

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: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet S Parts I-III Date/Time Prepared: 3/14/2012 4:02 pm
--	----------------------	---	--

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

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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

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

 Title

 Date

Cost Center Description	Title V		Title XVIII		HIT	Title XIX	
	1.00	2.00	Part A	Part B			
PART III - SETTLEMENT SUMMARY							
1.00 Hospital	0	79,816		-54,233	0		0 1.00
2.00 Subprovider - IPF	0	0		0			0 2.00
3.00 Subprovider - IRF	0	0		0			0 3.00
4.00 SUBPROVIDER I	0	0		0			0 4.00
5.00 Swing bed - SNF	0	11,336		0			0 5.00
6.00 Swing bed - NF	0	0		0			0 6.00
7.00 SKILLED NURSING FACILITY	0	0		0			0 7.00
8.00 NURSING FACILITY	0	0		0			0 8.00
9.00 HOME HEALTH AGENCY I	0	0		0			0 9.00
10.00 RURAL HEALTH CLINIC I	0	0		0			0 10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0		0			0 11.00
12.00 CMHC I	0	0		0			0 12.00
200.00 Total	0	91,152		-54,233	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: 151315		Period: From 10/01/2010 To 09/30/2011		Worksheet S-2 Part I Date/Time Prepared: 3/14/2012 4:02 pm					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 416 E MAUMEE STREET		PO Box:						1.00		
2.00	City: ANGOLA		State: IN		Zip Code: 47803-		County: STEUBEN		2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00	2.00	3.00	4.00	5.00	V	XVIII	XIX		
		6.00	7.00	8.00							
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		CAMERON MEMORIAL COMMUNITY	151315	99915	1	02/01/2003	N	O	P	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF		CAMERON MEMORIAL COMMUNITY	15Z315	99915		02/01/2003	N	O	N	7.00
8.00	Swing Beds - NF							N		N	8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA		CAMERON HOME HEALTH CARE	157117	99915		04/01/1984	N	P	N	12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice		CAMERON HOSPICE	151561	99915		05/01/1997				14.00
15.00	Hospital-Based Health Clinic - RHC							N	N	N	15.00
16.00	Hospital-Based Health Clinic - FOHC							N	N	N	16.00
17.00	Hospital-Based (CMHC) 1										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
						From:	To:				
						1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					10/01/2010	09/30/2011		20.00		
21.00	Type of Control (see instructions)					2		21.00			
Inpatient PPS Information											
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					N		N		22.00	
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.					2		N		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.		0	0	0	0	0	0	24.00		
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.		0	0	0	0	0	0	25.00		
						1.00					
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.							2 26.00			
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period? Enter (1) for urban or (2) for rural.							2 27.00			
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							0 35.00			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part I Date/Time Prepared: 3/14/2012 4:02 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	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)	N	0.00	0.00	61.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1 / (col. 1 + col. 2)) 3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00	
		Program Name 1.00	Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3 / (col. 3 + col. 4)) 5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151315		Period: From 10/01/2010 To 09/30/2011		Worksheet S-2 Part I Date/Time Prepared: 3/14/2012 4:02 pm	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1 the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
					1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	76.00
					1.00		
80.00	Long Term Care Hospital PPS Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.					N	80.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part I Date/Time Prepared: 3/14/2012 4:02 pm	
			1.00		
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(i)? Enter "Y" for yes and "N" for no.		N		86.00
			V 1.00	XIX 2.00	
Title V or XIX Inpatient Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	Y
			1.00	2.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.		N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1	118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.		250,000	5,000,000	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part I Date/Time Prepared: 3/14/2012 4:02 pm			
		1.00	2.00				
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y			140.00	
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?		Y	144.00			
145.00	If costs for renal services are claimed on Worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N	145.00			
				1.00			
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N			146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N			147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N			148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N			149.00	
		Part A		Part B			
		1.00		2.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital		N		N	155.00	
156.00	Subprovider - IPF		N		N	156.00	
157.00	Subprovider - IRF		N		N	157.00	
158.00	SUBPROVIDER		N		N	158.00	
159.00	SNF		N		N	159.00	
160.00	HOME HEALTH AGENCY		N		N	160.00	
161.00	CMHC				N	161.00	
				1.00			
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
				1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.				N	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0168.00	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.00169.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part II Date/Time Prepared: 3/14/2012 4:02 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		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.		Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.		N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
			Part A		
			Description	Y/N	Date
			0	1.00	2.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		Y	12/01/2011	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part II Date/Time Prepared: 3/14/2012 4:02 pm
---	--	----------------------	---	--

		Part A			
		Description	Y/N	Date	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	1.00 N	2.00	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		Y		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		Y		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
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		Y		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		35.00
					Y/N
					Date
					1.00
					2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	12/01/2011	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151315

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

Worksheet S-3
Part I
Date/Time Prepared:
3/14/2012 4:02 pm

Cost Center	Description	Worksheet A	No. of Beds	Bed Days	CAH Hours	
		Line Number		Avai lable		
		1.00	2.00	3.00	4.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	23	8,395	68,568.00	1.00
2.00	HMO					2.00
3.00	HMO IPF					3.00
4.00	HMO IRF					4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					5.00
6.00	Hospital Adults & Peds. Swing Bed NF					6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		23	8,395	68,568.00	7.00
8.00	INTENSIVE CARE UNIT	31.00	2	730	1,320.00	8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY	43.00				13.00
14.00	Total (see instructions)		25	9,125	69,888.00	14.00
15.00	CAH visits					15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY	101.00				22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE	116.00	0	0		24.00
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC	88.00				26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				26.25
27.00	Total (sum of lines 14-26)		25			27.00
28.00	Observation Bed Days					28.00
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: 151315

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

Worksheet S-3
Part I
Date/Time Prepared:
3/14/2012 4:02 pm

Cost Center Description	I/P Days / O/P Visits / Trips				Total All Patients	
	Title V	Title XVIII	Title XIX			
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	1,195	357	2,857	1.00	
2.00 HMO		0	0		2.00	
3.00 HMO IPF		0	0		3.00	
4.00 HMO IRF		0	0		4.00	
5.00 Hospital Adults & Peds. Swing Bed SNF	0	510	0	510	5.00	
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	389	6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,705	357	3,756	7.00	
8.00 INTENSIVE CARE UNIT	0	21	0	55	8.00	
9.00 CORONARY CARE UNIT					9.00	
10.00 BURN INTENSIVE CARE UNIT					10.00	
11.00 SURGICAL INTENSIVE CARE UNIT					11.00	
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00	
13.00 NURSERY	0		173	330	13.00	
14.00 Total (see instructions)	0	1,726	530	4,141	14.00	
15.00 CAH visits	0	0	0	0	15.00	
16.00 SUBPROVIDER - IPF					16.00	
17.00 SUBPROVIDER - IRF					17.00	
18.00 SUBPROVIDER					18.00	
19.00 SKILLED NURSING FACILITY					19.00	
20.00 NURSING FACILITY					20.00	
21.00 OTHER LONG TERM CARE					21.00	
22.00 HOME HEALTH AGENCY	0	1,788	586	3,709	22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00	
24.00 HOSPICE		0	0	0	24.00	
25.00 CMHC - CMHC					25.00	
26.00 RURAL HEALTH CLINIC	0	0	0	0	26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	26.25	
27.00 Total (sum of lines 14-26)					27.00	
28.00 Observation Bed Days	0		8	282	28.00	
29.00 Ambulance Trips		0			29.00	
30.00 Employee discount days (see instruction)				0	30.00	
31.00 Employee discount days - IRF				0	31.00	
32.00 Labor & delivery days (see instructions)			0	0	32.00	
33.00 LTCH non-covered days		0			33.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151315

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

Worksheet S-3
Part I
Date/Time Prepared:
3/14/2012 4:02 pm

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	332	1.00
2.00 HMO					0	2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	285.21	0.00	0	332	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00	13.84	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00	2.23	0.00			24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00	0.00	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00 Total (sum of lines 14-26)	0.00	301.28	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151315

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

Worksheet S-3
Part I
Date/Time Prepared:
3/14/2012 4:02 pm

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	123	1,073		1.00
2.00 HMO				2.00
3.00 HMO IPF				3.00
4.00 HMO IRF				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF				5.00
6.00 Hospital Adults & Peds. Swing Bed NF				6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)				7.00
8.00 INTENSIVE CARE UNIT				8.00
9.00 CORONARY CARE UNIT				9.00
10.00 BURN INTENSIVE CARE UNIT				10.00
11.00 SURGICAL INTENSIVE CARE UNIT				11.00
12.00 OTHER SPECIAL CARE (SPECIFY)				12.00
13.00 NURSERY				13.00
14.00 Total (see instructions)	123	1,073		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 151315		Period: From 10/01/2010 To 09/30/2011		Worksheet S-4	
		Component CCN: 157117				Date/Time Prepared: 3/14/2012 4:02 pm	
				Home Health Agency I		PPS	
						1.00	
0.00	County			STUEBEN		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	386	222	792	1,400	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	137.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	0.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.02	0.00	1.02	4.00
5.00	Other Administrative Personnel			3.50	0.00	3.50	5.00
6.00	Direct Nursing Service			4.67	0.00	4.67	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			1.45	0.00	1.45	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.34	0.00	0.34	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.02	0.00	0.02	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.25	0.00	0.25	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.67	0.00	0.67	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	PRIVATE DUTY NURSING			1.97	0.00	1.97	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99915			20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (col s. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	534	0	50	0	584	21.00
22.00	Skilled Nursing Visit Charges	98,424	0	9,248	0	107,672	22.00
23.00	Physical Therapy Visits	685	0	3	0	688	23.00
24.00	Physical Therapy Visit Charges	133,915	0	587	0	134,502	24.00
25.00	Occupational Therapy Visits	230	0	3	0	233	25.00
26.00	Occupational Therapy Visit Charges	43,326	0	567	0	43,893	26.00
27.00	Speech Pathology Visits	34	0	1	0	35	27.00
28.00	Speech Pathology Visit Charges	6,430	0	189	0	6,619	28.00
29.00	Medical Social Service Visits	5	0	0	0	5	29.00
30.00	Medical Social Service Visit Charges	1,233	0	0	0	1,233	30.00
31.00	Home Health Aide Visits	243	0	0	0	243	31.00
32.00	Home Health Aide Visit Charges	20,309	0	0	0	20,309	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,731	0	57	0	1,788	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)	303,637	0	10,591	0	314,228	35.00
36.00	Total Number of Episodes (standard/non outlier)	118		19	0	137	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	8,409	0	2,618	0	11,027	38.00

HOSPITAL IDENTIFICATION DATA	Provider CCN: 151315 Component CCN: 151561	Period: From 10/01/2010 To 09/30/2011	Worksheet S-9 Parts I & II Date/Time Prepared: 3/14/2012 4:02 pm
------------------------------	---	---	---

	Unduplicated Days					All Other	
	Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility			
	1.00	2.00	3.00	4.00	5.00		
PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	1.00
2.00	Routine Home Care	3,708	0	0	0	0	2.00
3.00	Inpatient Respite Care	10	0	0	0	0	3.00
4.00	General Inpatient Care	12	0	0	0	0	4.00
5.00	Total Hospice Days	3,730	0	0	0	0	5.00
Part II - CENSUS DATA							
6.00	Number of Patients Receiving Hospice Care	84	0	0	0	0	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00			7.00
8.00	Average Length of Stay (line 5/line 6)	44.40	0.00	0.00	0.00	0.00	8.00
9.00	Unduplicated Census Count	0	0	0	0	0	9.00

HOSPITAL IDENTIFICATION DATA		Provider CCN: 151315 Component CCN: 151561	Period: From 10/01/2010 To 09/30/2011	Worksheet S-9 Parts I & II Date/Time Prepared: 3/14/2012 4:02 pm
		Hospice I		

		Unduplicated Days	
		Total (sum of cols. 1, 2 & 5)	
		6.00	
PART I - ENROLLMENT DAYS			
1.00	Continuous Home Care	0	1.00
2.00	Routine Home Care	3,708	2.00
3.00	Inpatient Respite Care	10	3.00
4.00	General Inpatient Care	12	4.00
5.00	Total Hospice Days	3,730	5.00
Part II - CENSUS DATA			
6.00	Number of Patients Receiving Hospice Care	84	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare		7.00
8.00	Average Length of Stay (line 5/line 6)	44.40	8.00
9.00	Unduplicated Census Count	0	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet S-10 Date/Time Prepared: 3/14/2012 4:02 pm
---	----------------------	---	--

				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)		0.457604		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		1,409,371		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N		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		8,085,714		6.00
7.00	Medicaid cost (line 1 times line 6)		3,700,055		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)		2,290,684		8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		363		9.00
10.00	Stand-alone SCHIP charges		4,654		10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		2,130		11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		1,767		12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		2,292,451		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,077,037	190,653	1,267,690	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	492,856	87,244	580,100	21.00
22.00	Partial payment by patients approved for charity care	149,028	74,830	223,858	22.00
23.00	Cost of charity care (line 21 minus line 22)	343,828	12,414	356,242	23.00
				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?		N		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)		3,851,800		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		389,428		27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		3,462,372		28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		1,584,395		29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		1,940,637		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		4,233,088		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151315

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

Worksheet A
Date/Time Prepared:
3/14/2012 4:02 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT		2,164,295	2,164,295	-1,148,346	1,015,949	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		847,953	847,953	1,720,795	2,568,748	2.00
4.00 EMPLOYEE BENEFITS	0	5,245,223	5,245,223	0	5,245,223	4.00
5.00 ADMINISTRATIVE & GENERAL	2,418,843	5,621,339	8,040,182	51,161	8,091,343	5.00
7.00 OPERATION OF PLANT	460,817	1,143,917	1,604,734	26,215	1,630,949	7.00
8.00 LAUNDRY & LINEN SERVICE	0	110,280	110,280	0	110,280	8.00
9.00 HOUSEKEEPING	396,195	115,817	512,012	0	512,012	9.00
10.00 DIETARY	351,403	374,098	725,501	-623,744	101,757	10.00
11.00 CAFETERIA	0	0	0	521,451	521,451	11.00
13.00 NURSING ADMINISTRATION	514,807	7,911	522,718	0	522,718	13.00
14.00 CENTRAL SERVICES & SUPPLY	112,758	63,344	176,102	0	176,102	14.00
15.00 PHARMACY	364,689	1,375,078	1,739,767	0	1,739,767	15.00
16.00 MEDICAL RECORDS & LIBRARY	539,140	352,657	891,797	0	891,797	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1,306,867	477,234	1,784,101	77,628	1,861,729	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	25,748	25,748	31.00
43.00 NURSERY	0	0	0	23,263	23,263	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	1,184,955	1,373,838	2,558,793	-391,149	2,167,644	50.00
51.00 RECOVERY ROOM	0	97,627	97,627	391,149	488,776	51.00
52.00 DELIVERY ROOM & LABOR ROOM	473,063	66,668	539,731	-126,639	413,092	52.00
54.00 RADIOLOGY-DIAGNOSTIC	1,233,801	853,402	2,087,203	0	2,087,203	54.00
60.00 LABORATORY	865,476	972,330	1,837,806	0	1,837,806	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	32,833	662,831	695,664	-167,140	528,524	65.00
65.01 SLEEP LAB	0	0	0	143,256	143,256	65.01
66.00 PHYSICAL THERAPY	584,725	33,648	618,373	0	618,373	66.00
69.00 ELECTROCARDIOLOGY	0	219,627	219,627	23,884	243,511	69.00
69.01 CARDIAC REHAB	44,549	8,647	53,196	0	53,196	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	829,999	829,999	-102,376	727,623	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	102,376	102,376	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 CHEMICAL DEPENDENCY	127,728	12,292	140,020	0	140,020	76.00
76.01 ONCOLOGY	0	1,611,512	1,611,512	0	1,611,512	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	91,073	20,659	111,732	0	111,732	90.00
91.00 EMERGENCY	1,318,555	102,577	1,421,132	0	1,421,132	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	642,170	71,640	713,810	13,673	727,483	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE		445,932	445,932	-445,932	0	113.00
114.00 UTILIZATION REVIEW - SNF	0	0	0	0	0	114.00
116.00 HOSPICE	113,189	43,490	156,679	-13,673	143,006	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	13,177,636	25,325,865	38,503,501	101,600	38,605,101	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00 DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01 MOB	0	30,605	30,605	-26,215	4,390	194.01
194.02 COMMUNITY HEALTH	70,138	5,384	75,522	0	75,522	194.02
194.03 ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04 EDUCATION	84,443	50,023	134,466	-93,435	41,031	194.04
194.05 MARKETING	122,812	263,545	386,357	-84,243	302,114	194.05
194.06 GUEST MEALS	0	0	0	102,293	102,293	194.06
194.07 OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08 CANCER CENTER	0	0	0	0	0	194.08
194.09 URGENT CARE	380,269	598,727	978,996	0	978,996	194.09
200.00 TOTAL (SUM OF LINES 118-199)	13,835,298	26,274,149	40,109,447	0	40,109,447	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151315

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

Worksheet A
Date/Time Prepared:
3/14/2012 4:02 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	-113,969	901,980	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-506,286	2,062,462	2.00
4.00	EMPLOYEE BENEFITS	-184,956	5,060,267	4.00
5.00	ADMINISTRATIVE & GENERAL	-3,326,553	4,764,790	5.00
7.00	OPERATION OF PLANT	-12,570	1,618,379	7.00
8.00	LAUNDRY & LINEN SERVICE	0	110,280	8.00
9.00	HOUSEKEEPING	0	512,012	9.00
10.00	DIETARY	-45,685	56,072	10.00
11.00	CAFETERIA	-128,673	392,778	11.00
13.00	NURSING ADMINISTRATION	0	522,718	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	176,102	14.00
15.00	PHARMACY	-119,443	1,620,324	15.00
16.00	MEDICAL RECORDS & LIBRARY	-720	891,077	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-335,556	1,526,173	30.00
31.00	INTENSIVE CARE UNIT	0	25,748	31.00
43.00	NURSERY	0	23,263	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	-1,033,286	1,134,358	50.00
51.00	RECOVERY ROOM	0	488,776	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	413,092	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	2,087,203	54.00
60.00	LABORATORY	-8,243	1,829,563	60.00
64.00	INTRAVENOUS THERAPY	0	0	64.00
65.00	RESPIRATORY THERAPY	0	528,524	65.00
65.01	SLEEP LAB	0	143,256	65.01
66.00	PHYSICAL THERAPY	0	618,373	66.00
69.00	ELECTROCARDIOLOGY	0	243,511	69.00
69.01	CARDIAC REHAB	0	53,196	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	727,623	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	102,376	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	CHEMICAL DEPENDENCY	0	140,020	76.00
76.01	ONCOLOGY	0	1,611,512	76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	CLINIC	0	111,732	90.00
91.00	EMERGENCY	-17,201	1,403,931	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	HOME HEALTH AGENCY	0	727,483	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	0	0	113.00
114.00	UTILIZATION REVIEW - SNF	0	0	114.00
116.00	HOSPICE	0	143,006	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-5,833,141	32,771,960	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	DAYCARE-INFANT/TODDLER	0	0	194.00
194.01	MOB	0	4,390	194.01
194.02	COMMUNITY HEALTH	0	75,522	194.02
194.03	ASSISTED LIVING/CAMERON WOODS	0	0	194.03
194.04	EDUCATION	0	41,031	194.04
194.05	MARKETING	0	302,114	194.05
194.06	GUEST MEALS	0	102,293	194.06
194.07	OUTSIDE LAUNDRY	0	0	194.07
194.08	CANCER CENTER	0	0	194.08
194.09	URGENT CARE	0	978,996	194.09
200.00	TOTAL (SUM OF LINES 118-199)	-5,833,141	34,276,306	200.00

RECLASSIFICATIONS

Provider CCN: 151315

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

Worksheet A-6
Date/Time Prepared:
3/14/2012 4:02 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - LABOR & DELIVERY RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	103,376	0	1.00
2.00	NURSERY	43.00	23,263	0	2.00
	TOTALS		126,639	0	
B - PROPERTY INSURANCE RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	66,110	1.00
	TOTALS		0	66,110	
C - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	252,570	268,881	1.00
2.00	GUEST MEALS	194.06	49,546	52,747	2.00
	TOTALS		302,116	321,628	
D - INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	237,577	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	208,355	2.00
	TOTALS		0	445,932	
F - DEPRECIATION EXPENSE RECLASS					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	1,512,440	1.00
	TOTALS		0	1,512,440	
G - ICU RECLASS					
1.00	INTENSIVE CARE UNIT	31.00	18,861	6,887	1.00
	TOTALS		18,861	6,887	
H - ADVERTISING COSTS RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	16,993	82,026	1.00
	TOTALS		16,993	82,026	
I - PROPERTY TAX RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	60,407	1.00
	TOTALS		0	60,407	
L - EDUCATION COST RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	84,443	8,992	1.00
	TOTALS		84,443	8,992	
M - SLEEP LAB RECLASS					
1.00	SLEEP LAB	65.01	0	143,256	1.00
2.00	ELECTROCARDIOLOGY	69.00	0	23,884	2.00
	TOTALS		0	167,140	
O - UTILITIES RECLASS					
1.00	OPERATION OF PLANT	7.00	0	26,215	1.00
	TOTALS		0	26,215	
P - PUBLIC RELATIONS RECLASS					
1.00	MARKETING	194.05	0	14,776	1.00
	TOTALS		0	14,776	
R - MSW SALARY RECLASS					
1.00	HOME HEALTH AGENCY	101.00	13,673	0	1.00
	TOTALS		13,673	0	
S - RECOVERY ROOM SALARY RECLASS					
1.00	RECOVERY ROOM	51.00	391,149	0	1.00
	TOTALS		391,149	0	
T - IMPLANTABLE DEVICE RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	102,376	1.00
	TOTALS		0	102,376	
500.00	Grand Total: Increases		953,874	2,814,929	500.00

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - LABOR & DELIVERY RECLASS							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	126,639	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		126,639	0			
B - PROPERTY INSURANCE RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	66,110	12		1.00
	TOTALS		0	66,110			
C - CAFETERIA RECLASS							
1.00	DIETARY	10.00	302,116	321,628	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		302,116	321,628			
D - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	445,932	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	445,932			
F - DEPRECIATION EXPENSE RECLASS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,512,440	9		1.00
	TOTALS		0	1,512,440			
G - ICU RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	18,861	6,887	0		1.00
	TOTALS		18,861	6,887			
H - ADVERTISING COSTS RECLASS							
1.00	MARKETING	194.05	16,993	82,026	0		1.00
	TOTALS		16,993	82,026			
I - PROPERTY TAX RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	60,407	13		1.00
	TOTALS		0	60,407			
L - EDUCATION COST RECLASS							
1.00	EDUCATION	194.04	84,443	8,992	0		1.00
	TOTALS		84,443	8,992			
M - SLEEP LAB RECLASS							
1.00	RESPIRATORY THERAPY	65.00	0	167,140	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	167,140			
O - UTILITIES RECLASS							
1.00	MOB	194.01	0	26,215	0		1.00
	TOTALS		0	26,215			
P - PUBLIC RELATIONS RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	14,776	0		1.00
	TOTALS		0	14,776			
R - MSW SALARY RECLASS							
1.00	HOSPICE	116.00	13,673	0	0		1.00
	TOTALS		13,673	0			
S - RECOVERY ROOM SALARY RECLASS							
1.00	OPERATING ROOM	50.00	391,149	0	0		1.00
	TOTALS		391,149	0			
T - IMPLANTABLE DEVICE RECLASS							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	102,376	0		1.00
	TOTALS		0	102,376			
500.00	Grand Total: Decreases		953,874	2,814,929			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151315

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
3/14/2012 4:02 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,043,373	0	0	0	1.00
2.00	Land Improvements	22,142,302	879,170	0	879,170	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	13,830,670	1,887,592	0	1,887,592	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	37,016,345	2,766,762	0	2,766,762	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	37,016,345	2,766,762	0	2,766,762	10.00
SUMMARY OF CAPITAL						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,164,295	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	847,953	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,012,248	0	0	0	3.00
COMPUTATION OF RATIOS						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	24,064,845	0	24,064,845	0.730465	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	15,718,262	6,838,537	8,879,725	0.269535	2.00
3.00	Total (sum of lines 1-2)	39,783,107	6,838,537	32,944,570	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151315

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
3/14/2012 4:02 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,043,373	0		1.00		
2.00	Land Improvements	23,021,472	0		2.00		
3.00	Buildings and Fixtures	0	0		3.00		
4.00	Building Improvements	0	0		4.00		
5.00	Fixed Equipment	0	0		5.00		
6.00	Movable Equipment	15,718,262	0		6.00		
7.00	HIT designated Assets	0	0		7.00		
8.00	Subtotal (sum of lines 1-7)	39,783,107	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	39,783,107	0		10.00		
SUMMARY OF CAPITAL							
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,164,295		1.00		
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	847,953		2.00		
3.00	Total (sum of lines 1-2)	0	3,012,248		3.00		
ALLOCATION OF OTHER CAPITAL							
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	622,673	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	2,062,462	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,685,135	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151315

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
3/14/2012 4:02 pm

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	152,790	66,110	60,407	0	901,980	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,062,462	2.00
3.00	Total (sum of lines 1-2)	152,790	66,110	60,407	0	2,964,442	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151315

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

Worksheet A-8

Date/Time Prepared:
3/14/2012 4:02 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center		Line #
			1.00	2.00	3.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-84,787	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	A	-208,355	NEW CAP REL COSTS-MVBLE EQUIP		2.00
3.00 Investment income - other (chapter 2)		0			3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			5.00
6.00 Rental of provider space by suppliers (chapter 8)	B	-12,178	NEW CAP REL COSTS-MVBLE EQUIP		6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			7.00
8.00 Television and radio service (chapter 21)		0			8.00
9.00 Parking lot (chapter 21)		0			9.00
10.00 Provider-based physician adjustment	A-8-2	-343,799			10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-522,747			12.00
13.00 Laundry and linen service		0			13.00
14.00 Cafeteria-employees and guests	B	-128,673	CAFETERIA		14.00
15.00 Rental of quarters to employee and others		0			15.00
16.00 Sale of medical and surgical supplies to other than patients		0			16.00
17.00 Sale of drugs to other than patients	B	-119,443	PHARMACY		17.00
18.00 Sale of medical records and abstracts	B	-720	MEDICAL RECORDS & LIBRARY		18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			19.00
20.00 Vending machines	B	-33,731	DIETARY		20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	UTILIZATION REVIEW - SNF		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT		26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP		27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***		28.00
29.00 Physicians' assistant		0	*** Cost Center Deleted ***		29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***		30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			32.00
33.00 MRI DEPRECIATION CARRYFORWARD ADJUST	A	-5,676	NEW CAP REL COSTS-MVBLE EQUIP		33.00
34.00 BAD DEBT EXPENSE ADJUSTMENT	A	-3,073,850	ADMINISTRATIVE & GENERAL		34.00
35.00 LOBBYING EXPENSES	A	-4,165	ADMINISTRATIVE & GENERAL		35.00
36.00 EMPLOYEE CHRISTMAS PARTY	A	-14,176	ADMINISTRATIVE & GENERAL		36.00
37.00 PHYSICIAN RECRUITMENT	B	-70,800	ADMINISTRATIVE & GENERAL		37.00
38.00 MEALS ON WHEELS	B	-11,954	DIETARY		38.00
39.00 REIMB FOUNDATION DEVELOP OFFICE	B	-63,535	ADMINISTRATIVE & GENERAL		39.00
40.00 OTHER RECEIPTS	B	-10,763	ADMINISTRATIVE & GENERAL		40.00
41.00 EMS OTHER	B	-2,710	EMERGENCY		41.00
42.00 ANESTHESIA SUBSIDY	A	-1,033,286	OPERATING ROOM		42.00
43.00 RENTAL INCOME OFFSET - CANCER CENTER	B	-29,182	NEW CAP REL COSTS-BLDG & FIXT		43.00
44.00 SLEEP CENTER TRAINING INCOME	B	-2,500	ADMINISTRATIVE & GENERAL		44.00
45.00 ATM SURCHARGE REVENUE	B	-1,700	ADMINISTRATIVE & GENERAL		45.00
45.01 PHYSICIAN GUARANTEE	B	-30,500	ADMINISTRATIVE & GENERAL		45.01
45.02 PHYSICIAN GUARANTEE	B	-14,491	EMERGENCY		45.02

Provider CCN: 151315

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

Worksheet A-8
 Date/Time Prepared:
 3/14/2012 4:02 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center	Line #	
			1.00	2.00	
45.03 OP EDUCATION	B	-150	EMPLOYEE BENEFITS	4.00	45.03
45.05 DUMPSTER LEASE	B	-9,270	OPERATION OF PLANT	7.00	45.05
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,833,141			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151315

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

Worksheet A-8

Date/Time Prepared:
3/14/2012 4:02 pm

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	11	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	11	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	9	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	MRI DEPRECIATION CARRYFORWARD ADJUST	9	33.00
34.00	BAD DEBT EXPENSE ADJUSTMENT	0	34.00
35.00	LOBBYING EXPENSES	0	35.00
36.00	EMPLOYEE CHRISTMAS PARTY	0	36.00
37.00	PHYSICIAN RECRUITMENT	0	37.00
38.00	MEALS ON WHEELS	0	38.00
39.00	REIMB FOUNDATION DEVELOP OFFICE	0	39.00
40.00	OTHER RECEIPTS	0	40.00
41.00	EMS OTHER	0	41.00
42.00	ANESTHESIA SUBSIDY	0	42.00
43.00	RENTAL INCOME OFFSET - CANCER CENTER	9	43.00
44.00	SLEEP CENTER TRAINING INCOME	0	44.00
45.00	ATM SURCHARGE REVENUE	0	45.00
45.01	PHYSICIAN GUARANTEE	0	45.01
45.02	PHYSICIAN GUARANTEE	0	45.02
45.03	OP EDUCATION	0	45.03
45.05	DUMPSTER LEASE	0	45.05
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

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

Provider CCN: 151315

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

Worksheet A-8-1

Date/Time Prepared:
3/14/2012 4:02 pm

		Line No.	Cost Center	Expense Items	
		1.00	2.00	3.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		4.00	EMPLOYEE BENEFITS	CMO OVERHEAD - BENEFITS	1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	CMO OVERHEAD - A&G	2.00
3.00		7.00	OPERATION OF PLANT	CMO OVERHEAD - PLANT OPS	3.00
4.00		2.00	NEW CAP REL COSTS-MVBLE EQUIP	RENT PAID TO CMO	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				5.00

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

		Symbol (1)	Name	Percentage of Ownership	
		1.00	2.00	3.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

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

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

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

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

Provider CCN: 151315

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

Worksheet A-8-1

Date/Time Prepared:
3/14/2012 4:02 pm

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	4.00	5.00	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	0	184,806	-184,806	0	1.00
2.00	0	54,564	-54,564	0	2.00
3.00	0	3,300	-3,300	0	3.00
4.00	77,078	357,155	-280,077	9	4.00
5.00	77,078	599,825	-522,747		5.00
TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.					

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

Related Organization(s) and/or Home Office			
Name	Percentage of Ownership	Type of Business	
4.00	5.00	6.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:			

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151315

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

Worksheet A-8-2

Date/Time Prepared:
3/14/2012 4:02 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	60.00	MEDICAL SPECIALIST	18,000	8,243	1.00
2.00	30.00	HOSPITALIST	335,556	335,556	2.00
3.00	0.00		0	0	3.00
4.00	0.00		0	0	4.00
5.00	0.00		0	0	5.00
6.00	0.00		0	0	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00		TOTAL (lines 1.00 through 199.00)	353,556	343,799	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151315

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

Worksheet A-8-2

Date/Time Prepared:
3/14/2012 4:02 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	9,757	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	9,757		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151315

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

Worksheet A-8-2

Date/Time Prepared:
3/14/2012 4:02 pm

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151315

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

Worksheet A-8-2
Date/Time Prepared:
3/14/2012 4:02 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	8,243	1.00
2.00	0	335,556	2.00
3.00	0	0	3.00
4.00	0	0	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	343,799	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151315		Period: From 10/01/2010 To 09/30/2011		Worksheet A-8-3 Par Date/Time Prepared: 3/14/2012 4:02 pm	
				Respiratory Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					365	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					3.25	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	1,951.00	14,638.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	60.25	58.08	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	29.04	29.04	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					117,548	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					850,175	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					967,723	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)					967,723	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					967,723	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					10,600	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)					10,600	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,186	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					11,786	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151315		Period: From 10/01/2010 To 09/30/2011		Worksheet A-8-3 Part Date/Time Prepared: 3/14/2012 4:02 pm	
				Respiratory 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)	132.00	0.00	0.00	0.00	132.00	47.00
48.00	Overtime rate (see instructions)	87.12	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	11,499.84	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)	100.00	0.00	0.00	0.00	100.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	2,080.00	0.00	0.00	0.00	2,080.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	58.08	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	120,806	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	11,500	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	7,667	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.)	3,833	0	0	0	3,833	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					967,723	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					3,833	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)					971,556	63.00
64.00	Total cost of outside supplier services (from your records)					0	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					10,600	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,186	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					11,786	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,186	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					1,186	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: 151315

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

Worksheet B
Part I
Date/Time Prepared:
3/14/2012 4:02 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT	901,980	901,980				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	2,062,462		2,062,462			2.00
4.00 EMPLOYEE BENEFITS	5,060,267	0	0	5,060,267		4.00
5.00 ADMINISTRATIVE & GENERAL	4,764,790	131,970	301,765	921,799	6,120,324	5.00
7.00 OPERATION OF PLANT	1,618,379	123,160	281,617	168,544	2,191,700	7.00
8.00 LAUNDRY & LINEN SERVICE	110,280	10,779	24,648	0	145,707	8.00
9.00 HOUSEKEEPING	512,012	741	1,695	144,908	659,356	9.00
10.00 DIETARY	56,072	32,408	74,103	18,027	180,610	10.00
11.00 CAFETERIA	392,778	15,443	35,313	92,377	535,911	11.00
13.00 NURSING ADMINISTRATION	522,718	3,475	7,945	188,291	722,429	13.00
14.00 CENTRAL SERVICES & SUPPLY	176,102	15,992	36,566	41,241	269,901	14.00
15.00 PHARMACY	1,620,324	8,061	18,433	133,385	1,780,203	15.00
16.00 MEDICAL RECORDS & LIBRARY	891,077	11,567	26,449	197,190	1,126,283	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1,526,173	67,155	153,556	508,898	2,255,782	30.00
31.00 INTENSIVE CARE UNIT	25,748	3,884	8,881	6,898	45,411	31.00
43.00 NURSERY	23,263	3,089	7,063	8,508	41,923	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	1,134,358	71,047	162,455	290,335	1,658,195	50.00
51.00 RECOVERY ROOM	488,776	16,076	36,760	143,063	684,675	51.00
52.00 DELIVERY ROOM & LABOR ROOM	413,092	18,764	42,905	126,705	601,466	52.00
54.00 RADIOLOGY-DIAGNOSTIC	2,087,203	46,716	106,820	451,263	2,692,002	54.00
60.00 LABORATORY	1,829,563	26,269	60,067	316,548	2,232,447	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	528,524	6,533	14,937	12,009	562,003	65.00
65.01 SLEEP LAB	143,256	12,849	29,380	0	185,485	65.01
66.00 PHYSICAL THERAPY	618,373	32,029	73,238	213,863	937,503	66.00
69.00 ELECTROCARDIOLOGY	243,511	1,158	2,648	0	247,317	69.00
69.01 CARDIAC REHAB	53,196	13,644	31,199	16,294	114,333	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	727,623	0	0	0	727,623	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	102,376	0	0	0	102,376	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 CHEMICAL DEPENDENCY	140,020	19,150	43,788	46,717	249,675	76.00
76.01 ONCOLOGY	1,611,512	85,710	195,984	0	1,893,206	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	111,732	1,506	3,443	33,310	149,991	90.00
91.00 EMERGENCY	1,403,931	43,674	99,864	482,261	2,029,730	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	727,483	10,710	24,489	239,875	1,002,557	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 UTILIZATION REVIEW - SNF	0	0	0	0	0	114.00
116.00 HOSPICE	143,006	2,193	5,014	36,398	186,611	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	32,771,960	835,752	1,911,025	4,838,707	32,332,735	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,992	4,555	0	6,547	190.00
194.00 DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01 MOB	4,390	8,293	18,963	0	31,646	194.01
194.02 COMMUNITY HEALTH	75,522	0	0	25,653	101,175	194.02
194.03 ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04 EDUCATION	41,031	0	0	0	41,031	194.04
194.05 MARKETING	302,114	6,463	14,778	38,703	362,058	194.05
194.06 GUEST MEALS	102,293	0	0	18,121	120,414	194.06
194.07 OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08 CANCER CENTER	0	0	0	0	0	194.08
194.09 URGENT CARE	978,996	49,480	113,141	139,083	1,280,700	194.09
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers					0	201.00
202.00 TOTAL (sum lines 118-201)	34,276,306	901,980	2,062,462	5,060,267	34,276,306	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 151315		Period: From 10/01/2010 To 09/30/2011		Worksheet B Part I Date/Time Prepared: 3/14/2012 4:02 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	6,120,324					5.00
7.00	OPERATION OF PLANT	476,414	2,668,114				7.00
8.00	LAUNDRY & LINEN SERVICE	31,673	44,463	221,843			8.00
9.00	HOUSEKEEPING	143,326	3,058	66,324	872,064		9.00
10.00	DIETARY	39,260	133,675	3,416	0	356,961	10.00
11.00	CAFETERIA	116,492	63,700	0	41,527	0	11.00
13.00	NURSING ADMINISTRATION	157,036	14,333	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	58,669	65,962	0	8,979	0	14.00
15.00	PHARMACY	386,966	33,251	0	12,346	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	244,822	47,711	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	490,344	277,000	44,412	187,432	351,808	30.00
31.00	INTENSIVE CARE UNIT	9,871	16,021	1,088	3,367	5,153	31.00
43.00	NURSERY	9,113	12,740	7,616	38,160	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	360,445	293,053	22,478	71,830	0	50.00
51.00	RECOVERY ROOM	148,829	66,312	10,445	19,080	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	130,742	77,396	1,719	14,591	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	585,167	192,693	18,344	59,484	0	54.00
60.00	LABORATORY	485,271	108,354	305	47,139	0	60.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	122,164	26,945	22	7,856	0	65.00
65.01	SLEEP LAB	40,319	52,999	2,524	7,856	0	65.01
66.00	PHYSICAL THERAPY	203,787	132,114	1,958	37,037	0	66.00
69.00	ELECTROCARDIOLOGY	53,760	4,778	22	0	0	69.00
69.01	CARDIAC REHAB	24,853	56,279	1,958	0	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	158,165	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	22,254	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	CHEMICAL DEPENDENCY	54,272	78,988	0	12,346	0	76.00
76.01	ONCOLOGY	411,530	353,535	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	32,604	6,211	305	2,245	0	90.00
91.00	EMERGENCY	441,206	180,144	38,820	151,517	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	217,928	44,176	0	16,835	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	UTILIZATION REVIEW - SNF	0	0	0	0	0	114.00
116.00	HOSPICE	40,564	9,045	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	5,697,846	2,394,936	221,756	739,627	356,961	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,423	8,217	0	0	0	190.00
194.00	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	MOB	6,879	34,207	87	88,665	0	194.01
194.02	COMMUNITY HEALTH	21,993	0	0	0	0	194.02
194.03	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	EDUCATION	8,919	0	0	0	0	194.04
194.05	MARKETING	78,701	26,659	0	0	0	194.05
194.06	GUEST MEALS	26,175	0	0	0	0	194.06
194.07	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	CANCER CENTER	0	0	0	0	0	194.08
194.09	URGENT CARE	278,388	204,095	0	43,772	0	194.09
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	6,120,324	2,668,114	221,843	872,064	356,961	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151315

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

Worksheet B
Part I
Date/Time Prepared:
3/14/2012 4:02 pm

Cost Center Description	CAFETERIA	NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA	757,630					11.00
13.00 NURSING ADMINISTRATION	24,728	918,526				13.00
14.00 CENTRAL SERVICES & SUPPLY	13,447	0	416,958			14.00
15.00 PHARMACY	19,013	0	1,536	2,233,315		15.00
16.00 MEDICAL RECORDS & LIBRARY	45,122	0	338	0	1,464,276	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	109,744	181,534	17,996	0	13,032	30.00
31.00 INTENSIVE CARE UNIT	1,494	2,501	0	0	513	31.00
43.00 NURSERY	1,457	2,424	0	0	4,846	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	57,299	94,778	50,794	0	34,855	50.00
51.00 RECOVERY ROOM	28,015	46,370	20,611	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	21,814	36,077	5,798	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	84,530	139,833	9,033	0	405,490	54.00
60.00 LABORATORY	73,959	122,377	109,475	0	439,398	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	1,307	0	3,645	0	41,378	65.00
65.01 SLEEP LAB	0	0	0	0	0	65.01
66.00 PHYSICAL THERAPY	37,465	62,002	1,820	0	118,917	66.00
69.00 ELECTROCARDIOLOGY	0	0	620	0	64,786	69.00
69.01 CARDIAC REHAB	3,100	0	299	0	45,929	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	153,619	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	21,614	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	2,233,315	0	73.00
76.00 CHEMICAL DEPENDENCY	11,056	0	106	0	25,007	76.00
76.01 ONCOLOGY	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	7,396	12,248	3,277	0	37,557	90.00
91.00 EMERGENCY	96,221	159,205	6,559	0	232,568	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	51,696	59,177	2,052	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 UTILIZATION REVIEW - SNF	0	0	0	0	0	114.00
116.00 HOSPICE	8,330	0	900	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	697,193	918,526	410,092	2,233,315	1,464,276	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00 DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01 MOB	0	0	927	0	0	194.01
194.02 COMMUNITY HEALTH	5,267	0	574	0	0	194.02
194.03 ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04 EDUCATION	0	0	840	0	0	194.04
194.05 MARKETING	9,674	0	459	0	0	194.05
194.06 GUEST MEALS	6,985	0	0	0	0	194.06
194.07 OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08 CANCER CENTER	0	0	0	0	0	194.08
194.09 URGENT CARE	38,511	0	4,066	0	0	194.09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	757,630	918,526	416,958	2,233,315	1,464,276	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151315

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

Worksheet B
Part I
Date/Time Prepared:
3/14/2012 4:02 pm

Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00 EMPLOYEE BENEFITS				4.00
5.00 ADMINISTRATIVE & GENERAL				5.00
7.00 OPERATION OF PLANT				7.00
8.00 LAUNDRY & LINEN SERVICE				8.00
9.00 HOUSEKEEPING				9.00
10.00 DIETARY				10.00
11.00 CAFETERIA				11.00
13.00 NURSING ADMINISTRATION				13.00
14.00 CENTRAL SERVICES & SUPPLY				14.00
15.00 PHARMACY				15.00
16.00 MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS	3,929,084	0	3,929,084	30.00
31.00 INTENSIVE CARE UNIT	85,419	0	85,419	31.00
43.00 NURSERY	118,279	0	118,279	43.00
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	2,643,727	0	2,643,727	50.00
51.00 RECOVERY ROOM	1,024,337	0	1,024,337	51.00
52.00 DELIVERY ROOM & LABOR ROOM	889,603	0	889,603	52.00
54.00 RADIOLOGY-DIAGNOSTIC	4,186,576	0	4,186,576	54.00
60.00 LABORATORY	3,618,725	0	3,618,725	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	64.00
65.00 RESPIRATORY THERAPY	765,320	0	765,320	65.00
65.01 SLEEP LAB	289,183	0	289,183	65.01
66.00 PHYSICAL THERAPY	1,532,603	0	1,532,603	66.00
69.00 ELECTROCARDIOLOGY	371,283	0	371,283	69.00
69.01 CARDIAC REHAB	246,751	0	246,751	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,039,407	0	1,039,407	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	146,244	0	146,244	72.00
73.00 DRUGS CHARGED TO PATIENTS	2,233,315	0	2,233,315	73.00
76.00 CHEMICAL DEPENDENCY	431,450	0	431,450	76.00
76.01 ONCOLOGY	2,658,271	0	2,658,271	76.01
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00 CLINIC	251,834	0	251,834	90.00
91.00 EMERGENCY	3,335,970	0	3,335,970	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00 HOME HEALTH AGENCY	1,394,421	0	1,394,421	101.00
SPECIAL PURPOSE COST CENTERS				
113.00 INTEREST EXPENSE	0	0	0	113.00
114.00 UTILIZATION REVIEW - SNF	0	0	0	114.00
116.00 HOSPICE	245,450	0	245,450	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	31,437,252	0	31,437,252	118.00
NONREIMBURSABLE COST CENTERS				
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,187	0	16,187	190.00
194.00 DAYCARE-INFANT/TODDLER	0	0	0	194.00
194.01 MOB	162,411	0	162,411	194.01
194.02 COMMUNITY HEALTH	129,009	0	129,009	194.02
194.03 ASSISTED LIVING/CAMERON WOODS	0	0	0	194.03
194.04 EDUCATION	50,790	0	50,790	194.04
194.05 MARKETING	477,551	0	477,551	194.05
194.06 GUEST MEALS	153,574	0	153,574	194.06
194.07 OUTSIDE LAUNDRY	0	0	0	194.07
194.08 CANCER CENTER	0	0	0	194.08
194.09 URGENT CARE	1,849,532	0	1,849,532	194.09
200.00 Cross Foot Adjustments	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	34,276,306	0	34,276,306	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151315

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

Worksheet B
Part II
Date/Time Prepared:
3/14/2012 4:02 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	0	0	0	0	4.00
5.00	ADMINISTRATIVE & GENERAL	0	131,970	301,765	433,735	5.00
7.00	OPERATION OF PLANT	0	123,160	281,617	404,777	7.00
8.00	LAUNDRY & LINEN SERVICE	0	10,779	24,648	35,427	8.00
9.00	HOUSEKEEPING	0	741	1,695	2,436	9.00
10.00	DIETARY	0	32,408	74,103	106,511	10.00
11.00	CAFETERIA	0	15,443	35,313	50,756	11.00
13.00	NURSING ADMINISTRATION	0	3,475	7,945	11,420	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	15,992	36,566	52,558	14.00
15.00	PHARMACY	0	8,061	18,433	26,494	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	11,567	26,449	38,016	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	67,155	153,556	220,711	30.00
31.00	INTENSIVE CARE UNIT	0	3,884	8,881	12,765	31.00
43.00	NURSERY	0	3,089	7,063	10,152	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	71,047	162,455	233,502	50.00
51.00	RECOVERY ROOM	0	16,076	36,760	52,836	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	18,764	42,905	61,669	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	46,716	106,820	153,536	54.00
60.00	LABORATORY	0	26,269	60,067	86,336	60.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	6,533	14,937	21,470	65.00
65.01	SLEEP LAB	0	12,849	29,380	42,229	65.01
66.00	PHYSICAL THERAPY	0	32,029	73,238	105,267	66.00
69.00	ELECTROCARDIOLOGY	0	1,158	2,648	3,806	69.00
69.01	CARDIAC REHAB	0	13,644	31,199	44,843	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	CHEMICAL DEPENDENCY	0	19,150	43,788	62,938	76.00
76.01	ONCOLOGY	0	85,710	195,984	281,694	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	CLINIC	0	1,506	3,443	4,949	90.00
91.00	EMERGENCY	0	43,674	99,864	143,538	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	10,710	24,489	35,199	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	113.00
114.00	UTILIZATION REVIEW - SNF	0	0	0	0	114.00
116.00	HOSPICE	0	2,193	5,014	7,207	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	835,752	1,911,025	2,746,777	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,992	4,555	6,547	190.00
194.00	DAYCARE-INFANT/TODDLER	0	0	0	0	194.00
194.01	MOB	0	8,293	18,963	27,256	194.01
194.02	COMMUNITY HEALTH	0	0	0	0	194.02
194.03	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	194.03
194.04	EDUCATION	0	0	0	0	194.04
194.05	MARKETING	0	6,463	14,778	21,241	194.05
194.06	GUEST MEALS	0	0	0	0	194.06
194.07	OUTSIDE LAUNDRY	0	0	0	0	194.07
194.08	CANCER CENTER	0	0	0	0	194.08
194.09	URGENT CARE	0	49,480	113,141	162,621	194.09
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	901,980	2,062,462	2,964,442	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151315		Period: From 10/01/2010 To 09/30/2011		Worksheet B Part II Date/Time Prepared: 3/14/2012 4:02 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	433,735					5.00
7.00	OPERATION OF PLANT	33,763	438,540				7.00
8.00	LAUNDRY & LINEN SERVICE	2,245	7,308	44,980			8.00
9.00	HOUSEKEEPING	10,157	503	13,446	26,542		9.00
10.00	DIETARY	2,782	21,971	693	0	131,957	10.00
11.00	CAFETERIA	8,256	10,470	0	1,264	0	11.00
13.00	NURSING ADMINISTRATION	11,129	2,356	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	4,158	10,842	0	273	0	14.00
15.00	PHARMACY	27,424	5,465	0	376	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	17,350	7,842	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	34,750	45,529	9,005	5,706	130,052	30.00
31.00	INTENSIVE CARE UNIT	700	2,633	221	102	1,905	31.00
43.00	NURSERY	646	2,094	1,544	1,161	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	25,544	48,167	4,558	2,186	0	50.00
51.00	RECOVERY ROOM	10,547	10,899	2,118	581	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	9,266	12,721	349	444	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	41,462	31,672	3,719	1,810	0	54.00
60.00	LABORATORY	34,391	17,809	62	1,435	0	60.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	8,658	4,429	4	239	0	65.00
65.01	SLEEP LAB	2,857	8,711	512	239	0	65.01
66.00	PHYSICAL THERAPY	14,442	21,715	397	1,127	0	66.00
69.00	ELECTROCARDIOLOGY	3,810	785	4	0	0	69.00
69.01	CARDIAC REHAB	1,761	9,250	397	0	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,209	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	1,577	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	CHEMICAL DEPENDENCY	3,846	12,983	0	376	0	76.00
76.01	ONCOLOGY	29,165	58,107	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	2,311	1,021	62	68	0	90.00
91.00	EMERGENCY	31,268	29,609	7,871	4,612	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	15,444	7,261	0	512	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	UTILIZATION REVIEW - SNF	0	0	0	0	0	114.00
116.00	HOSPICE	2,875	1,487	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	403,793	393,639	44,962	22,511	131,957	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	101	1,351	0	0	0	190.00
194.00	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	MOB	488	5,622	18	2,699	0	194.01
194.02	COMMUNITY HEALTH	1,559	0	0	0	0	194.02
194.03	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	EDUCATION	632	0	0	0	0	194.04
194.05	MARKETING	5,578	4,382	0	0	0	194.05
194.06	GUEST MEALS	1,855	0	0	0	0	194.06
194.07	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	CANCER CENTER	0	0	0	0	0	194.08
194.09	URGENT CARE	19,729	33,546	0	1,332	0	194.09
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	433,735	438,540	44,980	26,542	131,957	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet B Part II Date/Time Prepared: 3/14/2012 4:02 pm
-------------------------------------	--	----------------------	---	--

Cost Center Description	CAFETERIA	NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA	70,746					11.00
13.00 NURSING ADMINISTRATION	2,309	27,214				13.00
14.00 CENTRAL SERVICES & SUPPLY	1,256	0	69,087			14.00
15.00 PHARMACY	1,775	0	255	61,789		15.00
16.00 MEDICAL RECORDS & LIBRARY	4,213	0	56	0	67,477	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	10,249	5,378	2,982	0	601	30.00
31.00 INTENSIVE CARE UNIT	140	74	0	0	24	31.00
43.00 NURSERY	136	72	0	0	223	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	5,351	2,808	8,416	0	1,606	50.00
51.00 RECOVERY ROOM	2,616	1,374	3,415	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	2,037	1,069	961	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	7,893	4,143	1,497	0	18,686	54.00
60.00 LABORATORY	6,906	3,626	18,139	0	20,248	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	122	0	604	0	1,907	65.00
65.01 SLEEP LAB	0	0	0	0	0	65.01
66.00 PHYSICAL THERAPY	3,498	1,837	302	0	5,480	66.00
69.00 ELECTROCARDIOLOGY	0	0	103	0	2,985	69.00
69.01 CARDIAC REHAB	289	0	50	0	2,117	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	25,451	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	3,581	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	61,789	0	73.00
76.00 CHEMICAL DEPENDENCY	1,032	0	18	0	1,152	76.00
76.01 ONCOLOGY	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	691	363	543	0	1,731	90.00
91.00 EMERGENCY	8,985	4,717	1,087	0	10,717	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	4,827	1,753	340	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 UTILIZATION REVIEW - SNF	0	0	0	0	0	114.00
116.00 HOSPICE	778	0	149	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	65,103	27,214	67,949	61,789	67,477	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00 DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01 MOB	0	0	154	0	0	194.01
194.02 COMMUNITY HEALTH	492	0	95	0	0	194.02
194.03 ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04 EDUCATION	0	0	139	0	0	194.04
194.05 MARKETING	903	0	76	0	0	194.05
194.06 GUEST MEALS	652	0	0	0	0	194.06
194.07 OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08 CANCER CENTER	0	0	0	0	0	194.08
194.09 URGENT CARE	3,596	0	674	0	0	194.09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	70,746	27,214	69,087	61,789	67,477	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151315

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

Worksheet B
Part II
Date/Time Prepared:
3/14/2012 4:02 pm

Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00 EMPLOYEE BENEFITS				4.00
5.00 ADMINISTRATIVE & GENERAL				5.00
7.00 OPERATION OF PLANT				7.00
8.00 LAUNDRY & LINEN SERVICE				8.00
9.00 HOUSEKEEPING				9.00
10.00 DIETARY				10.00
11.00 CAFETERIA				11.00
13.00 NURSING ADMINISTRATION				13.00
14.00 CENTRAL SERVICES & SUPPLY				14.00
15.00 PHARMACY				15.00
16.00 MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS	464,963	0	464,963	30.00
31.00 INTENSIVE CARE UNIT	18,564	0	18,564	31.00
43.00 NURSERY	16,028	0	16,028	43.00
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	332,138	0	332,138	50.00
51.00 RECOVERY ROOM	84,386	0	84,386	51.00
52.00 DELIVERY ROOM & LABOR ROOM	88,516	0	88,516	52.00
54.00 RADIOLOGY-DIAGNOSTIC	264,418	0	264,418	54.00
60.00 LABORATORY	188,952	0	188,952	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	64.00
65.00 RESPIRATORY THERAPY	37,433	0	37,433	65.00
65.01 SLEEP LAB	54,548	0	54,548	65.01
66.00 PHYSICAL THERAPY	154,065	0	154,065	66.00
69.00 ELECTROCARDIOLOGY	11,493	0	11,493	69.00
69.01 CARDIAC REHAB	58,707	0	58,707	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	36,660	0	36,660	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	5,158	0	5,158	72.00
73.00 DRUGS CHARGED TO PATIENTS	61,789	0	61,789	73.00
76.00 CHEMICAL DEPENDENCY	82,345	0	82,345	76.00
76.01 ONCOLOGY	368,966	0	368,966	76.01
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00 CLINIC	11,739	0	11,739	90.00
91.00 EMERGENCY	242,404	0	242,404	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00 HOME HEALTH AGENCY	65,336	0	65,336	101.00
SPECIAL PURPOSE COST CENTERS				
113.00 INTEREST EXPENSE	0	0	0	113.00
114.00 UTILIZATION REVIEW - SNF	0	0	0	114.00
116.00 HOSPICE	12,496	0	12,496	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	2,661,104	0	2,661,104	118.00
NONREIMBURSABLE COST CENTERS				
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,999	0	7,999	190.00
194.00 DAYCARE-INFANT/TODDLER	0	0	0	194.00
194.01 MOB	36,237	0	36,237	194.01
194.02 COMMUNITY HEALTH	2,146	0	2,146	194.02
194.03 ASSISTED LIVING/CAMERON WOODS	0	0	0	194.03
194.04 EDUCATION	771	0	771	194.04
194.05 MARKETING	32,180	0	32,180	194.05
194.06 GUEST MEALS	2,507	0	2,507	194.06
194.07 OUTSIDE LAUNDRY	0	0	0	194.07
194.08 CANCER CENTER	0	0	0	194.08
194.09 URGENT CARE	221,498	0	221,498	194.09
200.00 Cross Foot Adjustments	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	2,964,442	0	2,964,442	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151315

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

Worksheet B-1

Date/Time Prepared:
3/14/2012 4:02 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT	116,812					1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		116,812				2.00
4.00 EMPLOYEE BENEFITS	0	0	13,835,298			4.00
5.00 ADMINISTRATIVE & GENERAL	17,091	17,091	2,520,279	-6,120,324	28,155,982	5.00
7.00 OPERATION OF PLANT	15,950	15,950	460,817	0	2,191,700	7.00
8.00 LAUNDRY & LINEN SERVICE	1,396	1,396	0	0	145,707	8.00
9.00 HOUSEKEEPING	96	96	396,195	0	659,356	9.00
10.00 DIETARY	4,197	4,197	49,287	0	180,610	10.00
11.00 CAFETERIA	2,000	2,000	252,570	0	535,911	11.00
13.00 NURSING ADMINISTRATION	450	450	514,807	0	722,429	13.00
14.00 CENTRAL SERVICES & SUPPLY	2,071	2,071	112,758	0	269,901	14.00
15.00 PHARMACY	1,044	1,044	364,689	0	1,780,203	15.00
16.00 MEDICAL RECORDS & LIBRARY	1,498	1,498	539,140	0	1,126,283	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	8,697	8,697	1,391,382	0	2,255,782	30.00
31.00 INTENSIVE CARE UNIT	503	503	18,861	0	45,411	31.00
43.00 NURSERY	400	400	23,263	0	41,923	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	9,201	9,201	793,806	0	1,658,195	50.00
51.00 RECOVERY ROOM	2,082	2,082	391,149	0	684,675	51.00
52.00 DELIVERY ROOM & LABOR ROOM	2,430	2,430	346,424	0	601,466	52.00
54.00 RADIOLOGY-DIAGNOSTIC	6,050	6,050	1,233,801	0	2,692,002	54.00
60.00 LABORATORY	3,402	3,402	865,476	0	2,232,447	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	846	846	32,833	0	562,003	65.00
65.01 SLEEP LAB	1,664	1,664	0	0	185,485	65.01
66.00 PHYSICAL THERAPY	4,148	4,148	584,725	0	937,503	66.00
69.00 ELECTROCARDIOLOGY	150	150	0	0	247,317	69.00
69.01 CARDIAC REHAB	1,767	1,767	44,549	0	114,333	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	727,623	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	102,376	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 CHEMICAL DEPENDENCY	2,480	2,480	127,728	0	249,675	76.00
76.01 ONCOLOGY	11,100	11,100	0	0	1,893,206	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	195	195	91,073	0	149,991	90.00
91.00 EMERGENCY	5,656	5,656	1,318,555	0	2,029,730	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	1,387	1,387	655,843	0	1,002,557	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 UTILIZATION REVIEW - SNF	0	0	0	0	0	114.00
116.00 HOSPICE	284	284	99,516	0	186,611	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	108,235	108,235	13,229,526	-6,120,324	26,212,411	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	258	258	0	0	6,547	190.00
194.00 DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01 MOB	1,074	1,074	0	0	31,646	194.01
194.02 COMMUNITY HEALTH	0	0	70,138	0	101,175	194.02
194.03 ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04 EDUCATION	0	0	0	0	41,031	194.04
194.05 MARKETING	837	837	105,819	0	362,058	194.05
194.06 GUEST MEALS	0	0	49,546	0	120,414	194.06
194.07 OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08 CANCER CENTER	0	0	0	0	0	194.08
194.09 URGENT CARE	6,408	6,408	380,269	0	1,280,700	194.09
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)	901,980	2,062,462	5,060,267		6,120,324	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	7.721638	17.656251	0.365750		0.217372	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			0		433,735	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000000		0.015405	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151315

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

Worksheet B-1
Date/Time Prepared:
3/14/2012 4:02 pm

Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
	7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT	83,771					7.00
8.00 LAUNDRY & LINEN SERVICE	1,396	10,195				8.00
9.00 HOUSEKEEPING	96	3,048	777			9.00
10.00 DIETARY	4,197	157	0	12,331		10.00
11.00 CAFETERIA	2,000	0	37	0	20,283	11.00
13.00 NURSING ADMINISTRATION	450	0	0	0	662	13.00
14.00 CENTRAL SERVICES & SUPPLY	2,071	0	8	0	360	14.00
15.00 PHARMACY	1,044	0	11	0	509	15.00
16.00 MEDICAL RECORDS & LIBRARY	1,498	0	0	0	1,208	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	8,697	2,041	167	12,153	2,938	30.00
31.00 INTENSIVE CARE UNIT	503	50	3	178	40	31.00
43.00 NURSERY	400	350	34	0	39	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	9,201	1,033	64	0	1,534	50.00
51.00 RECOVERY ROOM	2,082	480	17	0	750	51.00
52.00 DELIVERY ROOM & LABOR ROOM	2,430	79	13	0	584	52.00
54.00 RADIOLOGY-DIAGNOSTIC	6,050	843	53	0	2,263	54.00
60.00 LABORATORY	3,402	14	42	0	1,980	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	846	1	7	0	35	65.00
65.01 SLEEP LAB	1,664	116	7	0	0	65.01
66.00 PHYSICAL THERAPY	4,148	90	33	0	1,003	66.00
69.00 ELECTROCARDIOLOGY	150	1	0	0	0	69.00
69.01 CARDIAC REHAB	1,767	90	0	0	83	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 CHEMICAL DEPENDENCY	2,480	0	11	0	296	76.00
76.01 ONCOLOGY	11,100	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	195	14	2	0	198	90.00
91.00 EMERGENCY	5,656	1,784	135	0	2,576	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	1,387	0	15	0	1,384	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 UTILIZATION REVIEW - SNF	0	0	0	0	0	114.00
116.00 HOSPICE	284	0	0	0	223	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	75,194	10,191	659	12,331	18,665	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	258	0	0	0	0	190.00
194.00 DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01 MOB	1,074	4	79	0	0	194.01
194.02 COMMUNITY HEALTH	0	0	0	0	141	194.02
194.03 ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04 EDUCATION	0	0	0	0	0	194.04
194.05 MARKETING	837	0	0	0	259	194.05
194.06 GUEST MEALS	0	0	0	0	187	194.06
194.07 OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08 CANCER CENTER	0	0	0	0	0	194.08
194.09 URGENT CARE	6,408	0	39	0	1,031	194.09
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)	2,668,114	221,843	872,064	356,961	757,630	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	31.850091	21.759980	1,122.347490	28.948260	37.352956	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	438,540	44,980	26,542	131,957	70,746	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	5.234986	4.411967	34.159588	10.701241	3.487946	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151315

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

Worksheet B-1

Date/Time Prepared:
3/14/2012 4:02 pm

Cost Center Description	NURSING ADMINISTRATIVE (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 EMPLOYEE BENEFITS					4.00
5.00 ADMINISTRATIVE & GENERAL					5.00
7.00 OPERATION OF PLANT					7.00
8.00 LAUNDRY & LINEN SERVICE					8.00
9.00 HOUSEKEEPING					9.00
10.00 DIETARY					10.00
11.00 CAFETERIA					11.00
13.00 NURSING ADMINISTRATION	309,191				13.00
14.00 CENTRAL SERVICES & SUPPLY	0	1,974,968			14.00
15.00 PHARMACY	0	7,277	100		15.00
16.00 MEDICAL RECORDS & LIBRARY	0	1,600	0	94,272	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS	61,107	85,240	0	839	30.00
31.00 INTENSIVE CARE UNIT	842	0	0	33	31.00
43.00 NURSERY	816	0	0	312	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	31,904	240,592	0	2,244	50.00
51.00 RECOVERY ROOM	15,609	97,627	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	12,144	27,464	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	47,070	42,787	0	26,106	54.00
60.00 LABORATORY	41,194	518,543	0	28,289	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	17,266	0	2,664	65.00
65.01 SLEEP LAB	0	0	0	0	65.01
66.00 PHYSICAL THERAPY	20,871	8,622	0	7,656	66.00
69.00 ELECTROCARDIOLOGY	0	2,936	0	4,171	69.00
69.01 CARDIAC REHAB	0	1,416	0	2,957	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	727,623	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	102,376	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	100	0	73.00
76.00 CHEMICAL DEPENDENCY	0	502	0	1,610	76.00
76.01 ONCOLOGY	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 CLINIC	4,123	15,523	0	2,418	90.00
91.00 EMERGENCY	53,591	31,067	0	14,973	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS					
101.00 HOME HEALTH AGENCY	19,920	9,721	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00 INTEREST EXPENSE	0	0	0	0	113.00
114.00 UTILIZATION REVIEW - SNF	0	0	0	0	114.00
116.00 HOSPICE	0	4,262	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	309,191	1,942,444	100	94,272	118.00
NONREIMBURSABLE COST CENTERS					
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
194.00 DAYCARE-INFANT/TODDLER	0	0	0	0	194.00
194.01 MOB	0	4,390	0	0	194.01
194.02 COMMUNITY HEALTH	0	2,719	0	0	194.02
194.03 ASSISTED LIVING/CAMERON WOODS	0	0	0	0	194.03
194.04 EDUCATION	0	3,978	0	0	194.04
194.05 MARKETING	0	2,176	0	0	194.05
194.06 GUEST MEALS	0	0	0	0	194.06
194.07 OUTSIDE LAUNDRY	0	0	0	0	194.07
194.08 CANCER CENTER	0	0	0	0	194.08
194.09 URGENT CARE	0	19,261	0	0	194.09
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)	918,526	416,958	2,233,315	1,464,276	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	2.970740	0.211121	22,333.150000	15.532459	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	27,214	69,087	61,789	67,477	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.088017	0.034981	617.890000	0.715769	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151315

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

Worksheet C
Part I
Date/Time Prepared:
3/14/2012 4:02 pm

		Title XVIII		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS		3,929,084	0	0	30.00
31.00	INTENSIVE CARE UNIT		85,419	0	0	31.00
43.00	NURSERY		118,279	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM		2,643,727	0	0	50.00
51.00	RECOVERY ROOM		1,024,337	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM		889,603	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC		4,186,576	0	0	54.00
60.00	LABORATORY		3,618,725	0	0	60.00
64.00	INTRAVENOUS THERAPY		0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	765,320	0	0	65.00
65.01	SLEEP LAB	0	289,183	0	0	65.01
66.00	PHYSICAL THERAPY	0	1,532,603	0	0	66.00
69.00	ELECTROCARDIOLOGY		371,283	0	0	69.00
69.01	CARDIAC REHAB		246,751	0	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		1,039,407	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT		146,244	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS		2,233,315	0	0	73.00
76.00	CHEMICAL DEPENDENCY		431,450	0	0	76.00
76.01	ONCOLOGY		2,658,271	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC		0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
90.00	CLINIC		251,834	0	0	90.00
91.00	EMERGENCY		3,335,970	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		299,476	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY		1,394,421			101.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
114.00	UTILIZATION REVIEW - SNF					114.00
116.00	HOSPICE		245,450			116.00
200.00	Subtotal (see instructions)		31,736,728	0	0	200.00
201.00	Less Observation Beds		299,476			201.00
202.00	Total (see instructions)		31,437,252	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet C Part I Date/Time Prepared: 3/14/2012 4:02 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	5,064,840		5,064,840			30.00
31.00 INTENSIVE CARE UNIT	151,610		151,610			31.00
43.00 NURSERY	221,379		221,379			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	1,203,856	6,115,626	7,319,482	0.361190	0.000000	50.00
51.00 RECOVERY ROOM	230,683	1,236,657	1,467,340	0.698091	0.000000	51.00
52.00 DELIVERY ROOM & LABOR ROOM	341,441	100,881	442,322	2.011211	0.000000	52.00
54.00 RADIOLOGY-DIAGNOSTIC	1,027,779	16,359,338	17,387,117	0.240786	0.000000	54.00
60.00 LABORATORY	1,069,153	9,708,780	10,777,933	0.335753	0.000000	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00 RESPIRATORY THERAPY	570,091	368,235	938,326	0.815623	0.000000	65.00
65.01 SLEEP LAB	0	664,875	664,875	0.434943	0.000000	65.01
66.00 PHYSICAL THERAPY	536,250	1,866,972	2,403,222	0.637728	0.000000	66.00
69.00 ELECTROCARDIOLOGY	63,259	723,678	786,937	0.471808	0.000000	69.00
69.01 CARDIAC REHAB	851	232,116	232,967	1.059167	0.000000	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	695,873	1,155,005	1,850,878	0.561575	0.000000	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	51,018	191,276	242,294	0.603581	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	1,312,414	3,021,797	4,334,211	0.515276	0.000000	73.00
76.00 CHEMICAL DEPENDENCY	815	164,974	165,789	2.602404	0.000000	76.00
76.01 ONCOLOGY	0	4,525,215	4,525,215	0.587435	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0			88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00 CLINIC	137	353,158	353,295	0.712815	0.000000	90.00
91.00 EMERGENCY	261,251	7,902,219	8,163,470	0.408646	0.000000	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	88,893	342,802	431,695	0.693721	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	0	714,208	714,208			101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
114.00 UTILIZATION REVIEW - SNF						114.00
116.00 HOSPICE	0	714,739	714,739			116.00
200.00 Subtotal (see instructions)	12,891,593	56,462,551	69,354,144			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	12,891,593	56,462,551	69,354,144			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet C Part I Date/Time Prepared: 3/14/2012 4:02 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS			30.00
31.00	INTENSIVE CARE UNIT			31.00
43.00	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.000000		50.00
51.00	RECOVERY ROOM	0.000000		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	LABORATORY	0.000000		60.00
64.00	INTRAVENOUS THERAPY	0.000000		64.00
65.00	RESPIRATORY THERAPY	0.000000		65.00
65.01	SLEEP LAB	0.000000		65.01
66.00	PHYSICAL THERAPY	0.000000		66.00
69.00	ELECTROCARDIOLOGY	0.000000		69.00
69.01	CARDIAC REHAB	0.000000		69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	CHEMICAL DEPENDENCY	0.000000		76.00
76.01	ONCOLOGY	0.000000		76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	CLINIC	0.000000		90.00
91.00	EMERGENCY	0.000000		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE			113.00
114.00	UTILIZATION REVIEW - SNF			114.00
116.00	HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151315

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

Worksheet C
Part I
Date/Time Prepared:
3/14/2012 4:02 pm

		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	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,929,084		3,929,084	0	3,929,084	30.00
31.00	INTENSIVE CARE UNIT	85,419		85,419	0	85,419	31.00
43.00	NURSERY	118,279		118,279	0	118,279	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	2,643,727		2,643,727	0	2,643,727	50.00
51.00	RECOVERY ROOM	1,024,337		1,024,337	0	1,024,337	51.00
52.00	DELIVERY ROOM & LABOR ROOM	889,603		889,603	0	889,603	52.00
54.00	RADIOLOGY-DIAGNOSTIC	4,186,576		4,186,576	0	4,186,576	54.00
60.00	LABORATORY	3,618,725		3,618,725	0	3,618,725	60.00
64.00	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	RESPIRATORY THERAPY	765,320	0	765,320	0	765,320	65.00
65.01	SLEEP LAB	289,183	0	289,183	0	289,183	65.01
66.00	PHYSICAL THERAPY	1,532,603	0	1,532,603	0	1,532,603	66.00
69.00	ELECTROCARDIOLOGY	371,283		371,283	0	371,283	69.00
69.01	CARDIAC REHAB	246,751		246,751	0	246,751	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,039,407		1,039,407	0	1,039,407	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	146,244		146,244	0	146,244	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,233,315		2,233,315	0	2,233,315	73.00
76.00	CHEMICAL DEPENDENCY	431,450		431,450	0	431,450	76.00
76.01	ONCOLOGY	2,658,271		2,658,271	0	2,658,271	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	CLINIC	251,834		251,834	0	251,834	90.00
91.00	EMERGENCY	3,335,970		3,335,970	0	3,335,970	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	299,476		299,476	0	299,476	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	1,394,421		1,394,421		1,394,421	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
114.00	UTILIZATION REVIEW - SNF						114.00
116.00	HOSPICE	245,450		245,450		245,450	116.00
200.00	Subtotal (see instructions)	31,736,728	0	31,736,728	0	31,736,728	200.00
201.00	Less Observation Beds	299,476		299,476		299,476	201.00
202.00	Total (see instructions)	31,437,252	0	31,437,252	0	31,437,252	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet C Part I Date/Time Prepared: 3/14/2012 4:02 pm
		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			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	5,064,840		5,064,840			30.00
31.00 INTENSIVE CARE UNIT	151,610		151,610			31.00
43.00 NURSERY	221,379		221,379			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	1,203,856	6,115,626	7,319,482	0.361190	0.000000	50.00
51.00 RECOVERY ROOM	230,683	1,236,657	1,467,340	0.698091	0.000000	51.00
52.00 DELIVERY ROOM & LABOR ROOM	341,441	100,881	442,322	2.011211	0.000000	52.00
54.00 RADIOLOGY-DIAGNOSTIC	1,027,779	16,359,338	17,387,117	0.240786	0.000000	54.00
60.00 LABORATORY	1,069,153	9,708,780	10,777,933	0.335753	0.000000	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00 RESPIRATORY THERAPY	570,091	368,235	938,326	0.815623	0.000000	65.00
65.01 SLEEP LAB	0	664,875	664,875	0.434943	0.000000	65.01
66.00 PHYSICAL THERAPY	536,250	1,866,972	2,403,222	0.637728	0.000000	66.00
69.00 ELECTROCARDIOLOGY	63,259	723,678	786,937	0.471808	0.000000	69.00
69.01 CARDIAC REHAB	851	232,116	232,967	1.059167	0.000000	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	695,873	1,155,005	1,850,878	0.561575	0.000000	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	51,018	191,276	242,294	0.603581	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	1,312,414	3,021,797	4,334,211	0.515276	0.000000	73.00
76.00 CHEMICAL DEPENDENCY	815	164,974	165,789	2.602404	0.000000	76.00
76.01 ONCOLOGY	0	4,525,215	4,525,215	0.587435	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00 CLINIC	137	353,158	353,295	0.712815	0.000000	90.00
91.00 EMERGENCY	261,251	7,902,219	8,163,470	0.408646	0.000000	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	88,893	342,802	431,695	0.693721	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	0	714,208	714,208			101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
114.00 UTILIZATION REVIEW - SNF						114.00
116.00 HOSPICE	0	714,739	714,739			116.00
200.00 Subtotal (see instructions)	12,891,593	56,462,551	69,354,144			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	12,891,593	56,462,551	69,354,144			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet C Part I Date/Time Prepared: 3/14/2012 4:02 pm
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS		30.00
31.00	INTENSIVE CARE UNIT		31.00
43.00	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	0.361190	50.00
51.00	RECOVERY ROOM	0.698091	51.00
52.00	DELIVERY ROOM & LABOR ROOM	2.011211	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.240786	54.00
60.00	LABORATORY	0.335753	60.00
64.00	INTRAVENOUS THERAPY	0.000000	64.00
65.00	RESPIRATORY THERAPY	0.815623	65.00
65.01	SLEEP LAB	0.434943	65.01
66.00	PHYSICAL THERAPY	0.637728	66.00
69.00	ELECTROCARDIOLOGY	0.471808	69.00
69.01	CARDIAC REHAB	1.059167	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.561575	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.603581	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.515276	73.00
76.00	CHEMICAL DEPENDENCY	2.602404	76.00
76.01	ONCOLOGY	0.587435	76.01
OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC	0.000000	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	89.00
90.00	CLINIC	0.712815	90.00
91.00	EMERGENCY	0.408646	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.693721	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	HOME HEALTH AGENCY		101.00
SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE		113.00
114.00	UTILIZATION REVIEW - SNF		114.00
116.00	HOSPICE		116.00
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

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

Provider CCN: 151315

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

Worksheet C Part II Date/Time Prepared: 3/14/2012 4:02 pm

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	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	2,643,727	332,138	2,311,589	0	0	50.00
51.00	RECOVERY ROOM	1,024,337	84,386	939,951	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	889,603	88,516	801,087	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	4,186,576	264,418	3,922,158	0	0	54.00
60.00	LABORATORY	3,618,725	188,952	3,429,773	0	0	60.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	765,320	37,433	727,887	0	0	65.00
65.01	SLEEP LAB	289,183	54,548	234,635	0	0	65.01
66.00	PHYSICAL THERAPY	1,532,603	154,065	1,378,538	0	0	66.00
69.00	ELECTROCARDIOLOGY	371,283	11,493	359,790	0	0	69.00
69.01	CARDIAC REHAB	246,751	58,707	188,044	0	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,039,407	36,660	1,002,747	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	146,244	5,158	141,086	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,233,315	61,789	2,171,526	0	0	73.00
76.00	CHEMICAL DEPENDENCY	431,450	82,345	349,105	0	0	76.00
76.01	ONCOLOGY	2,658,271	368,966	2,289,305	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	251,834	11,739	240,095	0	0	90.00
91.00	EMERGENCY	3,335,970	242,404	3,093,566	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	299,476	0	299,476	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	1,394,421	65,336	1,329,085	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
114.00	UTILIZATION REVIEW - SNF						114.00
116.00	HOSPICE	245,450	12,496	232,954	0	0	116.00
200.00	Subtotal (sum of lines 50 thru 199)	27,603,946	2,161,549	25,442,397	0	0	200.00
201.00	Less Observation Beds	299,476	0	299,476	0	0	201.00
202.00	Total (line 200 minus line 201)	27,304,470	2,161,549	25,142,921	0	0	202.00

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

Provider CCN: 151315

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

Worksheet C
Part II
Date/Time Prepared:
3/14/2012 4:02 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	2,643,727	7,319,482	0.361190		50.00
51.00	RECOVERY ROOM	1,024,337	1,467,340	0.698091		51.00
52.00	DELIVERY ROOM & LABOR ROOM	889,603	442,322	2.011211		52.00
54.00	RADIOLOGY-DIAGNOSTIC	4,186,576	17,387,117	0.240786		54.00
60.00	LABORATORY	3,618,725	10,777,933	0.335753		60.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000		64.00
65.00	RESPIRATORY THERAPY	765,320	938,326	0.815623		65.00
65.01	SLEEP LAB	289,183	664,875	0.434943		65.01
66.00	PHYSICAL THERAPY	1,532,603	2,403,222	0.637728		66.00
69.00	ELECTROCARDIOLOGY	371,283	786,937	0.471808		69.00
69.01	CARDIAC REHAB	246,751	232,967	1.059167		69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,039,407	1,850,878	0.561575		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	146,244	242,294	0.603581		72.00
73.00	DRUGS CHARGED TO PATIENTS	2,233,315	4,334,211	0.515276		73.00
76.00	CHEMICAL DEPENDENCY	431,450	165,789	2.602404		76.00
76.01	ONCOLOGY	2,658,271	4,525,215	0.587435		76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0.000000		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000		89.00
90.00	CLINIC	251,834	353,295	0.712815		90.00
91.00	EMERGENCY	3,335,970	8,163,470	0.408646		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	299,476	431,695	0.693721		92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	1,394,421	714,208	1.952402		101.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
114.00	UTILIZATION REVIEW - SNF					114.00
116.00	HOSPICE	245,450	714,739	0.343412		116.00
200.00	Subtotal (sum of lines 50 thru 199)	27,603,946	0			200.00
201.00	Less Observation Beds	299,476	0			201.00
202.00	Total (line 200 minus line 201)	27,304,470	63,916,315			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part II Date/Time Prepared: 3/14/2012 4:02 pm
--	----------------------	---	--

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	332,138	7,319,482	0.045377	192,744	8,746	50.00
51.00	RECOVERY ROOM	84,386	1,467,340	0.057510	42,384	2,438	51.00
52.00	DELIVERY ROOM & LABOR ROOM	88,516	442,322	0.200117	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	264,418	17,387,117	0.015208	265,603	4,039	54.00
60.00	LABORATORY	188,952	10,777,933	0.017531	388,520	6,811	60.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	37,433	938,326	0.039893	293,399	11,705	65.00
65.01	SLEEP LAB	54,548	664,875	0.082042	0	0	65.01
66.00	PHYSICAL THERAPY	154,065	2,403,222	0.064108	85,607	5,488	66.00
69.00	ELECTROCARDIOLOGY	11,493	786,937	0.014605	51,597	754	69.00
69.01	CARDIAC REHAB	58,707	232,967	0.251997	0	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	36,660	1,850,878	0.019807	256,077	5,072	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	5,158	242,294	0.021288	72	2	72.00
73.00	DRUGS CHARGED TO PATIENTS	61,789	4,334,211	0.014256	451,084	6,431	73.00
76.00	CHEMICAL DEPENDENCY	82,345	165,789	0.496686	0	0	76.00
76.01	ONCOLOGY	368,966	4,525,215	0.081536	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	CLINIC	11,739	353,295	0.033227	0	0	90.00
91.00	EMERGENCY	242,404	8,163,470	0.029694	3,319	99	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	431,695	0.000000	17,312	0	92.00
200.00	Total (lines 50-199)	2,083,717	62,487,368		2,047,718	51,585	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151315

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

Worksheet D
Part IV
Date/Time Prepared:
3/14/2012 4:02 pm

Cost Center Description		Title XVIII				Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	OPERATING ROOM	0	0	0	0	0	0	50.00	
51.00	RECOVERY ROOM	0	0	0	0	0	0	51.00	
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00	
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00	
60.00	LABORATORY	0	0	0	0	0	0	60.00	
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00	
65.00	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00	
65.01	SLEEP LAB	0	0	0	0	0	0	65.01	
66.00	PHYSICAL THERAPY	0	0	0	0	0	0	66.00	
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00	
69.01	CARDIAC REHAB	0	0	0	0	0	0	69.01	
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00	
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00	
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00	
76.00	CHEMICAL DEPENDENCY	0	0	0	0	0	0	76.00	
76.01	ONCOLOGY	0	0	0	0	0	0	76.01	
OUTPATIENT SERVICE COST CENTERS									
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00	
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00	
90.00	CLINIC	0	0	0	0	0	0	90.00	
91.00	EMERGENCY	0	0	0	0	0	0	91.00	
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00	
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: 151315

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

Worksheet D
Part IV
Date/Time Prepared:
3/14/2012 4:02 pm

Cost Center Description		Title XVIII			Hospital		
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	7,319,482	0.000000	0.000000	192,744	50.00
51.00	RECOVERY ROOM	0	1,467,340	0.000000	0.000000	42,384	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	442,322	0.000000	0.000000	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	17,387,117	0.000000	0.000000	265,603	54.00
60.00	LABORATORY	0	10,777,933	0.000000	0.000000	388,520	60.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	RESPIRATORY THERAPY	0	938,326	0.000000	0.000000	293,399	65.00
65.01	SLEEP LAB	0	664,875	0.000000	0.000000	0	65.01
66.00	PHYSICAL THERAPY	0	2,403,222	0.000000	0.000000	85,607	66.00
69.00	ELECTROCARDIOLOGY	0	786,937	0.000000	0.000000	51,597	69.00
69.01	CARDIAC REHAB	0	232,967	0.000000	0.000000	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,850,878	0.000000	0.000000	256,077	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	242,294	0.000000	0.000000	72	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	4,334,211	0.000000	0.000000	451,084	73.00
76.00	CHEMICAL DEPENDENCY	0	165,789	0.000000	0.000000	0	76.00
76.01	ONCOLOGY	0	4,525,215	0.000000	0.000000	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	CLINIC	0	353,295	0.000000	0.000000	0	90.00
91.00	EMERGENCY	0	8,163,470	0.000000	0.000000	3,319	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	431,695	0.000000	0.000000	17,312	92.00
200.00	Total (lines 50-199)	0	62,487,368			2,047,718	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part IV Date/Time Prepared: 3/14/2012 4:02 pm
--	----------------------	---	--

Cost Center Description	Title XVIII			Hospital		PSA Adj. Non Physician Anesthetist Cost	Cost	
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School			
	11.00	12.00	13.00	21.00	22.00			
ANCILLARY SERVICE COST CENTERS								
50.00 OPERATING ROOM	0	0	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	0	54.00
60.00 LABORATORY	0	0	0	0	0	0	0	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	0	0	65.00
65.01 SLEEP LAB	0	0	0	0	0	0	0	65.01
66.00 PHYSICAL THERAPY	0	0	0	0	0	0	0	66.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	0	0	69.00
69.01 CARDIAC REHAB	0	0	0	0	0	0	0	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	0	73.00
76.00 CHEMICAL DEPENDENCY	0	0	0	0	0	0	0	76.00
76.01 ONCOLOGY	0	0	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151315

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

Worksheet D
Part IV
Date/Time Prepared:
3/14/2012 4:02 pm

Cost Center Description		PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	Title XVIII	Hospital	Cost
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0			50.00
51.00	RECOVERY ROOM	0	0			51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0			52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0			54.00
60.00	LABORATORY	0	0			60.00
64.00	INTRAVENOUS THERAPY	0	0			64.00
65.00	RESPIRATORY THERAPY	0	0			65.00
65.01	SLEEP LAB	0	0			65.01
66.00	PHYSICAL THERAPY	0	0			66.00
69.00	ELECTROCARDIOLOGY	0	0			69.00
69.01	CARDIAC REHAB	0	0			69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0			72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0			73.00
76.00	CHEMICAL DEPENDENCY	0	0			76.00
76.01	ONCOLOGY	0	0			76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0			89.00
90.00	CLINIC	0	0			90.00
91.00	EMERGENCY	0	0			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
200.00	Total (Lines 50-199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 3/14/2012 4:02 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
	1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.361190	0	1,317,892	0	50.00
51.00	RECOVERY ROOM	0.698091	0	255,337	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	2.011211	0	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.240786	0	4,030,387	0	54.00
60.00	LABORATORY	0.335753	0	3,142,951	0	60.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0.815623	0	261,898	0	65.00
65.01	SLEEP LAB	0.434943	0	26,620	0	65.01
66.00	PHYSICAL THERAPY	0.637728	0	717,698	0	66.00
69.00	ELECTROCARDIOLOGY	0.471808	0	221,863	0	69.00
69.01	CARDIAC REHAB	1.059167	0	90,719	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.561575	0	231,616	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.603581	0	72,468	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.515276	0	752,143	10,122	73.00
76.00	CHEMICAL DEPENDENCY	2.602404	0	0	0	76.00
76.01	ONCOLOGY	0.587435	0	1,758,906	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000				88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00	CLINIC	0.712815	0	142,222	0	90.00
91.00	EMERGENCY	0.408646	0	1,680,894	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.693721	0	320,304	0	92.00
200.00	Subtotal (see instructions)		0	15,023,918	10,122	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	15,023,918	10,122	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 3/14/2012 4:02 pm
--	----------------------	---	---

Cost Center Description	Costs			Hospital	Cost
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	476,009	0		50.00
51.00 RECOVERY ROOM	0	178,248	0		51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	970,461	0		54.00
60.00 LABORATORY	0	1,055,255	0		60.00
64.00 INTRAVENOUS THERAPY	0	0	0		64.00
65.00 RESPIRATORY THERAPY	0	213,610	0		65.00
65.01 SLEEP LAB	0	11,578	0		65.01
66.00 PHYSICAL THERAPY	0	457,696	0		66.00
69.00 ELECTROCARDIOLOGY	0	104,677	0		69.00
69.01 CARDIAC REHAB	0	96,087	0		69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	130,070	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	43,740	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	387,561	5,216		73.00
76.00 CHEMICAL DEPENDENCY	0	0	0		76.00
76.01 ONCOLOGY	0	1,033,243	0		76.01
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00 CLINIC	0	101,378	0		90.00
91.00 EMERGENCY	0	686,891	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	222,202	0		92.00
200.00 Subtotal (see instructions)	0	6,168,706	5,216		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	6,168,706	5,216		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151315 Component CCN: 15Z315	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 3/14/2012 4:02 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	
	1.00	2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.361190	0	0	0	50.00
51.00 RECOVERY ROOM	0.698091	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	2.011211	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0.240786	0	0	0	54.00
60.00 LABORATORY	0.335753	0	0	0	60.00
64.00 INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0.815623	0	0	0	65.00
65.01 SLEEP LAB	0.434943	0	0	0	65.01
66.00 PHYSICAL THERAPY	0.637728	0	0	0	66.00
69.00 ELECTROCARDIOLOGY	0.471808	0	0	0	69.00
69.01 CARDIAC REHAB	1.059167	0	0	0	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.561575	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.603581	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.515276	0	0	0	73.00
76.00 CHEMICAL DEPENDENCY	2.602404	0	0	0	76.00
76.01 ONCOLOGY	0.587435	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0.000000				88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00 CLINIC	0.712815	0	0	0	90.00
91.00 EMERGENCY	0.408646	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.693721	0	0	0	92.00
200.00 Subtotal (see instructions)		0	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)			0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151315 Component CCN: 15Z315	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 3/14/2012 4:02 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	0	0		50.00
51.00 RECOVERY ROOM	0	0	0		51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00 LABORATORY	0	0	0		60.00
64.00 INTRAVENOUS THERAPY	0	0	0		64.00
65.00 RESPIRATORY THERAPY	0	0	0		65.00
65.01 SLEEP LAB	0	0	0		65.01
66.00 PHYSICAL THERAPY	0	0	0		66.00
69.00 ELECTROCARDIOLOGY	0	0	0		69.00
69.01 CARDIAC REHAB	0	0	0		69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00 CHEMICAL DEPENDENCY	0	0	0		76.00
76.01 ONCOLOGY	0	0	0		76.01
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00 CLINIC	0	0	0		90.00
91.00 EMERGENCY	0	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00 Subtotal (see instructions)	0	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151315		Period: From 10/01/2010 To 09/30/2011		Worksheet D Part I Date/Time Prepared: 3/14/2012 4:02 pm	
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)	PPS
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	464,963	70,480	394,483	3,139	125.67	30.00
31.00	INTENSIVE CARE UNIT	18,564		18,564	55	337.53	31.00
43.00	NURSERY	16,028		16,028	330	48.57	43.00
200.00	Total (Lines 30-199)	499,555		429,075	3,524		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151315		Period: From 10/01/2010 To 09/30/2011		Worksheet D Part I Date/Time Prepared: 3/14/2012 4:02 pm	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Title XIX	Hospital	PPS	
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	357	44,864				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
43.00	NURSERY	173	8,403				43.00
200.00	Total (Lines 30-199)	530	53,267				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part II Date/Time Prepared: 3/14/2012 4:02 pm
--	----------------------	---	--

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	
Title XIX Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	332,138	7,319,482	0.045377	146,201	6,634	50.00
51.00	RECOVERY ROOM	84,386	1,467,340	0.057510	28,015	1,611	51.00
52.00	DELIVERY ROOM & LABOR ROOM	88,516	442,322	0.200117	41,466	8,298	52.00
54.00	RADIOLOGY-DIAGNOSTIC	264,418	17,387,117	0.015208	124,818	1,898	54.00
60.00	LABORATORY	188,952	10,777,933	0.017531	129,842	2,276	60.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	37,433	938,326	0.039893	69,234	2,762	65.00
65.01	SLEEP LAB	54,548	664,875	0.082042	0	0	65.01
66.00	PHYSICAL THERAPY	154,065	2,403,222	0.064108	65,124	4,175	66.00
69.00	ELECTROCARDIOLOGY	11,493	786,937	0.014605	5,865	86	69.00
69.01	CARDIAC REHAB	58,707	232,967	0.251997	103	26	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	36,660	1,850,878	0.019807	84,510	1,674	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	5,158	242,294	0.021288	6,196	132	72.00
73.00	DRUGS CHARGED TO PATIENTS	61,789	4,334,211	0.014256	159,385	2,272	73.00
76.00	CHEMICAL DEPENDENCY	82,345	165,789	0.496686	99	49	76.00
76.01	ONCOLOGY	368,966	4,525,215	0.081536	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	CLINIC	11,739	353,295	0.033227	17	1	90.00
91.00	EMERGENCY	242,404	8,163,470	0.029694	31,727	942	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	41,772	431,695	0.096763	38,126	3,689	92.00
200.00	Total (lines 50-199)	2,125,489	62,487,368		930,728	36,525	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151315		Period: From 10/01/2010 To 09/30/2011		Worksheet D Part III Date/Time Prepared: 3/14/2012 4:02 pm	
Cost Center Description		Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	PPS Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	NURSERY	0	0	0	0	0	43.00
200.00	Total (Lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151315		Period: From 10/01/2010 To 09/30/2011		Worksheet D Part III Date/Time Prepared: 3/14/2012 4:02 pm	
Cost Center Description		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	PPS
		6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,139	0.00	357	0	0	30.00
31.00	INTENSIVE CARE UNIT	55	0.00	0	0	0	31.00
43.00	NURSERY	330	0.00	173	0	0	43.00
200.00	Total (Lines 30-199)	3,524		530	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151315		Period: From 10/01/2010 To 09/30/2011		Worksheet D Part III Date/Time Prepared: 3/14/2012 4:02 pm	
Cost Center Description		PSA Adj . Allied Health Cost	PSA Adj . All Other Medical Education Cost	Title XIX	Hospital	PPS	
		12.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
43.00	NURSERY	0	0				43.00
200.00	Total (Lines 30-199)	0	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151315

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

Worksheet D
Part IV
Date/Time Prepared:
3/14/2012 4:02 pm

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		
ANCILLARY SERVICE COST CENTERS								
50.00	OPERATING ROOM	0	0	0	0	0	50.00	
51.00	RECOVERY ROOM	0	0	0	0	0	51.00	
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00	
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
60.00	LABORATORY	0	0	0	0	0	60.00	
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00	
65.01	SLEEP LAB	0	0	0	0	0	65.01	
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00	
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
69.01	CARDIAC REHAB	0	0	0	0	0	69.01	
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00	
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
76.00	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00	
76.01	ONCOLOGY	0	0	0	0	0	76.01	
OUTPATIENT SERVICE COST CENTERS								
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00	
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00	
90.00	CLINIC	0	0	0	0	0	90.00	
91.00	EMERGENCY	0	0	0	0	0	91.00	
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
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: 151315

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

Worksheet D
Part IV
Date/Time Prepared:
3/14/2012 4:02 pm

Cost Center Description		Title XIX			Hospital		PPS
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	7,319,482	0.000000	0.000000	146,201	50.00
51.00	RECOVERY ROOM	0	1,467,340	0.000000	0.000000	28,015	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	442,322	0.000000	0.000000	41,466	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	17,387,117	0.000000	0.000000	124,818	54.00
60.00	LABORATORY	0	10,777,933	0.000000	0.000000	129,842	60.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	RESPIRATORY THERAPY	0	938,326	0.000000	0.000000	69,234	65.00
65.01	SLEEP LAB	0	664,875	0.000000	0.000000	0	65.01
66.00	PHYSICAL THERAPY	0	2,403,222	0.000000	0.000000	65,124	66.00
69.00	ELECTROCARDIOLOGY	0	786,937	0.000000	0.000000	5,865	69.00
69.01	CARDIAC REHAB	0	232,967	0.000000	0.000000	103	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,850,878	0.000000	0.000000	84,510	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	242,294	0.000000	0.000000	6,196	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	4,334,211	0.000000	0.000000	159,385	73.00
76.00	CHEMICAL DEPENDENCY	0	165,789	0.000000	0.000000	99	76.00
76.01	ONCOLOGY	0	4,525,215	0.000000	0.000000	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	CLINIC	0	353,295	0.000000	0.000000	17	90.00
91.00	EMERGENCY	0	8,163,470	0.000000	0.000000	31,727	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	431,695	0.000000	0.000000	38,126	92.00
200.00	Total (lines 50-199)	0	62,487,368			930,728	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part IV Date/Time Prepared: 3/14/2012 4:02 pm
--	----------------------	---	--

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	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00 LABORATORY	0	0	0	0	0	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01 SLEEP LAB	0	0	0	0	0	65.01
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01 CARDIAC REHAB	0	0	0	0	0	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 CHEMICAL DEPENDENCY	0	0	0	0	0	76.00
76.01 ONCOLOGY	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 151315

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

Worksheet D
Part IV
Date/Time Prepared:
3/14/2012 4:02 pm

Cost Center Description		PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost		
		23.00	24.00		
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0		50.00
51.00	RECOVERY ROOM	0	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	LABORATORY	0	0		60.00
64.00	INTRAVENOUS THERAPY	0	0		64.00
65.00	RESPIRATORY THERAPY	0	0		65.00
65.01	SLEEP LAB	0	0		65.01
66.00	PHYSICAL THERAPY	0	0		66.00
69.00	ELECTROCARDIOLOGY	0	0		69.00
69.01	CARDIAC REHAB	0	0		69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	CHEMICAL DEPENDENCY	0	0		76.00
76.01	ONCOLOGY	0	0		76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	CLINIC	0	0		90.00
91.00	EMERGENCY	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Total (Lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 3/14/2012 4:02 pm
	Title XIX	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
	1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0.361190	0	706,655	0		50.00
51.00 RECOVERY ROOM	0.698091	0	142,895	0		51.00
52.00 DELIVERY ROOM & LABOR ROOM	2.011211	0	11,657	0		52.00
54.00 RADIOLOGY-DIAGNOSTIC	0.240786	0	1,890,307	0		54.00
60.00 LABORATORY	0.335753	0	1,121,841	0		60.00
64.00 INTRAVENOUS THERAPY	0.000000	0	0	0		64.00
65.00 RESPIRATORY THERAPY	0.815623	0	42,549	0		65.00
65.01 SLEEP LAB	0.434943	0	76,826	0		65.01
66.00 PHYSICAL THERAPY	0.637728	0	215,727	0		66.00
69.00 ELECTROCARDIOLOGY	0.471808	0	85,338	0		69.00
69.01 CARDIAC REHAB	1.059167	0	26,821	0		69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.561575	0	133,460	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.603581	0	22,102	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.515276	0	349,166	0		73.00
76.00 CHEMICAL DEPENDENCY	2.602404	0	19,063	0		76.00
76.01 ONCOLOGY	0.587435	0	522,885	0		76.01
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0.000000					88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00 CLINIC	0.712815	0	40,807	0		90.00
91.00 EMERGENCY	0.408646	0	913,094	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.693721	0	13,081	0		92.00
200.00 Subtotal (see instructions)		0	6,334,274	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	6,334,274	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 3/14/2012 4:02 pm
	Title XIX	Hospital	PPS

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	255,237	0		50.00
51.00 RECOVERY ROOM	0	99,754	0		51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	23,445	0		52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	455,159	0		54.00
60.00 LABORATORY	0	376,661	0		60.00
64.00 INTRAVENOUS THERAPY	0	0	0		64.00
65.00 RESPIRATORY THERAPY	0	34,704	0		65.00
65.01 SLEEP LAB	0	33,415	0		65.01
66.00 PHYSICAL THERAPY	0	137,575	0		66.00
69.00 ELECTROCARDIOLOGY	0	40,263	0		69.00
69.01 CARDIAC REHAB	0	28,408	0		69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	74,948	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	13,340	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	179,917	0		73.00
76.00 CHEMICAL DEPENDENCY	0	49,610	0		76.00
76.01 ONCOLOGY	0	307,161	0		76.01
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00 CLINIC	0	29,088	0		90.00
91.00 EMERGENCY	0	373,132	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	9,075	0		92.00
200.00 Subtotal (see instructions)	0	2,520,892	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	2,520,892	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 3/14/2012 4:02 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,038	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,139	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,139	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)		510	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)		389	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,195	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)		510	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		134.70	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		138.74	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,929,084	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)		53,970	25.00
26.00	Total swing-bed cost (see instructions)		595,575	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,333,509	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		5,463,363	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		5,463,363	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.610157	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)		1,740.48	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,333,509	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,061.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,269,054	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,269,054	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151315		Period: From 10/01/2010 To 09/30/2011		Worksheet D-1	
		Title XVIII		Hospital		Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	85,419	55	1,553.07	21	32,614	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,001,494	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,303,162	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)					541,605	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					541,605	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)					282	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,061.97	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					299,476	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151315		Period: From 10/01/2010 To 09/30/2011		Worksheet D-1 Date/Time Prepared: 3/14/2012 4:02 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 3/14/2012 4:02 pm
Cost Center Description		PPS		
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,038	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,139	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,139	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)		510	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)		389	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		357	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)		330	15.00
16.00	Nursery days (title V or XIX only)		173	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		134.70	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		138.74	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,929,084	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)		53,970	25.00
26.00	Total swing-bed cost (see instructions)		595,575	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,333,509	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		5,463,363	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		5,463,363	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.610157	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)		1,740.48	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,333,509	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,061.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		379,123	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)		379,123	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151315		Period: From 10/01/2010 To 09/30/2011		Worksheet D-1	
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)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	118,279	330	358.42	173	62,007	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	85,419	55	1,553.07	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)					503,295	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					944,425	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)					53,267	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					36,525	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					89,792	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					854,633	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)					282	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,061.97	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					299,476	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151315		Period: From 10/01/2010 To 09/30/2011		Worksheet D-1 Date/Time Prepared: 3/14/2012 4:02 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	464,963	3,333,509	0.139482	299,476	41,772	90.00
91.00	Nursing School cost	0	3,333,509	0.000000	299,476	0	91.00
92.00	Allied health cost	0	3,333,509	0.000000	299,476	0	92.00
93.00	All other Medical Education	0	3,333,509	0.000000	299,476	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet D-3 Date/Time Prepared: 3/14/2012 4:02 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		1,473,426		30.00
31.00	INTENSIVE CARE UNIT		45,589		31.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.361190	192,744	69,617	50.00
51.00	RECOVERY ROOM	0.698091	42,384	29,588	51.00
52.00	DELIVERY ROOM & LABOR ROOM	2.011211	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.240786	265,603	63,953	54.00
60.00	LABORATORY	0.335753	388,520	130,447	60.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	0.815623	293,399	239,303	65.00
65.01	SLEEP LAB	0.434943	0	0	65.01
66.00	PHYSICAL THERAPY	0.637728	85,607	54,594	66.00
69.00	ELECTROCARDIOLOGY	0.471808	51,597	24,344	69.00
69.01	CARDIAC REHAB	1.059167	0	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.561575	256,077	143,806	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.603581	72	43	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.515276	451,084	232,433	73.00
76.00	CHEMICAL DEPENDENCY	2.602404	0	0	76.00
76.01	ONCOLOGY	0.587435	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	0.712815	0	0	90.00
91.00	EMERGENCY	0.408646	3,319	1,356	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.693721	17,312	12,010	92.00
200.00	Total (sum of lines 50-94 and 96-98)		2,047,718	1,001,494	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)		2,047,718		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151315 Component CCN: 15Z315	Period: From 10/01/2010 To 09/30/2011	Worksheet D-3 Date/Time Prepared: 3/14/2012 4:02 pm
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		0	30.00
31.00	INTENSIVE CARE UNIT		0	31.00
43.00	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.361190	0	50.00
51.00	RECOVERY ROOM	0.698091	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	2.011211	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.240786	10,834	54.00
60.00	LABORATORY	0.335753	19,597	60.00
64.00	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	RESPIRATORY THERAPY	0.815623	11,626	65.00
65.01	SLEEP LAB	0.434943	0	65.01
66.00	PHYSICAL THERAPY	0.637728	239,599	66.00
69.00	ELECTROCARDIOLOGY	0.471808	1,257	69.00
69.01	CARDIAC REHAB	1.059167	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.561575	7,971	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.603581	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.515276	76,367	73.00
76.00	CHEMICAL DEPENDENCY	2.602404	0	76.00
76.01	ONCOLOGY	0.587435	0	76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	CLINIC	0.712815	0	90.00
91.00	EMERGENCY	0.408646	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.693721	1,280	92.00
200.00	Total (sum of lines 50-94 and 96-98)		368,531	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)		368,531	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet D-3 Date/Time Prepared: 3/14/2012 4:02 pm	
Cost Center Description		Title XIX	Hospital	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		615,094		30.00
31.00	INTENSIVE CARE UNIT		18,412		31.00
43.00	NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.361190	146,201	52,806	50.00
51.00	RECOVERY ROOM	0.698091	28,015	19,557	51.00
52.00	DELIVERY ROOM & LABOR ROOM	2.011211	41,466	83,397	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.240786	124,818	30,054	54.00
60.00	LABORATORY	0.335753	129,842	43,595	60.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	0.815623	69,234	56,469	65.00
65.01	SLEEP LAB	0.434943	0	0	65.01
66.00	PHYSICAL THERAPY	0.637728	65,124	41,531	66.00
69.00	ELECTROCARDIOLOGY	0.471808	5,865	2,767	69.00
69.01	CARDIAC REHAB	1.059167	103	109	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.561575	84,510	47,459	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.603581	6,196	3,740	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.515276	159,385	82,127	73.00
76.00	CHEMICAL DEPENDENCY	2.602404	99	258	76.00
76.01	ONCOLOGY	0.587435	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	CLINIC	0.712815	17	12	90.00
91.00	EMERGENCY	0.408646	31,727	12,965	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.693721	38,126	26,449	92.00
200.00	Total (sum of lines 50-94 and 96-98)		930,728	503,295	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)		930,728		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 3/14/2012 4:02 pm
		Title XVII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			6,173,922 1.00
2.00	Medical and other services reimbursed under OPPTS (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)			6,173,922 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			6,235,661 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			38,705 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,365,751 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			3,831,205 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			3,831,205 30.00
31.00	Primary payer payments			2,571 31.00
32.00	Subtotal (line 30 minus line 31)			3,828,634 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			350,635 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			350,635 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			307,497 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			4,179,269 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			4,179,269 40.00
41.00	Interim payments			4,233,502 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)			-54,233 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 3/14/2012 4:02 pm
		Title XVIII	Hospital	Cost
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 151315		Period: From 10/01/2010 To 09/30/2011		Worksheet E-1 Part I Date/Time Prepared: 3/14/2012 4:02 pm	
		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,947,319		4,312,228	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	04/07/2011	31,736	04/07/2011	13,145		3.01
3.02		09/13/2011	28,645		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	09/13/2011	91,871		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)		60,381		-78,726		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)		2,007,700		4,233,502		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		79,816		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		54,233		6.02
7.00	Total Medicare program liability (see instructions)		2,087,516		4,179,269		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: 151315

Period:

Worksheet E-1

Component CCN: 15Z315

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

Part I
Date/Time Prepared:
3/14/2012 4:02 pm

Title XVIII

Swing Beds - SNF

Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		749,263		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	09/13/2011	5,255		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	04/07/2011	1,020		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)		4,235		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)		753,498		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		11,336		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		764,834		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: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet E-2
		Component CCN: 15Z315	Date/Time Prepared: 3/14/2012 4:02 pm	
		Title XVIII	Swing Beds - SNF	Cost
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	547,021	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)	218,945	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	510	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)	765,966	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	765,966	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)	765,966	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,132	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)	764,834	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)	764,834	0	19.00
20.00	Interim payments	753,498	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)	11,336	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		Provider CCN: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet E-3 Part V Date/Time Prepared: 3/14/2012 4:02 pm
		Title XVII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services			2,303,162 1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 thru 3)			2,303,162 4.00
5.00	Primary payer payments			3,199 5.00
6.00	Total cost (line 4 less line 5) . For CAH (see instructions)			2,322,995 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2,322,995 19.00
20.00	Deductibles (exclude professional component)			265,328 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			2,057,667 22.00
23.00	Coinurance			8,944 23.00
24.00	Subtotal (line 22 minus line 23)			2,048,723 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			38,793 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			38,793 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			35,573 27.00
28.00	Subtotal (sum of lines 24 and 25 or 26)			2,087,516 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (line 28, plus or minus lines 29)			2,087,516 30.00
31.00	Interim payments			2,007,700 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)			79,816 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: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet E-3 Part VII Date/Time Prepared: 3/14/2012 4:02 pm
		Title XIX	Hospital	PPS
		1.00		
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0	1.00
2.00	Medical and other services		2,520,892	2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		2,520,892	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)		2,520,892	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		5,216,450	8.00
9.00	Ancillary service charges		7,265,002	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)		12,481,452	12.00
CUSTOMARY CHRGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		12,481,452	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		9,960,560	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		2,520,892	21.00
PROSPECTIVE PAYMENT AMOUNT				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		0	23.00
24.00	Program capital payments		0	24.00
25.00	Capital exception payments (see instructions)		0	25.00
26.00	Routine and Ancillary service other pass through costs		0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX enter the sum of lines 27 and 21.		2,520,892	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		2,520,892	31.00
32.00	Deductibles		0	32.00
33.00	Coinsurance		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Utilization review		0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		2,520,892	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		2,520,892	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)		2,520,892	40.00
41.00	Interim payments		2,520,892	41.00
42.00	Balance due provider/program (line 40 minus 41)		0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	43.00

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

Provider CCN: 151315

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

Worksheet G

Date/Time Prepared:
3/14/2012 4:02 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	2,415,567	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	9,672,451	0	0	0	4.00
5.00	Other receivable	836,776	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,564,143	0	0	0	6.00
7.00	Inventory	784,010	0	0	0	7.00
8.00	Prepaid expenses	326,473	0	0	0	8.00
9.00	Other current assets	1,662,172	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	13,133,306	0	0	0	11.00
FIXED ASSETS						
12.00	Land	7,383,200	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	16,681,645	0	0	0	15.00
16.00	Accumulated depreciation	-11,084,753	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	15,718,262	0	0	0	19.00
20.00	Accumulated depreciation	-12,215,369	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	16,482,985	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	11,875,256	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,378,215	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	13,253,471	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	42,869,762	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,451,701	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,562,019	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,112,545	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,157,221	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,283,486	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	15,325,097	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	15,325,097	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	20,608,583	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	22,261,179	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	22,261,179	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	42,869,762	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151315

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

Worksheet G-1

Date/Time Prepared:
3/14/2012 4:02 pm

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
		1.00	Fund balances at beginning of period		22,362,001		
2.00	Net income (loss) (from Wkst. G-3, line 29)		-76,795			2.00	
3.00	Total (sum of line 1 and line 2)		22,285,206		0	3.00	
4.00	ROUNDING	2		0		4.00	
5.00		0		0		5.00	
6.00		0		0		6.00	
7.00		0		0		7.00	
8.00		0		0		8.00	
9.00		0		0		9.00	
10.00	Total additions (sum of line 4-9)		2		0	10.00	
11.00	Subtotal (line 3 plus line 10)		22,285,208		0	11.00	
12.00	TRANSFERS FROM SUBSIDIARIES	24,029		0		12.00	
13.00		0		0		13.00	
14.00		0		0		14.00	
15.00		0		0		15.00	
16.00		0		0		16.00	
17.00		0		0		17.00	
18.00	Total deductions (sum of lines 12-17)		24,029		0	18.00	
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		22,261,179		0	19.00	

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151315

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

Worksheet G-1

Date/Time Prepared:
3/14/2012 4:02 pm

		Endowment Fund		Plant Fund			
		5.00	6.00	7.00	8.00		
		1.00	Fund balances at beginning of period		0		
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	ROUNDING	0		0		4.00	
5.00		0		0		5.00	
6.00		0		0		6.00	
7.00		0		0		7.00	
8.00		0		0		8.00	
9.00		0		0		9.00	
10.00	Total additions (sum of line 4-9)		0		0	10.00	
11.00	Subtotal (line 3 plus line 10)		0		0	11.00	
12.00	TRANSFERS FROM SUBSIDIARIES	0		0		12.00	
13.00		0		0		13.00	
14.00		0		0		14.00	
15.00		0		0		15.00	
16.00		0		0		16.00	
17.00		0		0		17.00	
18.00	Total deductions (sum of lines 12-17)		0		0	18.00	
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		0		0	19.00	

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151315

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

Worksheet G-2 Parts
Date/Time Prepared:
3/14/2012 4:02 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,735,144		4,735,144	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,735,144		4,735,144	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	157,543		157,543	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)	157,543		157,543	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,892,687		4,892,687	17.00
18.00	Ancillary services	7,667,207	55,350,569	63,017,776	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		726,045	726,045	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	717,721	717,721	26.00
27.00	OTHER (MARKETING & URGENT CARE)	0	2,082,402	2,082,402	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	12,559,894	58,876,737	71,436,631	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		40,109,447		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)		40,109,447		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151315

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

Worksheet G-3

Date/Time Prepared:
3/14/2012 4:02 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	71,436,631	1.00
2.00	Less contractual allowances and discounts on patients' accounts	32,387,543	2.00
3.00	Net patient revenues (line 1 minus line 2)	39,049,088	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	40,109,447	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,060,359	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	983,564	24.00
25.00	Total other income (sum of lines 6-24)	983,564	25.00
26.00	Total (line 5 plus line 25)	-76,795	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)	-76,795	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151315

Period:

Worksheet H

HHA CCN: 157117

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

Date/Time Prepared:
3/14/2012 4:02 pm

Home Health
Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00			0		0	1.00
2.00			0		0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	185,945	0	0	-7,457	59,895	5.00
HHA REIMBURSABLE SERVICES						
6.00	256,539	0	19,202	0	0	6.00
7.00	90,468	0	0	0	0	7.00
8.00	22,317	0	0	0	0	8.00
9.00	1,672	0	0	0	0	9.00
10.00	13,673	0	0	0	0	10.00
11.00	17,975	0	0	0	0	11.00
12.00	0	0	0	0	0	12.00
13.00	0	0	0	0	0	13.00
14.00	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES						
15.00	0	0	0	0	0	15.00
16.00	0	0	0	0	0	16.00
17.00	67,254	0	0	0	0	17.00
18.00	0	0	0	0	0	18.00
19.00	0	0	0	0	0	19.00
20.00	0	0	0	0	0	20.00
21.00	0	0	0	0	0	21.00
22.00	0	0	0	0	0	22.00
23.00	0	0	0	0	0	23.00
24.00	655,843	0	19,202	-7,457	59,895	24.00

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

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151315

Period: From 10/01/2010

Worksheet H

HHA CCN: 157117

To 09/30/2011

Date/Time Prepared: 3/14/2012 4:02 pm

Home Health Agency I

PPS

	Total (sum of col. 1 thru 5)	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
	6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00 Capital Related - Bldg. & Fixtures	0	0	0	0	0	1.00
2.00 Capital Related - Movable Equipment	0	0	0	0	0	2.00
3.00 Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00 Transportation	0	0	0	0	0	4.00
5.00 Administrative and General	238,383	0	238,383	0	238,383	5.00
HHA REIMBURSABLE SERVICES						
6.00 Skilled Nursing Care	275,741	0	275,741	0	275,741	6.00
7.00 Physical Therapy	90,468	0	90,468	0	90,468	7.00
8.00 Occupational Therapy	22,317	0	22,317	0	22,317	8.00
9.00 Speech Pathology	1,672	0	1,672	0	1,672	9.00
10.00 Medical Social Services	13,673	0	13,673	0	13,673	10.00
11.00 Home Health Aide	17,975	0	17,975	0	17,975	11.00
12.00 Supplies (see instructions)	0	0	0	0	0	12.00
13.00 Drugs	0	0	0	0	0	13.00
14.00 DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES						
15.00 Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00 Respiratory Therapy	0	0	0	0	0	16.00
17.00 Private Duty Nursing	67,254	0	67,254	0	67,254	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)	727,483	0	727,483	0	727,483	24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 151315	Period: From 10/01/2010	Worksheet H-1		
		HHA CCN: 157117	To 09/30/2011	Part I		
			Home Health Agency I	Date/Time Prepared: 3/14/2012 4:02 pm		
				PPS		
	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	
		Bldgs & Fixtures	Movable Equipment			
	0	1.00	2.00	3.00	4.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0			1.00
2.00	Capital Related - Movable Equipment	0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	238,383	0	0	0	5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	275,741	0	0	0	6.00
7.00	Physical Therapy	90,468	0	0	0	7.00
8.00	Occupational Therapy	22,317	0	0	0	8.00
9.00	Speech Pathology	1,672	0	0	0	9.00
10.00	Medical Social Services	13,673	0	0	0	10.00
11.00	Home Health Aide	17,975	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	67,254	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)	727,483	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 151315

Period:

Worksheet H-1

HHA CCN: 157117

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

Part I
Date/Time Prepared:
3/14/2012 4:02 pm

Home Health
Agency I

PPS

	Subtotal (col s. 0-4) 4A.00	Administrative & General 5.00	Total (col s. 4A + 5) 6.00	
GENERAL SERVICE COST CENTERS				
1.00 Capital Related - Bldg. & Fixtures	0			1.00
2.00 Capital Related - Movable Equipment	0			2.00
3.00 Plant Operation & Maintenance	0			3.00
4.00 Transportation				4.00
5.00 Administrative and General	238,383	238,383		5.00
HHA REIMBURSABLE SERVICES				
6.00 Skilled Nursing Care	275,741	134,394	410,135	6.00
7.00 Physical Therapy	90,468	44,093	134,561	7.00
8.00 Occupational Therapy	22,317	10,877	33,194	8.00
9.00 Speech Pathology	1,672	815	2,487	9.00
10.00 Medical Social Services	13,673	6,664	20,337	10.00
11.00 Home Health Aide	17,975	8,761	26,736	11.00
12.00 Supplies (see instructions)	0	0	0	12.00
13.00 Drugs	0	0	0	13.00
14.00 DME	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES				
15.00 Home Dialysis Aide Services	0	0	0	15.00
16.00 Respiratory Therapy	0	0	0	16.00
17.00 Private Duty Nursing	67,254	32,779	100,033	17.00
18.00 Clinic	0	0	0	18.00
19.00 Health Promotion Activities	0	0	0	19.00
20.00 Day Care Program	0	0	0	20.00
21.00 Home Delivered Meals Program	0	0	0	21.00
22.00 Homemaker Service	0	0	0	22.00
23.00 All Others (specify)	0	0	0	23.00
24.00 Total (sum of lines 1-23)	489,100		727,483	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 151315

Period: From 10/01/2010

Worksheet H-1

HHA CCN: 157117

To 09/30/2011

Part II
Date/Time Prepared:
3/14/2012 4:02 pm

Home Health Agency I

PPS

		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)				
		1.00	2.00	3.00	4.00	5A.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation (see instructions)	0	0	0	0	0	4.00
5.00	Administrative and General	0	0	0	0	-238,383	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-238,383	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		26.00

COST ALLOCATION - HHA STATISTICAL BASIS		Provider CCN: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet H-1 Part II Date/Time Prepared: 3/14/2012 4:02 pm
		HHA CCN: 157117	Home Health Agency I	PPS

		Administrative & General (ACCUM. COST)	
		5.00	
GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures		1.00
2.00	Capital Related - Movable Equipment		2.00
3.00	Plant Operation & Maintenance		3.00
4.00	Transportation (see instructions)		4.00
5.00	Administrative and General	489,100	5.00
HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	275,741	6.00
7.00	Physical Therapy	90,468	7.00
8.00	Occupational Therapy	22,317	8.00
9.00	Speech Pathology	1,672	9.00
10.00	Medical Social Services	13,673	10.00
11.00	Home Health Aide	17,975	11.00
12.00	Supplies (see instructions)	0	12.00
13.00	Drugs	0	13.00
14.00	DME	0	14.00
HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	15.00
16.00	Respiratory Therapy	0	16.00
17.00	Private Duty Nursing	67,254	17.00
18.00	Clinic	0	18.00
19.00	Health Promotion Activities	0	19.00
20.00	Day Care Program	0	20.00
21.00	Home Delivered Meals Program	0	21.00
22.00	Homemaker Service	0	22.00
23.00	All Others (specify)	0	23.00
24.00	Total (sum of lines 1-23)	489,100	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	238,383	25.00
26.00	Unit Cost Multiplier	0.487391	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151315

Period:

Worksheet H-2

HHA CCN: 157117

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

Part I
Date/Time Prepared:
3/14/2012 4:02 pm

Home Health
Agency I

PPS

	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS 4.00	Subtotal 4A		
		NEW BLDG & FIXT 1.00	NEW MVBLE EQUIP 2.00				
		0	1.00				2.00
1.00	Administrative and General	0	10,710	24,489	68,010	103,209	1.00
2.00	Skilled Nursing Care	410,135	0	0	93,829	503,964	2.00
3.00	Physical Therapy	134,561	0	0	33,089	167,650	3.00
4.00	Occupational Therapy	33,194	0	0	8,162	41,356	4.00
5.00	Speech Pathology	2,487	0	0	612	3,099	5.00
6.00	Medical Social Services	20,337	0	0	5,001	25,338	6.00
7.00	Home Health Aide	26,736	0	0	6,574	33,310	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	100,033	0	0	24,598	124,631	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	727,483	10,710	24,489	239,875	1,002,557	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000	21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151315

Period:

Worksheet H-2

HHA CCN: 157117

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

Part I
Date/Time Prepared:
3/14/2012 4:02 pm

Home Health
Agency I

PPS

	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	5.00	7.00	8.00	9.00	10.00	
1.00 Administrative and General	22,435	44,176	0	16,835	0	1.00
2.00 Skilled Nursing Care	109,547	0	0	0	0	2.00
3.00 Physical Therapy	36,442	0	0	0	0	3.00
4.00 Occupational Therapy	8,990	0	0	0	0	4.00
5.00 Speech Pathology	674	0	0	0	0	5.00
6.00 Medical Social Services	5,508	0	0	0	0	6.00
7.00 Home Health Aide	7,241	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	27,091	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	217,928	44,176	0	16,835	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: 151315 HHA CCN: 157117		Period: From 10/01/2010 To 09/30/2011		Worksheet H-2 Part I Date/Time Prepared: 3/14/2012 4:02 pm	
				Home Health Agency I		PPS	
		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	16,883	0	2,052	0	0	1.00
2.00	Skilled Nursing Care	17,257	30,794	0	0	0	2.00
3.00	Physical Therapy	5,416	8,942	0	0	0	3.00
4.00	Occupational Therapy	1,270	2,157	0	0	0	4.00
5.00	Speech Pathology	75	146	0	0	0	5.00
6.00	Medical Social Services	934	1,542	0	0	0	6.00
7.00	Home Health Aide	2,503	15,596	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	7,358	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	51,696	59,177	2,052	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: 151315 HHA CCN: 157117		Period: From 10/01/2010 To 09/30/2011		Worksheet H-2 Part I Date/Time Prepared: 3/14/2012 4:02 pm	
				Home Health Agency I		PPS	
		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	205,590	0	205,590			1.00
2.00	Skilled Nursing Care	661,562	0	661,562	114,406	775,968	2.00
3.00	Physical Therapy	218,450	0	218,450	37,778	256,228	3.00
4.00	Occupational Therapy	53,773	0	53,773	9,299	63,072	4.00
5.00	Speech Pathology	3,994	0	3,994	691	4,685	5.00
6.00	Medical Social Services	33,322	0	33,322	5,763	39,085	6.00
7.00	Home Health Aide	58,650	0	58,650	10,143	68,793	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	159,080	0	159,080	27,510	186,590	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	1,394,421	0	1,394,421	205,590	1,394,421	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.				0.172935		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: 151315
HHA CCN: 157117

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

Worksheet H-2
Part II
Date/Time Prepared:
3/14/2012 4:02 pm

		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
1.00	Administrative and General	1,387	1,387	185,945	0	103,209	1.00
2.00	Skilled Nursing Care	0	0	256,539	0	503,964	2.00
3.00	Physical Therapy	0	0	90,468	0	167,650	3.00
4.00	Occupational Therapy	0	0	22,317	0	41,356	4.00
5.00	Speech Pathology	0	0	1,672	0	3,099	5.00
6.00	Medical Social Services	0	0	13,673	0	25,338	6.00
7.00	Home Health Aide	0	0	17,975	0	33,310	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	67,254	0	124,631	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)	1,387	1,387	655,843		1,002,557	20.00
21.00	Total cost to be allocated	10,710	24,489	239,875		217,928	21.00
22.00	Unit cost multiplier	7.721702	17.656092	0.365751		0.217372	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 151315 HHA CCN: 157117	Period: From 10/01/2010 To 09/30/2011	Worksheet H-2 Part II Date/Time Prepared: 3/14/2012 4:02 pm
---	---	---	--

		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	1,387	0	15	0	452	1.00
2.00	Skilled Nursing Care	0	0	0	0	462	2.00
3.00	Physical Therapy	0	0	0	0	145	3.00
4.00	Occupational Therapy	0	0	0	0	34	4.00
5.00	Speech Pathology	0	0	0	0	2	5.00
6.00	Medical Social Services	0	0	0	0	25	6.00
7.00	Home Health Aide	0	0	0	0	67	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	197	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)	1,387	0	15	0	1,384	20.00
21.00	Total cost to be allocated	44,176	0	16,835	0	51,696	21.00
22.00	Unit cost multiplier	31.850036	0.000000	1,122.333333	0.000000	37.352601	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 151315 HHA CCN: 157117	Period: From 10/01/2010 To 09/30/2011	Worksheet H-2 Part II Date/Time Prepared: 3/14/2012 4:02 pm PPS
		Home Health Agency I	

	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
	13.00	14.00	15.00	16.00		
1.00 Administrative and General	0	9,721	0	0		1.00
2.00 Skilled Nursing Care	10,366	0	0	0		2.00
3.00 Physical Therapy	3,010	0	0	0		3.00
4.00 Occupational Therapy	726	0	0	0		4.00
5.00 Speech Pathology	49	0	0	0		5.00
6.00 Medical Social Services	519	0	0	0		6.00
7.00 Home Health Aide	5,250	0	0	0		7.00
8.00 Supplies (see instructions)	0	0	0	0		8.00
9.00 Drugs	0	0	0	0		9.00
10.00 DME	0	0	0	0		10.00
11.00 Home Dialysis Aide Services	0	0	0	0		11.00
12.00 Respiratory Therapy	0	0	0	0		12.00
13.00 Private Duty Nursing	0	0	0	0		13.00
14.00 Clinic	0	0	0	0		14.00
15.00 Health Promotion Activities	0	0	0	0		15.00
16.00 Day Care Program	0	0	0	0		16.00
17.00 Home Delivered Meals Program	0	0	0	0		17.00
18.00 Homemaker Service	0	0	0	0		18.00
19.00 All Others (specify)	0	0	0	0		19.00
20.00 Total (sum of lines 1-19)	19,920	9,721	0	0		20.00
21.00 Total cost to be allocated	59,177	2,052	0	0		21.00
22.00 Unit cost multiplier	2.970733	0.211089	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 151315 HHA CCN: 157117		Period: From 10/01/2010 To 09/30/2011		Worksheet H-3 Parts I-III Date/Time Prepared: 3/14/2012 4:02 pm	
		Title XVIII		Home Health Agency I		PPS	
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Visits	
		0	1.00	2.00	3.00	4.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	775,968		775,968	1,410	1.00
2.00	Physical Therapy	3.00	256,228	0	256,228	1,032	2.00
3.00	Occupational Therapy	4.00	63,072	0	63,072	356	3.00
4.00	Speech Pathology	5.00	4,685	0	4,685	40	4.00
5.00	Medical Social Services	6.00	39,085		39,085	12	5.00
6.00	Home Health Aide	7.00	68,793		68,793	859	6.00
7.00	Total (sum of lines 1-6)		1,207,831	0	1,207,831	3,709	7.00
				Program Visits			
				Part A		Part B	
						Not Subject to Deductibles & Coinsurance	Subject to Deductibles
		0	1.00	2.00	3.00	4.00	
Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	331	253		8.00
9.00	Physical Therapy		99915	403	285		9.00
10.00	Occupational Therapy		99915	122	111		10.00
11.00	Speech Pathology		99915	34	1		11.00
12.00	Medical Social Services		99915	4	1		12.00
13.00	Home Health Aide		99915	100	143		13.00
14.00	Total (sum of lines 8-13)			994	794		14.00
				Total HHA Costs (col. 1 + 2)		Total Charges (from HHA Record)	
		0	1.00	2.00	3.00	4.00	
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	16.00
				Total HHA Charge (from provider records)		HHA Shared Ancillary Costs (col. 1 x col. 2)	
				0	1.00	2.00	3.00
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy		66.00	0.637728	0	0	1.00
2.00	Occupational Therapy						2.00
3.00	Speech Pathology						3.00
4.00	Cost of Medical Supplies		71.00	0.561575	0	0	4.00
5.00	Cost of Drugs		73.00	0.515276	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 151315	Period: From 10/01/2010	Worksheet H-3	
		HHA CCN: 157117	To 09/30/2011	Parts I-III	
		Title XVIII	Home Health Agency I	Date/Time Prepared: 3/14/2012 4:02 pm	
		Program Visits		PPS	
Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	5.00	6.00	7.00	8.00	
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	550.33	331	253	1.00
2.00	Physical Therapy	248.28	403	285	2.00
3.00	Occupational Therapy	177.17	122	111	3.00
4.00	Speech Pathology	117.13	34	1	4.00
5.00	Medical Social Services	3,257.08	4	1	5.00
6.00	Home Health Aide	80.08	100	143	6.00
7.00	Total (sum of lines 1-6)		994	794	7.00
Cost Center Description					
		5.00	6.00	7.00	8.00
Limitation Cost Computation					
8.00	Skilled Nursing Care				8.00
9.00	Physical Therapy				9.00
10.00	Occupational Therapy				10.00
11.00	Speech Pathology				11.00
12.00	Medical Social Services				12.00
13.00	Home Health Aide				13.00
14.00	Total (sum of lines 8-13)				14.00
Cost Center Description					
		Ratio (col. 3 ÷ col. 4)	Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		5.00	6.00	7.00	8.00
Supplies and Drugs Cost Computations					
15.00	Cost of Medical Supplies	0.000000	3,472	7,555	15.00
16.00	Cost of Drugs	0.000000	0	426	16.00
Cost Center Description			Transfer to Part I as Indicated		
			4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS					
1.00	Physical Therapy		col. 2, line 2.00		1.00
2.00	Occupational Therapy				2.00
3.00	Speech Pathology				3.00
4.00	Cost of Medical Supplies		col. 2, line 15.00		4.00
5.00	Cost of Drugs		col. 2, line 16.00		5.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 151315 HHA CCN: 157117		Period: From 10/01/2010 To 09/30/2011		Worksheet H-3 Parts I-11 Date/Time Prepared: 3/14/2012 4:02 pm	
		Title XVIII		Home Health Agency I		PPS	
Cost Center Description	Cost of Services			Total Program Cost (sum of col.s. 9-10)			
	Part A	Part B					
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance				
9.00	10.00	11.00	12.00				
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	182,159	139,233		321,392		1.00
2.00	Physical Therapy	100,057	70,760		170,817		2.00
3.00	Occupational Therapy	21,615	19,666		41,281		3.00
4.00	Speech Pathology	3,982	117		4,099		4.00
5.00	Medical Social Services	13,028	3,257		16,285		5.00
6.00	Home Health Aide	8,008	11,451		19,459		6.00
7.00	Total (sum of lines 1-6)	328,849	244,484		573,333		7.00
Cost Center Description							
		10.00	11.00	12.00			
Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00
Cost of Services							
Cost Center Description	Part A	Part B					
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance				
	9.00	10.00	11.00				
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0			15.00
16.00	Cost of Drugs	0	0	0			16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 151315 HHA CCN: 157117	Period: From 10/01/2010 To 09/30/2011	Worksheet H-4 Part I-II Date/Time Prepared: 3/14/2012 4:02 pm
		Title XVII	Home Health Agency I	PPS

	Part A	Part B		
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2.00	

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES					
Reasonable Cost of Part A & Part B Services					
1.00	Reasonable cost of services (see instructions)	0	0	0	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	

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	187,678	132,961	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	2,994	3,614	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	0	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)	0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	190,672	136,575	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	190,672	136,575	24.00
25.00	Coinurance billed to program patients (from your records)	0	0	25.00
26.00	Net cost (line 24 minus line 25)	190,672	136,575	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	190,672	136,575	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	190,672	136,575	31.00
32.00	Interim payments (see instructions)	190,672	136,575	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: 151315 HHA CCN: 157117	Period: From 10/01/2010 To 09/30/2011	Worksheet H-5 Date/Time Prepared: 3/14/2012 4:02 pm PPS
		Home Health Agency I	

		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		190,672		136,575	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)		190,672		136,575	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)		190,672		136,575	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151315

Period: From 10/01/2010

Worksheet K

Hospice CCN: 151561

To 09/30/2011

Date/Time Prepared: 3/14/2012 4:02 pm

		Hospice I					
		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	27,781	0	0	0	10,075	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	52,855	0	0	10,667	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	20,954	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	18,880	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	1,794	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	99,516	0	20,954	10,667	11,869	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151315

Period: From 10/01/2010

Worksheet K

Hospice CCN: 151561

To 09/30/2011

Date/Time Prepared: 3/14/2012 4:02 pm

		Hospice I				
	Total (col. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
	6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	5.00
6.00	Administrative and General	37,856	0	37,856	0	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	63,522	0	63,522	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services	0	0	0	0	9.00
10.00	Nursing Care	20,954	0	20,954	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services	18,880	0	18,880	0	15.00
16.00	Spiritual Counseling	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	20.00
21.00	Other	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	1,794	0	1,794	0	31.00
32.00	Radiation Therapy	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	33.00
34.00	Other	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	143,006	0	143,006	0	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151315

Period: From 10/01/2010

Worksheet K-1

Hospice CCN: 151561

To 09/30/2011

Date/Time Prepared: 3/14/2012 4:02 pm

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	27,781	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	52,855	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	18,880	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	99,516	0	0	0	0	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151315

Period: From 10/01/2010

Worksheet K-1

Hospice CCN: 151561

To 09/30/2011

Date/Time Prepared: 3/14/2012 4:02 pm

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

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES		Provider CCN: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet K-3
		Hospice CCN: 151561		Date/Time Prepared: 3/14/2012 4:02 pm

		Administrator	Director	Social Services	Hospice I Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	10,667	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	0	10,667	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES	Provider CCN: 151315 Hospice CCN: 151561	Period: From 10/01/2010 To 09/30/2011	Worksheet K-3 Date/Time Prepared: 3/14/2012 4:02 pm
--	---	---	---

		Total Therapists	Aides	All-Other	Hospice I Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	0	0	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	10,667	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services		0	0	0	9.00
10.00	Nursing Care		0	0	0	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services		0	0	0	15.00
16.00	Spiritual Counseling		0	0	0	16.00
17.00	Dietary Counseling		0	0	0	17.00
18.00	Counseling - Other		0	0	0	18.00
19.00	Home Health Aide and Homemaker		0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	10,667	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151315

Period:

Worksheet K-4

Hospice CCN: 151561

From 10/01/2010

Part I

To 09/30/2011

Date/Time Prepared:

3/14/2012 4:02 pm

		CAPITAL RELATED COST				Hospice I	
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
			1.00	2.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	37,856	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	63,522	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	20,954	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	18,880	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	1,794	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	143,006	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151315

Period: From 10/01/2010

Worksheet K-4

Hospice CCN: 151561

To 09/30/2011

Part I
Date/Time Prepared:
3/14/2012 4:02 pm

		Hospice I				
		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col . 5A ± col . 6)	
		5.00	5A	6.00	7.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.		0			1.00
2.00	Capital Related Costs-Movable Equip.		0			2.00
3.00	Plant Operation and Maintenance		0			3.00
4.00	Transportation - Staff		0			4.00
5.00	Volunteer Service Coordination	0				5.00
6.00	Administrative and General	0	37,856			6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	63,522	22,869	86,391	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services	0	0	0	0	9.00
10.00	Nursing Care	0	20,954	7,544	28,498	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services	0	18,880	6,797	25,677	15.00
16.00	Spiritual Counseling	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	20.00
21.00	Other	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	1,794	646	2,440	31.00
32.00	Radiation Therapy	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	33.00
34.00	Other	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	105,150	37,856	143,006	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151315

Period: From 10/01/2010

Worksheet K-4

Hospice CCN: 151561

To 09/30/2011

Part II
Date/Time Prepared:
3/14/2012 4:02 pm

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151315

Period:

Worksheet K-4

Hospice CCN: 151561

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

Part II
Date/Time Prepared:
3/14/2012 4:02 pm

Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	
		6A	6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0		1.00
2.00	Capital Related Costs-Movable Equip.	0		2.00
3.00	Plant Operation and Maintenance	0		3.00
4.00	Transportation - Staff	0		4.00
5.00	Volunteer Service Coordination			5.00
6.00	Administrative and General	-37,856	105,150	6.00
INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	63,522	7.00
8.00	Inpatient - Respite Care	0	0	8.00
VISITING SERVICES				
9.00	Physician Services	0	0	9.00
10.00	Nursing Care	0	20,954	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	0	12.00
13.00	Occupational Therapy	0	0	13.00
14.00	Speech/ Language Pathology	0	0	14.00
15.00	Medical Social Services	0	18,880	15.00
16.00	Spiritual Counseling	0	0	16.00
17.00	Dietary Counseling	0	0	17.00
18.00	Counseling - Other	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00	Other	0	0	21.00
OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	0	22.00
23.00	Analgesics	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	24.00
25.00	Other - Specify	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	26.00
27.00	Patient Transportation	0	0	27.00
28.00	Imaging Services	0	0	28.00
29.00	Labs and Diagnostics	0	0	29.00
30.00	Medical Supplies	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	1,794	31.00
32.00	Radiation Therapy	0	0	32.00
33.00	Chemotherapy	0	0	33.00
34.00	Other	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0	35.00
36.00	Volunteer Program Costs	0	0	36.00
37.00	Fundraising	0	0	37.00
38.00	Other Program Costs	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		37,856	39.00
40.00	Unit Cost Multiplier		0.360019	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151315

Period: From 10/01/2010

Worksheet K-5

Hospice CCN: 151561

To 09/30/2011

Part I
Date/Time Prepared:
3/14/2012 4:02 pm

Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		1.00	2.00			
	0			4.00	4A	
1.00 Administrative and General		2,193	5,014	10,161	17,368	1.00
2.00 Inpatient - General Care	86,391	0	0	19,332	105,723	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	4.00
5.00 Nursing Care	28,498	0	0	0	28,498	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	25,677	0	0	6,905	32,582	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	2,440	0	0	0	2,440	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	143,006	2,193	5,014	36,398	186,611	34.00
35.00 Unit Cost Multiplier (see instructions)					0.000000	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151315

Period:

Worksheet K-5

Hospice CCN: 151561

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

Part I
Date/Time Prepared:
3/14/2012 4:02 pm

Cost Center Description		Hospice I					
		ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
1.00	Administrative and General	3,775	9,045	0	0	0	1.00
2.00	Inpatient - General Care	22,982	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	6,195	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	7,082	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	530	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	40,564	9,045	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151315

Period:

Worksheet K-5

Hospice CCN: 151561

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

Part I
Date/Time Prepared:
3/14/2012 4:02 pm

Cost Center Description	Hospice I					
	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
1.00 Administrative and General	8,330	0	900	0	0	1.00
2.00 Inpatient - General Care	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	4.00
5.00 Nursing Care	0	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	8,330	0	900	0	0	34.00
35.00 Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS		Provider CCN: 151315	Period: From 10/01/2010 To 09/30/2011	Worksheet K-5 Part I Date/Time Prepared: 3/14/2012 4:02 pm
		Hospice CCN: 151561	Hospice I	

Cost Center Description	Subtotal (col.s. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (col.s. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (col.s. 26 ± 27)	
	24.00	25.00	26.00	27.00	28.00	
1.00 Administrative and General	39,418					1.00
2.00 Inpatient - General Care	128,705	0	128,705	24,624	153,329	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	4.00
5.00 Nursing Care	34,693	0	34,693	6,637	41,330	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	39,664	0	39,664	7,589	47,253	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	2,970	0	2,970	568	3,538	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	245,450	0	245,450		245,450	34.00
35.00 Unit Cost Multiplier (see instructions)				0.191320		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151315

Hospice CCN: 151561

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

Worksheet K-5
Part II
Date/Time Prepared:
3/14/2012 4:02 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00				
1.00	Administrative and General	284	284	27,781	0	17,368	1.00
2.00	Inpatient - General Care	0	0	52,855	0	105,723	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	28,498	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	18,880	0	32,582	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	2,440	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	284	284	99,516		186,611	34.00
35.00	Total cost to be allocated	2,193	5,014	36,398		40,564	35.00
36.00	Unit Cost Multiplier (see instructions)	7.721831	17.654930	0.365750		0.217372	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151315

Period:

Worksheet K-5

Hospice CCN: 151561

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

Part II
Date/Time Prepared:
3/14/2012 4:02 pm

Cost Center Description		Hospice I					CAFETERIA (FTES)	
		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)			
		7.00	8.00	9.00	10.00	11.00		
1.00	Administrative and General	284	0	0	0	0	223	1.00
2.00	Inpatient - General Care	0	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	284	0	0	0	0	223	34.00
35.00	Total cost to be allocated	9,045	0	0	0	0	8,330	35.00
36.00	Unit Cost Multiplier (see instructions)	31.848592	0.000000	0.000000	0.000000	0.000000	37.354260	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151315
Hospice CCN: 151561

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

Worksheet K-5
Part II
Date/Time Prepared:
3/14/2012 4:02 pm

Cost Center Description	Hospice I					
	NURSING ADMINISTRATIVE (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
	13.00	14.00	15.00	16.00		
1.00 Administrative and General	0	4,262	0	0		1.00
2.00 Inpatient - General Care	0	0	0	0		2.00
3.00 Inpatient - Respite Care	0	0	0	0		3.00
4.00 Physician Services	0	0	0	0		4.00
5.00 Nursing Care	0	0	0	0		5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0		6.00
7.00 Physical Therapy	0	0	0	0		7.00
8.00 Occupational Therapy	0	0	0	0		8.00
9.00 Speech/ Language Pathology	0	0	0	0		9.00
10.00 Medical Social Services	0	0	0	0		10.00
11.00 Spiritual Counseling	0	0	0	0		11.00
12.00 Dietary Counseling	0	0	0	0		12.00
13.00 Counseling - Other	0	0	0	0		13.00
14.00 Home Health Aide and Homemaker	0	0	0	0		14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00
16.00 Other	0	0	0	0		16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0		17.00
18.00 Analgesics	0	0	0	0		18.00
19.00 Sedatives / Hypnotics	0	0	0	0		19.00
20.00 Other - Specify	0	0	0	0		20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0		21.00
22.00 Patient Transportation	0	0	0	0		22.00
23.00 Imaging Services	0	0	0	0		23.00
24.00 Labs and Diagnostics	0	0	0	0		24.00
25.00 Medical Supplies	0	0	0	0		25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0		26.00
27.00 Radiation Therapy	0	0	0	0		27.00
28.00 Chemotherapy	0	0	0	0		28.00
29.00 Other	0	0	0	0		29.00
30.00 Bereavement Program Costs	0	0	0	0		30.00
31.00 Volunteer Program Costs	0	0	0	0		31.00
32.00 Fundraising	0	0	0	0		32.00
33.00 Other Program Costs	0	0	0	0		33.00
34.00 Total (sum of lines 1 thru 33) (2)	0	4,262	0	0		34.00
35.00 Total cost to be allocated	0	900	0	0		35.00
36.00 Unit Cost Multiplier (see instructions)	0.000000	0.211168	0.000000	0.000000		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS		Provider CCN: 151315	Period: From 10/01/2010	Worksheet K-5	
		Hospice CCN: 151561	To 09/30/2011	Part III	
		Hospice I		Date/Time Prepared: 3/14/2012 4:02 pm	
Cost Center Description	Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
	0	1.00	2.00	3.00	
ANCI LLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.637728	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00		0	2.00
3.00	SPEECH PATHOLOGY	68.00		0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.515276	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00		0	5.00
6.00	LABORATORY	60.00	0.335753	0	6.00
6.01	BLOOD LABORATORY	60.01		0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.561575	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00		0	8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00		0	9.00
10.00	CHEMICAL DEPENDENCY	76.00	2.602404	0	10.00
10.01	ONCOLOGY	76.01	0.587435	0	10.01
10.02	OTHER ANCI LLARY SERVICE COST CENTERS	76.02		0	10.02
11.00	Totals (sum of lines 1-10)			0	11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 151315

Period:

Worksheet K-6

Hospice CCN: 151561

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

Date/Time Prepared:
3/14/2012 4:02 pm

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				245,450	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				3,730	2.00
3.00	Average cost per diem (line 1 divided by line 2)				65.80	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	3,730				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	245,434				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)			0		6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)			0		7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)			0		10.00
11.00	Aggregate NF cost (line 3 times line 10)			0		11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)				0	12.00
13.00	Aggregate cost for other days (line 3 times line 12)				0	13.00