330		Title XVIII		Subprovider - IPF	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	324,440	6,025,308	0.053846	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	5,010	159,352	0.031440	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	277,744	16,607,472	0.016724	4,736	79	54.00
60.00	06000 LABORATORY	147,217	15,851,886	0.009287	38,376	356	60.00
65.00	06500 RESPIRATORY THERAPY	52,099	5,483,950	0.009500	13,726	130	65.00
66.00	06600 PHYSICAL THERAPY	173,521	2,061,980	0.084153	269	23	66.00
67.00	06700 OCCUPATIONAL THERAPY	16,030	1,833,694	0.008742	359	3	67.00
68.00	06800 SPEECH PATHOLOGY	7,051	617,701	0.011415	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11,840	2,306,768	0.005133	19,310	99	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	3,050	1,020,718	0.002988	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	80,549	9,351,668	0.008613	76,588	660	73.00
76.00	03020 OP PSYCH	6,923	694,629	0.009966	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	97,303	223,499	0.435362	0	0	90.00
90.01	09001 CLINIC - AMO	6,574	417,956	0.015729	0	0	90.01
91.00	09100 EMERGENCY	190,503	2,870,421	0.066368	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,079,558	0.000000	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	25,620	217	118.064516	0	0	97.00
200.00	Total (lines 50-199)	1,425,474	66,606,777		153,364	1,350	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330  
Component CCN: 15M330

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

Worksheet D  
Part IV  
Date/Time Prepared:  
7/23/2013 10:17 am

Title XVIII

Subprovider -  
IPF

PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	OP PSYCH	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES					95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151330 Component CCN: 15M330	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 7/23/2013 10:17 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient Program Charges
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 + col. 7)	Ratio of Cost to Charges (col. 6 ÷ col. 7)	
	6.00	7.00	8.00	9.00	10.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0	6,025,308	0.000000	0.000000	0 50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	159,352	0.000000	0.000000	0 52.00
53.00 05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	16,607,472	0.000000	0.000000	4,736 54.00
60.00 06000 LABORATORY	0	15,851,886	0.000000	0.000000	38,376 60.00
65.00 06500 RESPIRATORY THERAPY	0	5,483,950	0.000000	0.000000	13,726 65.00
66.00 06600 PHYSICAL THERAPY	0	2,061,980	0.000000	0.000000	269 66.00
67.00 06700 OCCUPATIONAL THERAPY	0	1,833,694	0.000000	0.000000	359 67.00
68.00 06800 SPEECH PATHOLOGY	0	617,701	0.000000	0.000000	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0 69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,306,768	0.000000	0.000000	19,310 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	1,020,718	0.000000	0.000000	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	9,351,668	0.000000	0.000000	76,588 73.00
76.00 03020 OP PSYCH	0	694,629	0.000000	0.000000	0 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000 CLINIC	0	223,499	0.000000	0.000000	0 90.00
90.01 09001 CLINIC - AMO	0	417,956	0.000000	0.000000	0 90.01
91.00 09100 EMERGENCY	0	2,870,421	0.000000	0.000000	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,079,558	0.000000	0.000000	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00 09500 AMBULANCE SERVICES					95.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	217	0.000000	0.000000	0 97.00
200.00 Total (lines 50-199)	0	66,606,777			153,364 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151330 Component CCN: 15M330	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 7/23/2013 10:17 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020 OP PSYCH	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 CLINIC - AMO	0	0	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
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: 151330 Component CCN: 15M330	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 7/23/2013 10:17 am
	Title XVII I	Subprovider - IPF	PPS

Cost Center Description		PSA Adj . Allied Health	PSA Adj . AI I Other Medical Education Cost	
		23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020 OP PSYCH	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0	0	90.00
90.01	09001 CLINIC - AMO	0	0	90.01
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES			95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151330

Period: From 01/01/2011

Worksheet D

Component CCN: 15Z330

To 12/31/2011

Part V  
Date/Time Prepared:  
7/23/2013 10:17 am

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0.468214	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1.357692	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.169370	0	0	0	0	54.00
60.00 06000 LABORATORY	0.210194	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.153806	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.536121	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.347650	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.416297	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.437609	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.254781	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.379250	0	0	0	0	73.00
76.00 03020 OP PSYCH	0.524969	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	1.483935	0	0	0	0	90.00
90.01 09001 CLINIC - AMO	0.185232	0	0	0	0	90.01
91.00 09100 EMERGENCY	0.984149	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.535503	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES	0.580668		0	0		95.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	267.829493	0	0	0	0	97.00
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: 151330 Component CCN: 15Z330	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 7/23/2013 10:17 am
	Title XVIII	Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00 06000 LABORATORY	0	0		60.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00 03020 OP PSYCH	0	0		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 CLINIC - AMO	0	0		90.01
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00 09500 AMBULANCE SERVICES	0	0		95.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00 Subtotal (see instructions)	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330  
Component CCN: 155316

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

Worksheet D  
Part IV  
Date/Time Prepared:  
7/23/2013 10:17 am  
PPS

Title XVIII

Skilled Nursing Facility

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	OP PSYCH	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES					95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151330 Component CCN: 155316	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 7/23/2013 10:17 am PPS
		Title XVIII	Skilled Nursing Facility

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	6,025,308	0.000000	0.000000	1,410	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	159,352	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	16,607,472	0.000000	0.000000	35,445	54.00
60.00	06000 LABORATORY	0	15,851,886	0.000000	0.000000	144,243	60.00
65.00	06500 RESPIRATORY THERAPY	0	5,483,950	0.000000	0.000000	198,752	65.00
66.00	06600 PHYSICAL THERAPY	0	2,061,980	0.000000	0.000000	413,402	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,833,694	0.000000	0.000000	281,090	67.00
68.00	06800 SPEECH PATHOLOGY	0	617,701	0.000000	0.000000	36,443	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,306,768	0.000000	0.000000	315,039	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	1,020,718	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	9,351,668	0.000000	0.000000	641,624	73.00
76.00	03020 OP PSYCH	0	694,629	0.000000	0.000000	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	223,499	0.000000	0.000000	0	90.00
90.01	09001 CLINIC - AMO	0	417,956	0.000000	0.000000	0	90.01
91.00	09100 EMERGENCY	0	2,870,421	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,079,558	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	217	0.000000	0.000000	0	97.00
200.00	Total (lines 50-199)	0	66,606,777			2,067,448	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151330 Component CCN: 155316	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 7/23/2013 10:17 am PPS
		Title XVIII	Skilled Nursing Facility

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020 OP PSYCH	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 CLINIC - AMO	0	0	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
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: 151330 Component CCN: 155316	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 7/23/2013 10:17 am PPS
		Title XVIII	Skilled Nursing Facility

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020 OP PSYCH	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0	0	90.00
90.01	09001 CLINIC - AMO	0	0	90.01
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part I Date/Time Prepared: 7/23/2013 10:17 am
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Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	636,656	0	636,656	5,949	107.02	30.00
31.00	INTENSIVE CARE UNIT	126,744		126,744	728	174.10	31.00
40.00	SUBPROVIDER - IPF	224,648	0	224,648	2,194	102.39	40.00
43.00	NURSERY	15,997		15,997	378	42.32	43.00
44.00	SKILLED NURSING FACILITY	343,069		343,069	4,191	81.86	44.00
200.00	Total (lines 30-199)	1,347,114		1,347,114	13,440		200.00

Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
	6.00	7.00	

INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	288	30,822	30.00
31.00	INTENSIVE CARE UNIT	41	7,138	31.00
40.00	SUBPROVIDER - IPF	330	33,789	40.00
43.00	NURSERY	31	1,312	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30-199)	690	73,061	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151330

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

Worksheet D  
Part II  
Date/Time Prepared:  
7/23/2013 10:17 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	05000	OPERATING ROOM	324,440	6,025,308	0.053846	95,692	5,153	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,010	159,352	0.031440	26,827	843	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	277,744	16,607,472	0.016724	81,487	1,363	54.00
60.00	06000	LABORATORY	147,217	15,851,886	0.009287	171,734	1,595	60.00
65.00	06500	RESPIRATORY THERAPY	52,099	5,483,950	0.009500	131,512	1,249	65.00
66.00	06600	PHYSICAL THERAPY	173,521	2,061,980	0.084153	9,162	771	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,030	1,833,694	0.008742	5,752	50	67.00
68.00	06800	SPEECH PATHOLOGY	7,051	617,701	0.011415	2,934	33	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,840	2,306,768	0.005133	111,123	570	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,050	1,020,718	0.002988	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	80,549	9,351,668	0.008613	518,571	4,466	73.00
76.00	03020	OP PSYCH	6,923	694,629	0.009966	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	97,303	223,499	0.435362	15,797	6,877	90.00
90.01	09001	CLINIC - AMO	6,574	417,956	0.015729	0	0	90.01
91.00	09100	EMERGENCY	190,503	2,870,421	0.066368	20,228	1,342	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	76,091	1,079,558	0.070483	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	25,620	217	118.064516	0	0	97.00
200.00		Total (lines 50-199)	1,501,565	66,606,777		1,190,819	24,312	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part III Date/Time Prepared: 7/23/2013 10:17 am
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Cost Center Description		Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
200.00		Total (lines 30-199)	0	0	0	0	200.00
Cost Center Description		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
		6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,949	0.00	288	0	30.00
31.00	03100	INTENSIVE CARE UNIT	728	0.00	41	0	31.00
40.00	04000	SUBPROVIDER - IPF	2,194	0.00	330	0	40.00
43.00	04300	NURSERY	378	0.00	31	0	43.00
44.00	04400	SKILLED NURSING FACILITY	4,191	0.00	0	0	44.00
200.00		Total (lines 30-199)	13,440		690	0	200.00
Cost Center Description		PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost				
		12.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0			30.00
31.00	03100	INTENSIVE CARE UNIT	0	0			31.00
40.00	04000	SUBPROVIDER - IPF	0	0			40.00
43.00	04300	NURSERY	0	0			43.00
44.00	04400	SKILLED NURSING FACILITY	0	0			44.00
200.00		Total (lines 30-199)	0	0			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330

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

Worksheet D  
Part IV  
Date/Time Prepared:  
7/23/2013 10:17 am

Cost Center Description		Title XIX				Hospital	PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	OP PSYCH	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330

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

Worksheet D  
Part IV  
Date/Time Prepared:  
7/23/2013 10:17 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	6,025,308	0.000000	0.000000	95,692	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	159,352	0.000000	0.000000	26,827	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,607,472	0.000000	0.000000	81,487	54.00
60.00	06000	LABORATORY	0	15,851,886	0.000000	0.000000	171,734	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,483,950	0.000000	0.000000	131,512	65.00
66.00	06600	PHYSICAL THERAPY	0	2,061,980	0.000000	0.000000	9,162	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,833,694	0.000000	0.000000	5,752	67.00
68.00	06800	SPEECH PATHOLOGY	0	617,701	0.000000	0.000000	2,934	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,306,768	0.000000	0.000000	111,123	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,020,718	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,351,668	0.000000	0.000000	518,571	73.00
76.00	03020	OP PSYCH	0	694,629	0.000000	0.000000	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	223,499	0.000000	0.000000	15,797	90.00
90.01	09001	CLINIC - AMO	0	417,956	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	2,870,421	0.000000	0.000000	20,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,079,558	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	217	0.000000	0.000000	0	97.00
200.00		Total (lines 50-199)	0	66,606,777			1,190,819	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151330

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

Worksheet D  
Part IV  
Date/Time Prepared:  
7/23/2013 10:17 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	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020 OP PSYCH	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 CLINIC - AMO	0	0	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
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: 151330

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

Worksheet D  
Part IV  
Date/Time Prepared:  
7/23/2013 10:17 am

Cost Center Description		PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	Title XIX	Hospital	PPS
		23.00	24.00			
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			52.00
53.00	05300 ANESTHESIOLOGY	0	0			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0			54.00
60.00	06000 LABORATORY	0	0			60.00
65.00	06500 RESPIRATORY THERAPY	0	0			65.00
66.00	06600 PHYSICAL THERAPY	0	0			66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0			67.00
68.00	06800 SPEECH PATHOLOGY	0	0			68.00
69.00	06900 ELECTROCARDIOLOGY	0	0			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			73.00
76.00	03020 OP PSYCH	0	0			76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	0	0			90.00
90.01	09001 CLINIC - AMO	0	0			90.01
91.00	09100 EMERGENCY	0	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES	0	0			95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0			97.00
200.00	Total (Lines 50-199)	0	0			200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151330		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part II Date/Time Prepared: 7/23/2013 10:17 am	
		Component CCN: 15M330		Title XIX		Subprovider - IPF	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	324,440	6,025,308	0.053846	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	5,010	159,352	0.031440	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	277,744	16,607,472	0.016724	752	13	54.00
60.00	06000 LABORATORY	147,217	15,851,886	0.009287	29,875	277	60.00
65.00	06500 RESPIRATORY THERAPY	52,099	5,483,950	0.009500	8,070	77	65.00
66.00	06600 PHYSICAL THERAPY	173,521	2,061,980	0.084153	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	16,030	1,833,694	0.008742	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	7,051	617,701	0.011415	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11,840	2,306,768	0.005133	2,128	11	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	3,050	1,020,718	0.002988	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	80,549	9,351,668	0.008613	49,315	425	73.00
76.00	03020 OP PSYCH	6,923	694,629	0.009966	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	97,303	223,499	0.435362	0	0	90.00
90.01	09001 CLINIC - AMO	6,574	417,956	0.015729	0	0	90.01
91.00	09100 EMERGENCY	190,503	2,870,421	0.066368	287	19	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,079,558	0.000000	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	25,620	217	118.064516	0	0	97.00
200.00	Total (lines 50-199)	1,425,474	66,606,777		90,427	822	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151330 Component CCN: 15M330	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 7/23/2013 10:17 am
Title XIX		Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	OP PSYCH	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	CLINIC - AMO	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES					95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151330 Component CCN: 15M330	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 7/23/2013 10:17 am
Title XIX		Subprovider - IPF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	6,025,308	0.000000	0.000000	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	159,352	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	16,607,472	0.000000	0.000000	752	54.00
60.00	06000 LABORATORY	0	15,851,886	0.000000	0.000000	29,875	60.00
65.00	06500 RESPIRATORY THERAPY	0	5,483,950	0.000000	0.000000	8,070	65.00
66.00	06600 PHYSICAL THERAPY	0	2,061,980	0.000000	0.000000	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,833,694	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	617,701	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,306,768	0.000000	0.000000	2,128	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	1,020,718	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	9,351,668	0.000000	0.000000	49,315	73.00
76.00	03020 OP PSYCH	0	694,629	0.000000	0.000000	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	223,499	0.000000	0.000000	0	90.00
90.01	09001 CLINIC - AMO	0	417,956	0.000000	0.000000	0	90.01
91.00	09100 EMERGENCY	0	2,870,421	0.000000	0.000000	287	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,079,558	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	217	0.000000	0.000000	0	97.00
200.00	Total (lines 50-199)	0	66,606,777			90,427	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151330 Component CCN: 15M330	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 7/23/2013 10:17 am
Title XIX		Subprovider - IPF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020 OP PSYCH	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 CLINIC - AMO	0	0	0	0	0	90.01
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
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: 151330 Component CCN: 15M330	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 7/23/2013 10:17 am
	Title XIX	Subprovider - IPF	PPS

Cost Center Description	PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	
	23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 05000 OPERATING ROOM	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00 06000 LABORATORY	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00 03020 OP PSYCH	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00 09000 CLINIC	0	0	90.00
90.01 09001 CLINIC - AMO	0	0	90.01
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
95.00 09500 AMBULANCE SERVICES			95.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
200.00 Total (lines 50-199)	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Title XVIII		Hospital
				Cost
Cost Center Description				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)		6,069	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,949	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,238	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		120	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)		3,199	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<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		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,837,057	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,837,057	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		5,793,203	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		5,793,203	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.834954	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,106.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,837,057	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)		813.09	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,601,075	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)		2,601,075	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151330		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1	
Title XVIII		Hospital		Cost		Date/Time Prepared: 7/23/2013 10:17 am	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	1,299,975	728	1,785.68	343	612,488		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)					2,103,381		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,316,944		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						711	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						813.09	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						578,107	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151330		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 7/23/2013 10:17 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Component CCN: 15M330		Date/Time Prepared: 7/23/2013 10:17 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				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)		2,194	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,194	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,194	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		407	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<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		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,197,886	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,197,886	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		3,057,108	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		3,057,108	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.718943	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,393.39	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,197,886	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)		1,001.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		407,720	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)		407,720	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151330		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1	
		Component CCN: 15M330				Date/Time Prepared: 7/23/2013 10:17 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
<b>Cost Center Description</b>							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					48,744		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					456,464		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)					1,350		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,350		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					455,114		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)					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)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151330 Component CCN: 15M330		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 7/23/2013 10:17 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	2,197,886	0.000000	0	0	90.00
91.00	Nursing School cost	0	2,197,886	0.000000	0	0	91.00
92.00	Allied health cost	0	2,197,886	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,197,886	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151330 Component CCN: 155316	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 7/23/2013 10:17 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description				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)		4,191	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,191	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,191	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,364	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<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		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,479,752	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,479,752	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,995,950	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		1,995,950	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.242392	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)		476.25	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,479,752	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)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151330		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1	
		Component CCN: 155316				Date/Time Prepared: 7/23/2013 10:17 am	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						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						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						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)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						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)						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)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						2,479,752 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						591.69 71.00
72.00	Program routine service cost (line 9 x line 71)						1,398,755 72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						0 73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						1,398,755 74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						0 75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						0.00 76.00
77.00	Program capital-related costs (line 9 x line 76)						0 77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						0 78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						0 79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						0 80.00
81.00	Inpatient routine service cost per diem limitation						0.00 81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						0 82.00
83.00	Reasonable inpatient routine service costs (see instructions)						1,398,755 83.00
84.00	Program inpatient ancillary services (see instructions)						783,276 84.00
85.00	Utilization review - physician compensation (see instructions)						0 85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						2,182,031 86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)						0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151330 Component CCN: 155316		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 7/23/2013 10:17 am	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	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: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 7/23/2013 10:17 am
Cost Center Description				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)		6,069	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,949	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,238	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		120	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)		288	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		378	15.00
16.00	Nursery days (title V or XIX only)		31	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		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,837,057	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,837,057	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,837,057	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)		813.09	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		234,170	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)		234,170	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151330		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1	
Date/Time Prepared: 7/23/2013 10:17 am		Title XIX		Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	357,591	378	946.01	31	29,326		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	1,299,975	728	1,785.68	41	73,213		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)					448,130		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					784,839		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					39,272		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					24,312		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					63,584		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					721,255		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					711		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					813.09		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					578,107		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151330		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 7/23/2013 10:17 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	636,656	4,837,057	0.131621	578,107	76,091	90.00
91.00	Nursing School cost	0	4,837,057	0.000000	578,107	0	91.00
92.00	Allied health cost	0	4,837,057	0.000000	578,107	0	92.00
93.00	All other Medical Education	0	4,837,057	0.000000	578,107	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Component CCN: 15M330		Date/Time Prepared: 7/23/2013 10:17 am
		Title XIX	Subprovider - IPF	PPS
Cost Center Description				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)		2,194	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,194	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,194	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		330	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		378	15.00
16.00	Nursery days (title V or XIX only)		31	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		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,197,886	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,197,886	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,197,886	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)		1,001.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		330,584	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)		330,584	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151330		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1	
		Component CCN: 15M330				Date/Time Prepared: 7/23/2013 10:17 am	
		Title XIX		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					27,564		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					358,148		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)					33,789		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					822		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					34,611		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					323,537		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)					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)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151330 Component CCN: 15M330		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 7/23/2013 10:17 am	
		Title XIX		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	224,648	2,197,886	0.102211	0	0	90.00
91.00	Nursing School cost	0	2,197,886	0.000000	0	0	91.00
92.00	Allied health cost	0	2,197,886	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,197,886	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 7/23/2013 10:17 am
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		3,535,137	30.00
31.00	03100	INTENSIVE CARE UNIT		743,400	31.00
40.00	04000	SUBPROVIDER - IPF		350,181	40.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.468214	225,718	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.357692	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169370	600,479	54.00
60.00	06000	LABORATORY	0.210194	1,151,297	60.00
65.00	06500	RESPIRATORY THERAPY	0.153806	972,112	65.00
66.00	06600	PHYSICAL THERAPY	0.536121	118,706	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.347650	48,697	67.00
68.00	06800	SPEECH PATHOLOGY	0.416297	42,706	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.437609	1,568,002	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.254781	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.379250	1,891,098	73.00
76.00	03020	OP PSYCH	0.524969	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	1.483935	0	90.00
90.01	09001	CLINIC - AMO	0.185232	0	90.01
91.00	09100	EMERGENCY	0.984149	2,805	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.535503	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	267.829493	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		6,621,620	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)		6,621,620	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3	
		Component CCN: 15M330		Date/Time Prepared: 7/23/2013 10:17 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		514,776		40.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.468214	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.357692	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.169370	4,736	802	54.00
60.00	06000 LABORATORY	0.210194	38,376	8,066	60.00
65.00	06500 RESPIRATORY THERAPY	0.153806	13,726	2,111	65.00
66.00	06600 PHYSICAL THERAPY	0.536121	269	144	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.347650	359	125	67.00
68.00	06800 SPEECH PATHOLOGY	0.416297	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.437609	19,310	8,450	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.254781	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.379250	76,588	29,046	73.00
76.00	03020 OP PSYCH	0.524969	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	1.483935	0	0	90.00
90.01	09001 CLINIC - AMO	0.185232	0	0	90.01
91.00	09100 EMERGENCY	0.984149	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.535503	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	267.829493	0	0	97.00
200.00	Total (sum of lines 50-94 and 96-98)		153,364	48,744	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)		153,364		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3	
		Component CCN: 15Z330		Date/Time Prepared: 7/23/2013 10:17 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	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.468214	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.357692	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169370	0	54.00
60.00	06000	LABORATORY	0.210194	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.153806	0	65.00
66.00	06600	PHYSICAL THERAPY	0.536121	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.347650	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.416297	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.437609	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.254781	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.379250	0	73.00
76.00	03020	OP PSYCH	0.524969	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	1.483935	0	90.00
90.01	09001	CLINIC - AMO	0.185232	0	90.01
91.00	09100	EMERGENCY	0.984149	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.535503	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	267.829493	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151330 Component CCN: 155316	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 7/23/2013 10:17 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		0	40.00
43.00	04300 NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.468214	1,410	660 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.357692	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.169370	35,445	6,003 54.00
60.00	06000 LABORATORY	0.210194	144,243	30,319 60.00
65.00	06500 RESPIRATORY THERAPY	0.153806	198,752	30,569 65.00
66.00	06600 PHYSICAL THERAPY	0.536121	413,402	221,633 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.347650	281,090	97,721 67.00
68.00	06800 SPEECH PATHOLOGY	0.416297	36,443	15,171 68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.437609	315,039	137,864 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.254781	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.379250	641,624	243,336 73.00
76.00	03020 OP PSYCH	0.524969	0	0 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	1.483935	0	0 90.00
90.01	09001 CLINIC - AMO	0.185232	0	0 90.01
91.00	09100 EMERGENCY	0.984149	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.535503	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES			95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	267.829493	0	0 97.00
200.00	Total (sum of lines 50-94 and 96-98)		2,067,448	783,276 200.00
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)		2,067,448	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 7/23/2013 10:17 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		316,635	30.00
31.00	03100	INTENSIVE CARE UNIT		152,600	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY		17,776	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.468214	95,692	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.357692	26,827	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169370	81,487	54.00
60.00	06000	LABORATORY	0.210194	171,734	60.00
65.00	06500	RESPIRATORY THERAPY	0.153806	131,512	65.00
66.00	06600	PHYSICAL THERAPY	0.536121	9,162	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.347650	5,752	67.00
68.00	06800	SPEECH PATHOLOGY	0.416297	2,934	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.437609	111,123	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.254781	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.379250	518,571	73.00
76.00	03020	OP PSYCH	0.524969	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	1.483935	15,797	90.00
90.01	09001	CLINIC - AMO	0.185232	0	90.01
91.00	09100	EMERGENCY	0.984149	20,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.535503	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	267.829493	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		1,190,819	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)		1,190,819	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3	
		Component CCN: 15M330		Date/Time Prepared: 7/23/2013 10:17 am	
		Title XIX	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		393,866		40.00
43.00	04300 NURSERY		0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.468214	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.357692	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.169370	752	127	54.00
60.00	06000 LABORATORY	0.210194	29,875	6,280	60.00
65.00	06500 RESPIRATORY THERAPY	0.153806	8,070	1,241	65.00
66.00	06600 PHYSICAL THERAPY	0.536121	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.347650	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.416297	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.437609	2,128	931	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.254781	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.379250	49,315	18,703	73.00
76.00	03020 OP PSYCH	0.524969	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	1.483935	0	0	90.00
90.01	09001 CLINIC - AMO	0.185232	0	0	90.01
91.00	09100 EMERGENCY	0.984149	287	282	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.535503	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	267.829493	0	0	97.00
200.00	Total (sum of lines 50-94 and 96-98)		90,427	27,564	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)		90,427		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3	
		Component CCN: 15Z330		Date/Time Prepared: 7/23/2013 10:17 am	
Cost Center Description		Title XIX	Swing Beds - SNF	PPS	
		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	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.468214	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.357692	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.169370	0	54.00
60.00	06000	LABORATORY	0.210194	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.153806	0	65.00
66.00	06600	PHYSICAL THERAPY	0.536121	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.347650	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.416297	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.437609	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.254781	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.379250	0	73.00
76.00	03020	OP PSYCH	0.524969	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	1.483935	0	90.00
90.01	09001	CLINIC - AMO	0.185232	0	90.01
91.00	09100	EMERGENCY	0.984149	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.535503	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			95.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	267.829493	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 7/23/2013 10:17 am
		Title VIII	Hospital	Cost
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			3,660,857 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			3,660,857 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
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
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			3,697,466 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
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)			57,368 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,933,314 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)			1,706,784 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)			1,706,784 30.00
31.00	Primary payer payments			377 31.00
32.00	Subtotal (line 30 minus line 31)			1,706,407 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			100,268 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			100,268 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			100,268 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			1,806,675 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.98	AB Re-billing demo amount (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			1,806,675 40.00
41.00	Interim payments			1,770,782 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)			35,893 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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
				Overrides
				1.00
<b>WORKSHEET OVERRIDE VALUES</b>				
112.00	Override of Ancillary service charges (line 12)			0 112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 7/23/2013 10:17 am
		Component CCN: 15M330	Title XVII	Subprovider - IPF
		PPS		
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
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
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		0	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	AB Re-billing demo amount (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		0	40.00
41.00	Interim payments		0	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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
		Overrides		
		1.00		
<b>WORKSHEET OVERRIDE VALUES</b>				
112.00	Override of Ancillary service charges (line 12)		0	112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151330 Component CCN: 155316	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 7/23/2013 10:17 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
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
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		0	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R			38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	AB Re-billing demo amount (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		0	40.00
41.00	Interim payments		0	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00
				Overrides
				1.00
<b>WORKSHEET OVERRIDE VALUES</b>				
112.00	Override of Ancillary service charges (line 12)			0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151330

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
7/23/2013 10:17 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		4,883,789		1,781,847	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	09/13/2012	550,510	09/12/2011	135,227	3.01	
3.02			0	09/13/2012	218,461	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	09/12/2011	461,384	11/22/2011	364,753	3.50	
3.51		11/22/2011	44,619		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)		44,507		-11,065	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)		4,928,296		1,770,782	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		37,381		35,893	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		4,965,677		1,806,675	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: 151330  
Component CCN: 15M330

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
7/23/2013 10:17 am  
PPS

Title XVIII

Subprovider -  
IPF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		317,178		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		317,178		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		317,178		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151330  
Component CCN: 15Z330

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
7/23/2013 10:17 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		0		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151330  
Component CCN: 155316

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
7/23/2013 10:17 am  
PPS

Title XVIII

Skilled Nursing Facility

		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		769,878		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		769,878		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		769,878		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151330

Period:

Worksheet E-2

Component CCN: 15Z330

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

Date/Time Prepared:  
7/23/2013 10:17 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)		0	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)		0	0			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)					0.00	4.00
5.00	Program days		0	0			5.00
6.00	Interns and residents not in approved teaching program (see instructions)					0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0				7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	0			8.00
9.00	Primary payer payments (see instructions)		0	0			9.00
10.00	Subtotal (line 8 minus line 9)		0	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)		0	0			12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		0	0			13.00
14.00	80% of Part B costs (line 12 x 80%)					0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0	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)		0	0			19.00
20.00	Interim payments		0	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)		0	0			22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2		0	0			23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

		Provider CCN: 151330	Period: From 01/01/2011	Worksheet E-2
		Component CCN: 15Z330	To 12/31/2011	Date/Time Prepared: 7/23/2013 10:17 am
		Title XIX	Swing Beds - SNF	PPS
			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)		0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		0	2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)		0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days		0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0	8.00
9.00	Primary payer payments (see instructions)		0	9.00
10.00	Subtotal (line 8 minus line 9)		0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	11.00
12.00	Subtotal (line 10 minus line 11)		0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	16.00
17.00	Reimbursable bad debts (see instructions)		0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)		0	19.00
20.00	Interim payments		0	20.00
21.00	Tentative settlement (for contractor use only)		0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)		0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2		0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part V Date/Time Prepared: 7/23/2013 10:17 am
		Title XVIII	Hospital	Cost
				1.00
<b>PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)</b>				
1.00	Inpatient services			5,316,944 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)			5,316,944 4.00
5.00	Primary payer payments			1,926 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			5,368,187 6.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
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
<b>Customary charges</b>				
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
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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)			5,368,187 19.00
20.00	Deductibles (exclude professional component)			565,904 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			4,802,283 22.00
23.00	Coinsurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			4,802,283 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			163,394 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			163,394 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			163,394 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			4,965,677 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)			4,965,677 30.00
31.00	Interim payments			4,928,296 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)			37,381 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part II Date/Time Prepared: 7/23/2013 10:17 am
		Component CCN: 15M330	Title XVII	Subprovider - IPF PPS
				1.00
<b>PART II - MEDICARE PART A SERVICES - IPF PPS</b>				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		352,474	1.00
2.00	Net IPF PPS Outlier Payments		896	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		6.010959	9.00
10.00	Medical Education Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$ .		0.000000	10.00
11.00	Medical Education Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		353,370	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition		0	14.00
15.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	15.00
16.00	Subtotal (see instructions)		353,370	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		353,370	18.00
19.00	Deductibles		36,192	19.00
20.00	Subtotal (line 18 minus line 19)		317,178	20.00
21.00	Coinsurance		0	21.00
22.00	Subtotal (line 20 minus line 21)		317,178	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	25.00
26.00	Subtotal (sum of lines 22 and 24)		317,178	26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.99	Recovery of Accelerated Depreciation		0	30.99
31.00	Total amount payable to the provider (see instructions)		317,178	31.00
32.00	Interim payments		317,178	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus the sum lines 32 and 33)		0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	35.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		896	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151330 Component CCN: 155316	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part VI Date/Time Prepared: 7/23/2013 10:17 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		852,514	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		852,514	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		82,636	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Allowable reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)		769,878	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14)		769,878	15.00
16.00	Interim payments		769,878	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus the sum of lines 16 and 17)		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2		0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part VII Date/Time Prepared: 7/23/2013 10:17 am	
		Title XIX	Hospital	PPS	
		Inpatient	Outpatient		
		1.00	2.00		
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services	0		1.00	
2.00	Medical and other services		0	2.00	
3.00	Organ acquisition (certified transplant centers only)	0		3.00	
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00	
5.00	Inpatient primary payer payments	0		5.00	
6.00	Outpatient primary payer payments		0	6.00	
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00	
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges	0		8.00	
9.00	Ancillary service charges	1,190,819	0	9.00	
10.00	Organ acquisition charges, net of revenue	0		10.00	
11.00	Incentive from target amount computation	0		11.00	
12.00	Total reasonable charges (sum of lines 8 through 11)	1,190,819	0	12.00	
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00	
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	0	14.00	
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00	
16.00	Total customary charges (see instructions)	1,190,819	0	16.00	
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,190,819	0	17.00	
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00	
19.00	Interns and Residents (see instructions)	0	0	19.00	
20.00	Cost of Teaching Physicians (see instructions)	0	0	20.00	
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00	
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments	0	0	22.00	
23.00	Outlier payments	0	0	23.00	
24.00	Program capital payments	0		24.00	
25.00	Capital exception payments (see instructions)	0		25.00	
26.00	Routine and Ancillary service other pass through costs	0	0	26.00	
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00	
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00	
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00	
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)	0	0	30.00	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00	
32.00	Deductibles	0		32.00	
33.00	Coinurance	0		33.00	
34.00	Allowable bad debts (see instructions)	0		34.00	
35.00	Utilization review	0		35.00	
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00	
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		37.00	
38.00	Subtotal (line 36 ± line 37)	0	0	38.00	
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00	
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00	
41.00	Interim payments	0		41.00	
42.00	Balance due provider/program (line 40 minus 41)	0	0	42.00	
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	0	43.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part VII Date/Time Prepared: 7/23/2013 10:17 am	
		Title XIX	Subprovider - IPF	PPS	
		Inpatient	Outpatient		
		1.00	2.00		
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services	0			1.00
2.00	Medical and other services		0		2.00
3.00	Organ acquisition (certified transplant centers only)	0			3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0		4.00
5.00	Inpatient primary payer payments	0			5.00
6.00	Outpatient primary payer payments		0		6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0		7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges	0			8.00
9.00	Ancillary service charges	90,427	0		9.00
10.00	Organ acquisition charges, net of revenue	0			10.00
11.00	Incentive from target amount computation	0			11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	90,427	0		12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0		13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	0		14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000		15.00
16.00	Total customary charges (see instructions)	90,427	0		16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	90,427	0		17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0		18.00
19.00	Interns and Residents (see instructions)	0	0		19.00
20.00	Cost of Teaching Physicians (see instructions)	0	0		20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0		21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments	0	0		22.00
23.00	Outlier payments	0	0		23.00
24.00	Program capital payments	0	0		24.00
25.00	Capital exception payments (see instructions)	0	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0		26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0		27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0		29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)	0	0		30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0		31.00
32.00	Deductibles	0	0		32.00
33.00	Coinurance	0	0		33.00
34.00	Allowable bad debts (see instructions)	0	0		34.00
35.00	Utilization review	0	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0		36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0		37.00
38.00	Subtotal (line 36 ± line 37)	0	0		38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0		40.00
41.00	Interim payments	0	0		41.00
42.00	Balance due provider/program (line 40 minus 41)	0	0		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	0		43.00

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

Provider CCN: 151330

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

Worksheet G

Date/Time Prepared:  
7/23/2013 10:17 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	1,052,646	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	8,768,041	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	669,669	0	0	0	7.00
8.00	Prepaid expenses	178,298	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	11,383,539	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	22,052,193	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	361,028	0	0	0	12.00
13.00	Land improvements	1,468,246	0	0	0	13.00
14.00	Accumulated depreciation	-916,827	0	0	0	14.00
15.00	Buildings	35,810,829	0	0	0	15.00
16.00	Accumulated depreciation	-10,530,505	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	4,333,082	0	0	0	19.00
20.00	Accumulated depreciation	-1,412,765	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	17,700,758	0	0	0	23.00
24.00	Accumulated depreciation	-13,871,459	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)	32,942,387	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	10,343,178	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	10,343,178	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	65,337,758	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	872,746	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,012,702	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	426,971	0	0	0	43.00
44.00	Other current liabilities	2,863,663	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,176,082	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	35,138,102	0	0	0	46.00
47.00	Notes payable	2,136,866	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)	37,274,968	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	42,451,050	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	22,886,708				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	22,886,708	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	65,337,758	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151330

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

Worksheet G-1

Date/Time Prepared:  
7/23/2013 10:17 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		24,336,601		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-1,238,397				2.00
3.00	Total (sum of line 1 and line 2)		23,098,204		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		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)		23,098,204		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		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)		23,098,204		0		19.00
		Endowment Fund		Plant Fund			
		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				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			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				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			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: 151330

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
7/23/2013 10:17 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	5,793,203		5,793,203	1.00
2.00	SUBPROVIDER - IPF	3,057,108		3,057,108	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	1,995,950		1,995,950	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	10,846,261		10,846,261	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	1,527,085		1,527,085	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)	1,527,085		1,527,085	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	12,373,346		12,373,346	17.00
18.00	Ancillary services	18,733,514	55,543,929	74,277,443	18.00
19.00	Outpatient services	0	2,984,838	2,984,838	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		287,345	287,345	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	31,106,860	58,816,112	89,922,972	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		45,099,314		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		45,099,314		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151330

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

Worksheet G-3

Date/Time Prepared:  
7/23/2013 10:17 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	89,922,972	1.00
2.00	Less contractual allowances and discounts on patients' accounts	49,150,677	2.00
3.00	Net patient revenues (line 1 minus line 2)	40,772,295	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	45,099,314	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,327,019	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	128,462	6.00
7.00	Income from investments	153,594	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	394,403	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	15,838	17.00
18.00	Revenue from sale of medical records and abstracts	24,133	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	146,811	22.00
23.00	Governmental appropriations	432,173	23.00
24.00	TRANSPORTATION	1,700	24.00
24.01	LIFELINE	19,508	24.01
24.02	OB RENTALS	282	24.02
24.03	WORTHMAN FITNESS CENTER	85,872	24.03
24.04	CEDIT	896,388	24.04
24.05	GRANT REVENUE	11,763	24.05
24.06	INSTITUTIONAL PHARMACY	567,526	24.06
24.07	MISC INCOME	26,915	24.07
24.08	PRIMARY CARE	195,208	24.08
24.09	PRO FEES ANESTHESIOLOGY	-11,954	24.09
25.00	Total other income (sum of lines 6-24)	3,088,622	25.00
26.00	Total (line 5 plus line 25)	-1,238,397	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,238,397	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151330

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

Worksheet H

HHA CCN: 157172

Date/Time Prepared: 7/23/2013 10:17 am

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	165,823	0	0	0	34,762	200,585	5.00
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	157,802	0	0	0	0	157,802	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	11,854	0	0	0	0	11,854	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	335,479	0	0	0	34,762	370,241	24.00
		Reclassifi cation	Reclassifi ed Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	200,585	0	200,585			5.00
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	0	157,802	0	157,802			6.00
7.00	Physical Therapy	0	0	0	0			7.00
8.00	Occupational Therapy	0	0	0	0			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	11,854	0	11,854			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
<b>HHA NONREIMBURSABLE SERVICES</b>								
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	0	370,241	0	370,241			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.  
 X: \\HFSdata\clients\Hospital\Adams\amh11amd.mcrx

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet H-1 Part I Date/Time Prepared: 7/23/2013 10:17 am
		HHA CCN: 157172	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		Bldgs & Fixtures	Movable Equipment				
		1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00
2.00	Capital Related - Movable Equipment	0	0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	200,585	0	0	0	200,585	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	157,802	0	0	0	157,802	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	11,854	0	0	0	11,854	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)	370,241	0	0	0	370,241	24.00
		Administrative & General	Total (cols. 4A + 5)				
		5.00	6.00				
<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						4.00
5.00	Administrative and General	200,585					5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	186,570	344,372				6.00
7.00	Physical Therapy	0	0				7.00
8.00	Occupational Therapy	0	0				8.00
9.00	Speech Pathology	0	0				9.00
10.00	Medical Social Services	0	0				10.00
11.00	Home Health Aide	14,015	25,869				11.00
12.00	Supplies (see instructions)	0	0				12.00
13.00	Drugs	0	0				13.00
14.00	DME	0	0				14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0				15.00
16.00	Respiratory Therapy	0	0				16.00
17.00	Private Duty Nursing	0	0				17.00
18.00	Clinic	0	0				18.00
19.00	Health Promotion Activities	0	0				19.00
20.00	Day Care Program	0	0				20.00
21.00	Home Delivered Meals Program	0	0				21.00
22.00	Homemaker Service	0	0				22.00
23.00	All Others (specify)	0	0				23.00
24.00	Total (sum of lines 1-23)		370,241				24.00

COST ALLOCATION - HHA STATISTICAL BASIS		Provider CCN: 151330 HHA CCN: 157172	Period: From 01/01/2011 To 12/31/2011	Worksheet H-1 Part II Date/Time Prepared: 7/23/2013 10:17 am PPS
			Home Health Agency I	

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & 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		4.00
5.00	Administrative and General	0	0	0	0	-200,585	169,656
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	0	0	0	0	0	157,802
7.00	Physical Therapy	0	0	0	0	0	0
8.00	Occupational Therapy	0	0	0	0	0	0
9.00	Speech Pathology	0	0	0	0	0	0
10.00	Medical Social Services	0	0	0	0	0	0
11.00	Home Health Aide	0	0	0	0	0	11,854
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-200,585	169,656
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		200,585
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		1.182304

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151330

Period: From 01/01/2011

Worksheet H-2

HHA CCN: 157172

To 12/31/2011

Part I  
Date/Time Prepared:  
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Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP	OTHER CAP			
		1.00	2.00	2.01			
1.00 Administrative and General	0	0	0	8,649	107,029	115,678	1.00
2.00 Skilled Nursing Care	344,372	0	0	0	0	344,372	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	25,869	0	0	0	0	25,869	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	370,241	0	0	8,649	107,029	485,919	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
Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	BIO-MEDICAL	UTILITIES - HOSPITAL	UTILITIES - OFFSITE BLDGS	LAUNDRY & LINEN SERVICE	
	5.00	7.00	7.01	7.02	7.03	8.00	
1.00 Administrative and General	22,471	146,273	65	0	0	0	1.00
2.00 Skilled Nursing Care	66,895	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	5,025	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	94,391	146,273	65	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: 151330

Period: From 01/01/2011

Worksheet H-2

HHA CCN: 157172

To 12/31/2011

Part I  
Date/Time Prepared: 7/23/2013 10:17 am

Home Health Agency I

PPS

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	70,243	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	70,243	0	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
Cost Center Description		MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part I)	Total HHA Costs	
		16.00	24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	0	354,730	0	354,730	0	0	1.00
2.00	Skilled Nursing Care	0	411,267	0	411,267	329,945	741,212	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	30,894	0	30,894	24,785	55,679	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	796,891	0	796,891	354,730	796,891	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.					0.802264		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: 151330

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

Worksheet H-2 Part II Date/Time Prepared: 7/23/2013 10:17 am

HHA CCN: 157172

Home Health Agency I

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Cost Center Description	CAPITAL RELATED COSTS				EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	OTHER CAP (SQUARE FEET)					
	1.00	2.00	2.01	4.00				
1.00 Administrative and General	0	0	10,928	335,479	5A	115,678	1.00	
2.00 Skilled Nursing Care	0	0	0	0		344,372	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		25,869	7.00	
8.00 Supplies (see instructions)	0	0	0	0		0	8.00	
9.00 Drugs	0	0	0	0		0	9.00	
10.00 DME	0	0	0	0		0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0		0	11.00	
12.00 Respiratory Therapy	0	0	0	0		0	12.00	
13.00 Private Duty Nursing	0	0	0	0		0	13.00	
14.00 Clinic	0	0	0	0		0	14.00	
15.00 Health Promotion Activities	0	0	0	0		0	15.00	
16.00 Day Care Program	0	0	0	0		0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0		0	17.00	
18.00 Homemaker Service	0	0	0	0		0	18.00	
19.00 All Others (specify)	0	0	0	0		0	19.00	
20.00 Total (sum of lines 1-19)	0	0	10,928	335,479		485,919	20.00	
21.00 Total cost to be allocated	0	0	8,649	107,029		94,391	21.00	
22.00 Unit cost multiplier	0.000000	0.000000	0.791453	0.319033		0.194253	22.00	
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	BI O-MEDICAL (COST)	UT I L I T I E S - H O S P I T A L (SQUARE FEET)	UT I L I T I E S - O F F S I T E B L D G S (COST)	LAUNDRY & L I N E N S E R V I C E (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)		
	7.00	7.01	7.02	7.03	8.00	9.00		
1.00 Administrative and General	10,928	3,131	0	0	0	10,928	1.00	
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00	
3.00 Physical Therapy	0	0	0	0	0	0	3.00	
4.00 Occupational Therapy	0	0	0	0	0	0	4.00	
5.00 Speech Pathology	0	0	0	0	0	0	5.00	
6.00 Medical Social Services	0	0	0	0	0	0	6.00	
7.00 Home Health Aide	0	0	0	0	0	0	7.00	
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19)	10,928	3,131	0	0	0	10,928	20.00	
21.00 Total cost to be allocated	146,273	65	0	0	0	70,243	21.00	
22.00 Unit cost multiplier	13.385157	0.020760	0.000000	0.000000	0.000000	6.427800	22.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151330  
HHA CCN: 157172

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

Worksheet H-2  
Part II  
Date/Time Prepared:  
7/23/2013 10:17 am  
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Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
	10.00	11.00	13.00	14.00	15.00	16.00	
1.00 Administrative and General	0	0	0	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	0	0	0	0	20.00
21.00 Total cost to be allocated	0	0	0	0	0	0	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet H-3 Part I Date/Time Prepared: 7/23/2013 10:17 am	
				HHA CCN: 157172	Title XVIII		Home Health Agency I
				Total HHA Costs (cols. 1 + 2)		Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)
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)				
	0	1.00	2.00	3.00		4.00	5.00
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	741,212		741,212	1,564	473.92
2.00	Physical Therapy	3.00	0	0	0	296	0.00
3.00	Occupational Therapy	4.00	0	0	0	72	0.00
4.00	Speech Pathology	5.00	0	0	0	72	0.00
5.00	Medical Social Services	6.00	0	0	0	0	0.00
6.00	Home Health Aide	7.00	55,679		55,679	1,176	47.35
7.00	Total (sum of lines 1-6)		796,891	0	796,891	3,180	
Program Visits							
Part B							
Not Subject to Deductibles & Coinsurance							
Subject to Deductibles							
Cost Center Description	Cost Limits	CBSA No. (1)	Part A				
	0	1.00	2.00	3.00		4.00	5.00
Limitation Cost Computation							
8.00	Skilled Nursing Care		23060	0	0		8.00
8.01	Skilled Nursing Care		99915	599	234		8.01
9.00	Physical Therapy		23060	0	0		9.00
9.01	Physical Therapy		99915	89	103		9.01
10.00	Occupational Therapy		23060	0	0		10.00
10.01	Occupational Therapy		99915	30	15		10.01
11.00	Speech Pathology		23060	0	0		11.00
11.01	Speech Pathology		99915	38	10		11.01
12.00	Medical Social Services		23060	0	0		12.00
12.01	Medical Social Services		99915	0	0		12.01
13.00	Home Health Aide		23060	0	0		13.00
13.01	Home Health Aide		99915	52	145		13.01
14.00	Total (sum of lines 8-13)			808	507		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)	Ratio (col. 3 ÷ col. 4)	
	0	1.00	2.00	3.00		4.00	5.00
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	3,087	0.000000
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000
Program Visits							
Cost of Services							
Part B							
Part A							
Not Subject to Deductibles & Coinsurance							
Subject to Deductibles & Coinsurance							
Cost Center Description	Part A	Part B		Part A		Part B	
	6.00	7.00	8.00	9.00		10.00	11.00
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	599	234		283,878	110,897	1.00
2.00	Physical Therapy	89	103		0	0	2.00
3.00	Occupational Therapy	30	15		0	0	3.00
4.00	Speech Pathology	38	10		0	0	4.00
5.00	Medical Social Services	0	0		0	0	5.00
6.00	Home Health Aide	52	145		2,462	6,866	6.00
7.00	Total (sum of lines 1-6)	808	507		286,340	117,763	7.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 151330	Period: From 01/01/2011	Worksheet H-3
		HHA CCN: 157172	To 12/31/2011	Part I Date/Time Prepared: 7/23/2013 10:17 am
		Title XVIII	Home Health Agency I	PPS

Cost Center Description		6.00	7.00	8.00	9.00	10.00	11.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00
Cost Center Description		Program Covered Charges			Cost of Services			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies							15.00
16.00	Cost of Drugs		0	0		0	0	16.00
Cost Center Description		Total Program Cost (sum of col s. 9-10)						
		12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	394,775						1.00
2.00	Physical Therapy	0						2.00
3.00	Occupational Therapy	0						3.00
4.00	Speech Pathology	0						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	9,328						6.00
7.00	Total (sum of lines 1-6)	404,103						7.00
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151330

Period:

Worksheet H-3

HHA CCN: 157172

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

Part II  
Date/Time Prepared:  
7/23/2013 10:17 am

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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)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
<b>PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS</b>							
1.00 Physical Therapy	66.00	0.536121	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.347650	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.416297	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.437609	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.379250	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 151330 HHA CCN: 157172	Period: From 01/01/2011 To 12/31/2011	Worksheet H-4 Part I-II Date/Time Prepared: 7/23/2013 10:17 am	
		Title XVII	Home Health Agency I	PPS	
		Part A	Part B	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00	
<b>PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES</b>					
Reasonable Cost of Part A & Part B Services					
1.00	Reasonable cost of services (see instructions)		0	0	0 1.00
2.00	Total charges		0	0	0 2.00
Customary Charges					
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)		0	0	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)		0	0	0 6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)		0	0	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
			Part A Services	Part B Services	
			1.00	2.00	
<b>PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT</b>					
10.00	Total reasonable cost (see instructions)		0	0	0 10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		139,808	79,157	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		1,997	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes		3,411	1,173	13.00
14.00	Total PPS Reimbursement - PEP Episodes		0	0	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		338	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 21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		145,554	80,330	22.00
23.00	Excess reasonable cost (from line 8)		0	0	23.00
24.00	Subtotal (line 22 minus line 23)		145,554	80,330	24.00
25.00	Coinsurance billed to program patients (from your records)			0	25.00
26.00	Net cost (line 24 minus line 25)		145,554	80,330	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

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 151330 HHA CCN: 157172	Period: From 01/01/2011 To 12/31/2011	Worksheet H-4 Part I-II Date/Time Prepared: 7/23/2013 10:17 am	
		Title XVIII	Home Health Agency I	PPS	
				Part A Services	Part B Services
				1.00	2.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)		145,554	80,330	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)		145,554	80,330	31.00
32.00	Interim payments (see instructions)		145,554	80,330	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. 15-11, section 115.2		0	0	35.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 151330	Period: From 01/01/2011 To 12/31/2011	Worksheet H-5
	HHA CCN: 157172		Date/Time Prepared: 7/23/2013 10:17 am
		Home Health Agency I	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		145,554		80,330	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		145,554		80,330	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		145,554		80,330	7.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 151330 HHA CCN: 157172	Period: From 01/01/2011 To 12/31/2011	Worksheet H-5 Date/Time Prepared: 7/23/2013 10:17 am PPS
			Home Health Agency I	
			Contractor Number	Date (Mo/Day/Yr)
		0	1.00	2.00
8.00	Name of Contractor			8.00