

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: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet S Parts I-III Date/Time Prepared: 5/24/2012 9:41 am
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PART I - COST REPORT STATUS

Provider use only	1. <input type="checkbox"/> Electronically filed cost report	Date: 5/24/2012	Time: 9:41 am
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 04 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 DECATUR CO. MEMORIAL HOSPITAL for the cost reporting period beginning 01/01/2011 and ending 12/31/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	35,029	-172,244	0	-243,390	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	66,720	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	101,749	-172,244	0	-243,390	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: 151332		Period: From 01/01/2011 To 12/31/2011		Worksheet S-2 Part I Date/Time Prepared: 5/24/2012 9:40 am					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 702 NORTH LINCOLN STREET			PO Box:						1.00	
2.00	City: GREENSBURG			State: IN		Zip Code: 47240-1398		County: DECATUR		2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
				1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00
								V	XVIII	XIX	
3.00	Hospital and Hospital-Based Component Identification:										
	Hospital		DECATUR CO. MEMORIAL HOSPITAL	151332	99915	1	12/01/2005	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		DECATUR CO. SWING BED	15Z332	99915		12/01/2005	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		DECATUR CO. HHA	157153	99915		03/01/1985	N	P	N	12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC							N	N	N	15.00
16.00	Hospital-Based Health Clinic - FQHC							N	N	N	16.00
17.00	Hospital-Based (CMHC) 1										17.00
17.10	Hospital-Based (CORF) 1							N	N	N	17.10
17.20	Hospital-Based (OPT) 1							N	N	N	17.20
17.30	Hospital-Based (OOT) 1							N	N	N	17.30
17.40	Hospital-Based (OSP) 1							N	N	N	17.40
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2011	12/31/2011		20.00	
21.00	Type of Control (see instructions)						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		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.						0		23.00		
		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0		24.00		
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.	0	0	0	0	0	0		25.00		
							Urban/Rural	Date of Geogr			
							1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.						1		26.00		
27.00	For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification (in column 2).						1		27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0		35.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/24/2012 9:40 am		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V 1.00	XVIII 2.00	XIX 3.00		
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)		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. If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00	
		Program Name 1.00	Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151332

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

Worksheet S-2
Part I
Date/Time Prepared:
5/24/2012 9:40 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
65.00	If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. Use subscripted lines 65.01 through 65.50 for each additional primary care program. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4.			0.00	0.00	0.000000	65.00	
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
				1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010 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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/24/2012 9:40 am	
			1.00	2.00	3.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.		N		75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.			N	80.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(i)? Enter "Y" for yes and "N" for no.			N	86.00
			V	XIX	
			1.00	2.00	
Title V or XIX Inpatient Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		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)		Y		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
			Physical	Occupational	Speech
			1.00	2.00	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.		Y	N	109.00
			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

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			1.00			2.00				
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.								126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.								127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.								128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.								129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.								130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.								131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.								132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.								133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.								134.00	
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 1.00	Part B 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
161.10	CORF								N	161.10
161.20	OUTPATIENT PHYSICAL THERAPY								N	161.20
161.30	OUTPATIENT OCCUPATIONAL THERAPY								N	161.30
161.40	OUTPATIENT SPEECH PATHOLOGY								N	161.40
								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	166.00
								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)									168.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/24/2012 9:40 am
			1.00
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00		169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part II Date/Time Prepared: 5/24/2012 9:40 am
			Y/N	Date
			1.00	2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
			Y/N	Date
			1.00	2.00
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.			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)			3.00
			Y/N	Date
			1.00	2.00
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.			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.			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?			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			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.			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.			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.			11.00
			Y/N	
			1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			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.			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			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)			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 151332

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

Worksheet S-2
Part II
Date/Time Prepared:
5/24/2012 9:40 am

		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	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			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.			23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			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.			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			29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			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.			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.			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.			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.			35.00
				Y/N
				Date
				1.00
				2.00
Home Office Costs				
36.00	Were home office costs claimed on the cost report?			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	
PS&R Data		3.00	4.00	
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151332

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

Worksheet S-3
Part I
Date/Time Prepared:
5/24/2012 9:40 am

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours		
	Line Number					
	1.00	2.00	3.00	4.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	22	8,030	74,400.00		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)		22	8,030	74,400.00		7.00
8.00 INTENSIVE CARE UNIT	31.00	3	1,095	26,280.00		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	100,680.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0			17.00
18.00 SUBPROVIDER	42.00	0	0			18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	46.00	0	0			21.00
22.00 HOME HEALTH AGENCY	101.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10					25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20					25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30					25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40					25.40
26.00 RURAL HEALTH CLINIC	88.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00					26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days						28.00
28.02 SUBPROVIDER - IRF	41.00					28.02
28.03 SUBPROVIDER	42.00					28.03
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151332

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

Worksheet S-3
Part I
Date/Time Prepared:
5/24/2012 9:40 am

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	1,553	200	3,100		1.00
2.00 HMO		0	1,002			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	295	0	295		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	71		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,848	200	3,466		7.00
8.00 INTENSIVE CARE UNIT	0	96	0	175		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		0	618		13.00
14.00 Total (see instructions)	0	1,944	200	4,259		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0		17.00
18.00 SUBPROVIDER	0	0	0	0		18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE				0		21.00
22.00 HOME HEALTH AGENCY	0	5,130	0	10,789		22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0		25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0		25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0		25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0		25.40
26.00 RURAL HEALTH CLINIC	0	0	0	0		26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	1,451		28.00
28.02 SUBPROVIDER - IRF				0		28.02
28.03 SUBPROVIDER				0		28.03
29.00 Ambulance Trips		18,196				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: 151332

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

Worksheet S-3
Part I
Date/Time Prepared:
5/24/2012 9:40 am

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	462	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	375.00	0.00	0	462	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0.00	0.00	0	0	17.00
18.00 SUBPROVIDER	0.00	0.00	0.00	0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	0.00	0.00	0.00			21.00
22.00 HOME HEALTH AGENCY	0.00	0.00	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00	0.00	0.00			25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00	0.00	0.00			25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00	0.00	0.00			25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00	0.00	0.00			25.40
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	375.00	0.00			27.00
28.00 Observation Bed Days						28.00
28.02 SUBPROVIDER - IRF						28.02
28.03 SUBPROVIDER						28.03
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151332

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

Worksheet S-3
Part I
Date/Time Prepared:
5/24/2012 9:40 am

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)	69	1,159		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)	69	1,159		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF	0	0		17.00
18.00 SUBPROVIDER	0	0		18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE		0		21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
25.10 CMHC - CORF				25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY				25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY				25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY				25.40
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
28.02 SUBPROVIDER - IRF				28.02
28.03 SUBPROVIDER				28.03
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 151332 Component CCN: 157153		Period: From 01/01/2011 To 12/31/2011		Worksheet S-4 Date/Time Prepared: 5/24/2012 9:40 am	
				Home Health Agency I		PPS	
						1.00	
0.00	County					0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	
2.00	Unduplicated Census Count (see instructions)	0.00	207.00	0.00	0.00	0.00	
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
				0	1.00	2.00	3.00
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	0.00		0.00	0.00	0.00	
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	
5.00	Other Administrative Personnel			0.00	0.00	0.00	
6.00	Direct Nursing Service			0.00	0.00	0.00	
7.00	Nursing Supervisor			0.00	0.00	0.00	
8.00	Physical Therapy Service			0.00	0.00	0.00	
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	
10.00	Occupational Therapy Service			0.00	0.00	0.00	
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	
12.00	Speech Pathology Service			0.00	0.00	0.00	
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	
14.00	Medical Social Service			0.00	0.00	0.00	
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	
16.00	Home Health Aide			0.00	0.00	0.00	
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	
18.00	Other (specify)			0.00	0.00	0.00	
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).						
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	2,572	0	119	27	2,718	
22.00	Skilled Nursing Visit Charges	485,454	0	22,434	5,137	513,025	
23.00	Physical Therapy Visits	873	0	38	34	945	
24.00	Physical Therapy Visit Charges	164,909	0	7,147	6,469	178,525	
25.00	Occupational Therapy Visits	350	0	4	8	362	
26.00	Occupational Therapy Visit Charges	66,200	0	753	1,522	68,475	
27.00	Speech Pathology Visits	39	0	0	0	39	
28.00	Speech Pathology Visit Charges	7,420	0	0	0	7,420	
29.00	Medical Social Service Visits	21	0	2	1	24	
30.00	Medical Social Service Visit Charges	3,987	0	381	190	4,558	
31.00	Home Health Aide Visits	1,018	0	4	20	1,042	
32.00	Home Health Aide Visit Charges	115,930	0	460	2,300	118,690	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,873	0	167	90	5,130	
34.00	Other Charges	0	0	0	0	0	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	843,900	0	31,175	15,618	890,693	
36.00	Total Number of Episodes (standard/non outlier)	314		53	5	372	
37.00	Total Number of Outlier Episodes		0		0	0	
38.00	Total Non-Routine Medical Supply Charges	51,955	0	581	140	52,676	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet S-10 Date/Time Prepared: 5/24/2012 9:40 am
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			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)		0.488361	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		0	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		0	6.00
7.00	Medicaid cost (line 1 times line 6)		0	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone SCHIP		0	9.00
10.00	Stand-alone SCHIP charges		0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00
			1.00	
			2.00	
			3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	0	0	0
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	0	0	0
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	0	0	0
			1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		0	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		797,580	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		-797,580	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		-389,507	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		-389,507	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		-389,507	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151332

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

Worksheet A
Date/Time Prepared:
5/24/2012 9:40 am

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT		2,651,908	2,651,908	0	2,651,908	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
3.00 OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00 EMPLOYEE BENEFITS	146,901	5,691,319	5,838,220	16,583	5,854,803	4.00
5.00 ADMINISTRATIVE & GENERAL	2,450,515	1,975,687	4,426,202	277,846	4,704,048	5.00
6.00 MAINTENANCE & REPAIRS	445,551	227,809	673,360	-60,432	612,928	6.00
7.00 OPERATION OF PLANT	0	561,200	561,200	3,682	564,882	7.00
8.00 LAUNDRY & LINEN SERVICE	60,502	32,400	92,902	0	92,902	8.00
9.00 HOUSEKEEPING	402,988	206,335	609,323	0	609,323	9.00
10.00 DIETARY	385,734	326,109	711,843	-510,695	201,148	10.00
11.00 CAFETERIA	0	0	0	510,695	510,695	11.00
13.00 NURSING ADMINISTRATION	780,760	25,148	805,908	0	805,908	13.00
14.00 CENTRAL SERVICES & SUPPLY	25,292	2,341	27,633	0	27,633	14.00
16.00 MEDICAL RECORDS & LIBRARY	431,370	72,822	504,192	84,462	588,654	16.00
17.00 SOCIAL SERVICE	135,840	2,804	138,644	0	138,644	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,448,137	97,174	2,545,311	-231,897	2,313,414	30.00
31.00 INTENSIVE CARE UNIT	380,036	17,125	397,161	0	397,161	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	0	0	0	162,670	162,670	43.00
46.00 OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	1,059,331	65,399	1,124,730	0	1,124,730	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	69,227	69,227	52.00
53.00 ANESTHESIOLOGY	393,942	486,913	880,855	60,432	941,287	53.00
54.00 RADIOLOGY-DIAGNOSTIC	1,239,675	555,727	1,795,402	-82,938	1,712,464	54.00
55.00 ULTRA SOUND	0	57,415	57,415	82,938	140,353	55.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	989,357	454,400	1,443,757	0	1,443,757	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	80,545	80,545	0	80,545	62.00
65.00 RESPIRATORY THERAPY	678,475	55,787	734,262	-120,726	613,536	65.00
66.00 PHYSICAL THERAPY	561,596	16,919	578,515	0	578,515	66.00
67.00 OCCUPATIONAL THERAPY	190,820	50,265	241,085	0	241,085	67.00
68.00 SPEECH PATHOLOGY	244,235	31,896	276,131	0	276,131	68.00
69.00 ELECTROCARDIOLOGY	35,092	170,924	206,016	120,726	326,742	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,424,342	2,424,342	-14,700	2,409,642	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	14,700	14,700	72.00
73.00 DRUGS CHARGED TO PATIENTS	729,223	1,633,078	2,362,301	0	2,362,301	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	561,040	82,456	643,496	0	643,496	90.00
90.01 ONCOLOGY	210,862	109,319	320,181	0	320,181	90.01
90.02 OUTPATIENT CLINIC	90,826	333,580	424,406	0	424,406	90.02
90.03 PROVIDER BASED CLINIC - RCMP	556,411	1,394,856	1,951,267	-231,363	1,719,904	90.03
90.04 PROVIDER BASED CLINIC - DCPC	828,937	61,888	890,825	-82,732	808,093	90.04
90.05 PROVIDER BASED CLINIC - WESTPORT	128,196	15,002	143,198	-24,968	118,230	90.05
90.06 CLINIC	189,438	264,410	453,848	0	453,848	90.06
91.00 EMERGENCY	2,088,857	221,346	2,310,203	0	2,310,203	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	637,797	115,426	753,223	0	753,223	95.00
99.10 CORF	0	0	0	0	0	99.10
99.20 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00 HOME HEALTH AGENCY	1,052,676	107,459	1,160,135	0	1,160,135	101.00
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET CELL ACQUISITION	0	0	0	0	0	111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	20,560,412	20,679,533	41,239,945	43,510	41,283,455	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,009	5,009	0	5,009	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 MARKETING	154,955	362,237	517,192	-43,510	473,682	194.00
194.01 WOMEN'S HEALTH SERVICES	29,282	73,296	102,578	0	102,578	194.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151332

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

Worksheet A
Date/Time Prepared:
5/24/2012 9:40 am

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	
200.00 TOTAL (SUM OF LINES 118-199)	20,744,649	21,120,075	41,864,724	0	41,864,724	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151332

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

Worksheet A
Date/Time Prepared:
5/24/2012 9:40 am

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	-180,427	2,471,481	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	EMPLOYEE BENEFITS	-438,702	5,416,101	4.00
5.00	ADMINISTRATIVE & GENERAL	-57,851	4,646,197	5.00
6.00	MAINTENANCE & REPAIRS	0	612,928	6.00
7.00	OPERATION OF PLANT	0	564,882	7.00
8.00	LAUNDRY & LINEN SERVICE	0	92,902	8.00
9.00	HOUSEKEEPING	0	609,323	9.00
10.00	DIETARY	0	201,148	10.00
11.00	CAFETERIA	-154,235	356,460	11.00
13.00	NURSING ADMINISTRATION	0	805,908	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	27,633	14.00
16.00	MEDICAL RECORDS & LIBRARY	-306	588,348	16.00
17.00	SOCIAL SERVICE	0	138,644	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-6,454	2,306,960	30.00
31.00	INTENSIVE CARE UNIT	0	397,161	31.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	162,670	43.00
46.00	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	1,124,730	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	69,227	52.00
53.00	ANESTHESIOLOGY	-822,145	119,142	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	1,712,464	54.00
55.00	ULTRA SOUND	0	140,353	55.00
57.00	CT SCAN	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	0	1,443,757	60.00
60.01	BLOOD LABORATORY	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	80,545	62.00
65.00	RESPIRATORY THERAPY	0	613,536	65.00
66.00	PHYSICAL THERAPY	0	578,515	66.00
67.00	OCCUPATIONAL THERAPY	-4,388	236,697	67.00
68.00	SPEECH PATHOLOGY	0	276,131	68.00
69.00	ELECTROCARDIOLOGY	-151,278	175,464	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	-277,387	2,132,255	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	14,700	72.00
73.00	DRUGS CHARGED TO PATIENTS	-2,528	2,359,773	73.00
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	-340,881	302,615	90.00
90.01	ONCOLOGY	0	320,181	90.01
90.02	OUTPATIENT CLINIC	-324,514	99,892	90.02
90.03	PROVIDER BASED CLINIC - TCMP	-1,234,313	485,591	90.03
90.04	PROVIDER BASED CLINIC - DCPC	0	808,093	90.04
90.05	PROVIDER BASED CLINIC - WESTPORT	0	118,230	90.05
90.06	CLINIC	-150,856	302,992	90.06
91.00	EMERGENCY	-885,273	1,424,930	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	0	753,223	95.00
99.10	CORF	0	0	99.10
99.20	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
101.00	HOME HEALTH AGENCY	0	1,160,135	101.00
SPECIAL PURPOSE COST CENTERS				
109.00	PANCREAS ACQUISITION	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	110.00
111.00	ISLET CELL ACQUISITION	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-5,031,538	36,251,917	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,009	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	MARKETING	0	473,682	194.00
194.01	WOMEN'S HEALTH SERVICES	0	102,578	194.01
200.00	TOTAL (SUM OF LINES 118-199)	-5,031,538	36,833,186	200.00

RECLASSIFICATIONS

Provider CCN: 151332

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

Worksheet A-6

Date/Time Prepared:
5/24/2012 9:40 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - ULTRASOUND SALARY						
1.00	ULTRA SOUND	55.00	82,938	0	1.00	
	TOTALS		82,938	0		
B - L&D AND NURSERY						
1.00	NURSERY	43.00	150,613	12,057	1.00	
2.00	DELIVERY ROOM & LABOR ROOM	52.00	64,096	5,131	2.00	
	TOTALS		214,709	17,188		
C - EKG SALARY						
1.00	ELECTROCARDIOLOGY	69.00	120,726	0	1.00	
	TOTALS		120,726	0		
D - CAFETERIA						
1.00	CAFETERIA	11.00	276,736	233,959	1.00	
	TOTALS		276,736	233,959		
E - ANESTHESIA GAS EXPENSE						
1.00	ANESTHESIOLOGY	53.00		60,432	1.00	
	TOTALS		0	60,432		
F - DIRECT EXPENSE ALLOCATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	250,919	0	1.00	
2.00		7.00	3,682	0	2.00	
3.00		16.00	84,462	0	3.00	
	TOTALS		339,063	0		
H - MARKETING						
1.00	EMPLOYEE BENEFITS	4.00	0	16,583	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	26,927	2.00	
	TOTALS		0	43,510		
I - IMPLANTABLE DEVICES						
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	14,700	1.00	
	TOTALS		0	14,700		
500.00	Grand Total: Increases		1,034,172	369,789	500.00	

RECLASSIFICATIONS

Provider CCN: 151332

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

Worksheet A-6
Date/Time Prepared:
5/24/2012 9:40 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - ULTRASOUND SALARY						
1.00		54.00	82,938	0	0		1.00
	TOTALS		82,938	0			
	B - L&D AND NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	214,709	17,188	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		214,709	17,188			
	C - EKG SALARY						
1.00	RESPIRATORY THERAPY	65.00	120,726	0	0		1.00
	TOTALS		120,726	0			
	D - CAFETERIA						
1.00	DIETARY	10.00	276,736	233,959	0		1.00
	TOTALS		276,736	233,959			
	E - ANESTHESIA GAS EXPENSE						
1.00		6.00		60,432	0		1.00
	TOTALS		0	60,432			
	F - DIRECT EXPENSE ALLOCATION						
1.00		90.03	231,363	0	0		1.00
2.00		90.04	82,732	0	0		2.00
3.00		90.05	24,968	0	0		3.00
	TOTALS		339,063	0			
	H - MARKETING						
1.00	MARKETING	194.00	0	43,510	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	43,510			
	I - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	14,700	0		1.00
	TOTALS		0	14,700			
500.00	Grand Total: Decreases		1,034,172	369,789			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151332

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/24/2012 9:40 am

	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	905,928	0	0	0	1.00
2.00	Land Improvements	353,413	22,567	0	22,567	2.00
3.00	Buildings and Fixtures	26,099,608	444,961	0	444,961	3.00
4.00	Building Improvements	459,200	405,156	0	405,156	4.00
5.00	Fixed Equipment	2,343,912	56,361	0	56,361	5.00
6.00	Movable Equipment	14,863,132	497,936	0	497,936	6.00
7.00	HIT designated Assets	0	129,834	0	129,834	7.00
8.00	Subtotal (sum of lines 1-7)	45,025,193	1,556,815	0	1,556,815	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	45,025,193	1,556,815	0	1,556,815	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	2,366,097	107,457	178,354	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,366,097	107,457	178,354	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	0	0	0	1.000000	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151332

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/24/2012 9:40 am

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	905,928	0		1.00		
2.00	Land Improvements	375,980	0		2.00		
3.00	Buildings and Fixtures	26,544,569	0		3.00		
4.00	Building Improvements	864,356	0		4.00		
5.00	Fixed Equipment	2,400,273	0		5.00		
6.00	Movable Equipment	15,361,068	0		6.00		
7.00	HIT designated Assets	129,834	0		7.00		
8.00	Subtotal (sum of lines 1-7)	46,582,008	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	46,582,008	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	2,651,908		1.00		
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00		
3.00	Total (sum of lines 1-2)	0	2,651,908		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	2,364,024	107,457	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,364,024	107,457	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151332

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/24/2012 9:40 am

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	0	0	0	0	2,471,481	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	2,471,481	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151332

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

Worksheet A-8

Date/Time Prepared:
5/24/2012 9:40 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center		Line #	
			1.00	2.00	3.00	4.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00 Investment income - other (chapter 2)		0	0		0.00	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0	0		0.00	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0	0		0.00	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0	0		0.00	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0	0		0.00	7.00
8.00 Television and radio service (chapter 21)		0	0		0.00	8.00
9.00 Parking lot (chapter 21)		0	0		0.00	9.00
10.00 Provider-based physician adjustment	A-8-2	-3,965,697	0			10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0	0		0.00	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	56,437	0			12.00
13.00 Laundry and linen service		0	0		0.00	13.00
14.00 Cafeteria-employees and guests		0	0		0.00	14.00
15.00 Rental of quarters to employee and others		0	0		0.00	15.00
16.00 Sale of medical and surgical supplies to other than patients		0	0		0.00	16.00
17.00 Sale of drugs to other than patients		0	0		0.00	17.00
18.00 Sale of medical records and abstracts		0	0		0.00	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0	0		0.00	19.00
20.00 Vending machines		0	0		0.00	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0	0		0.00	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0	0		0.00	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00	25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00	28.00
29.00 Physicians' assistant			0		0.00	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	-4,388	0	OCCUPATIONAL THERAPY	67.00	30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A		0		0.00	32.00
33.00 CAFETERIA MEALS-EMPLOYEE	B	-115,842	0	CAFETERIA	11.00	33.00
34.00 CAFETERIA MEALS-VISITOR	B	-38,393	0	CAFETERIA	11.00	34.00
35.00 MEDICAL RECORD TRANSCRIPTS FEES	B	-306	0	MEDICAL RECORDS & LIBRARY	16.00	35.00
36.00 CLASS FEES	B	-6,454	0	ADULTS & PEDIATRICS	30.00	36.00
37.00 OTHER INCOME	B	-2,472	0	ADMINISTRATIVE & GENERAL	5.00	37.00
38.00 PURCHASE DISCOUNTS	B	-2,023	0	ADMINISTRATIVE & GENERAL	5.00	38.00
39.00 BABY PICTURE COMMISSIONS	B	-7,209	0	ADMINISTRATIVE & GENERAL	5.00	39.00
40.00 CASH OVER/SHORT	B	-231	0	ADMINISTRATIVE & GENERAL	5.00	40.00
41.00 KING'S ISLAND TICKET SALES	B	-535	0	ADMINISTRATIVE & GENERAL	5.00	41.00
42.00 NON OPERATING INCOME	B	-1	0	ADMINISTRATIVE & GENERAL	5.00	42.00
43.00 REFUNDS & REIMBURSEMENTS	B	-274,497	0	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	43.00
44.00 SUPPLIES SOLD	B	-459	0	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	44.00
45.00 REBATES	B	-2,431	0	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	45.00
45.01 REBATES - PHARMACY	B	-2,008	0	DRUGS CHARGED TO PATIENTS	73.00	45.01
45.02 PHYSICIAN RECRUITMENT	A	-28,784	0	ADMINISTRATIVE & GENERAL	5.00	45.02
45.03 INTEREST EXPENSE	A	-178,354	0	NEW CAP REL COSTS-BLDG & FIXT	1.00	45.03

ADJUSTMENTS TO EXPENSES

Provider CCN: 151332

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

Worksheet A-8

Date/Time Prepared:
5/24/2012 9:40 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #
			Cost Center	Line #	
	1.00	2.00	3.00	4.00	
45.04 EMPLOYEE DRUG SALES	A	-520	DRUGS CHARGED TO PATIENTS	73.00	45.04
45.05 PATIENT TELEPHONE EXPENSE	A	-11,134	ADMINISTRATIVE & GENERAL	5.00	45.05
45.06 PATIENT TELEPHONE BENEFITS	A	-2,031	EMPLOYEE BENEFITS	4.00	45.06
45.07 TELEVISION	A	-2,073	NEW CAP REL COSTS-BLDG & FI XT	1.00	45.07
45.08 PHYSICIAN BENEFITS	A	-436,671	EMPLOYEE BENEFITS	4.00	45.08
45.09 AHA/IHA LOBBYING EXPENSE	A	-5,462	ADMINISTRATIVE & GENERAL	5.00	45.09
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,031,538			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151332

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

Worksheet A-8

Date/Time Prepared:
5/24/2012 9:40 am

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - 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	CAFETERIA MEALS-EMPLOYEE	0	33.00
34.00	CAFETERIA MEALS-VISITOR	0	34.00
35.00	MEDICAL RECORD TRANSCRIPTS FEES	0	35.00
36.00	CLASS FEES	0	36.00
37.00	OTHER INCOME	0	37.00
38.00	PURCHASE DISCOUNTS	0	38.00
39.00	BABY PICTURE COMMISSIONS	0	39.00
40.00	CASH OVER/SHORT	0	40.00
41.00	KING'S ISLAND TICKET SALES	0	41.00
42.00	NON OPERATING INCOME	0	42.00
43.00	REFUNDS & REIMBURSEMENTS	0	43.00
44.00	SUPPLIES SOLD	0	44.00
45.00	REBATES	0	45.00
45.01	REBATES - PHARMACY	0	45.01
45.02	PHYSICIAN RECRUITMENT	0	45.02
45.03	INTEREST EXPENSE	11	45.03
45.04	EMPLOYEE DRUG SALES	0	45.04
45.05	PATIENT TELEPHONE EXPENSE	0	45.05
45.06	PATIENT TELEPHONE BENEFITS	0	45.06
45.07	TELEVISION	9	45.07
45.08	PHYSICIAN BENEFITS	0	45.08
45.09	AHA/IHA LOBBYING EXPENSE	0	45.09
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: 151332

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

Worksheet A-8-1

Date/Time Prepared:
5/24/2012 9:40 am

	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	91.00	EMERGENCY	AMBULANCE SERVICES	1.00
2.00	0.00			2.00
3.00	0.00			3.00
4.00	0.00			4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5.00

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

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

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

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

6.00	G		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.

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

Provider CCN: 151332

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

Worksheet A-8-1

Date/Time Prepared: 5/24/2012 9:40 am

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	56,437	0	56,437	0	1.00
2.00	0	0	0	0	2.00
3.00	0	0	0	0	3.00
4.00	0	0	0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				5.00

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

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151332

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

Worksheet A-8-2

Date/Time Prepared:
5/24/2012 9:40 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	31.00	INTENSIVE CARE UNIT	11,000	0	1.00
2.00	53.00	ANESTHESIOLOGY	876,342	822,145	2.00
3.00	60.00	LABORATORY	50,000	0	3.00
4.00	65.00	RESPIRATORY THERAPY	16,999	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	151,278	151,278	5.00
6.00	90.00	CLINIC	356,084	340,881	6.00
7.00	90.01	ONCOLOGY	12,000	0	7.00
8.00	90.02	OUTPATIENT CLINIC	324,514	324,514	8.00
9.00	90.03	PROVIDER BASED CLINIC - TCMP	1,234,313	1,234,313	9.00
10.00	90.06	CLINIC	171,594	150,856	10.00
11.00	91.00	EMERGENCY	1,215,402	941,710	11.00
200.00			4,419,526	3,965,697	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151332

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

Worksheet A-8-2

Date/Time Prepared:
5/24/2012 9:40 am

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	11,000	0	0	0	0	1.00
2.00	54,197	0	0	0	0	2.00
3.00	50,000	0	0	0	0	3.00
4.00	16,999	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	15,203	0	0	0	0	6.00
7.00	12,000	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	20,738	0	0	0	0	10.00
11.00	273,692	0	0	0	0	11.00
200.00	453,829					200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151332

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

Worksheet A-8-2

Date/Time Prepared:
5/24/2012 9:40 am

	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	
	12.00	13.00	14.00	15.00	16.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
11.00	0	0	0	0	0	11.00
200.00	0	0	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151332

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

Worksheet A-8-2

Date/Time Prepared:
5/24/2012 9:40 am

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	0	1.00
2.00	0	822,145	2.00
3.00	0	0	3.00
4.00	0	0	4.00
5.00	0	151,278	5.00
6.00	0	340,881	6.00
7.00	0	0	7.00
8.00	0	324,514	8.00
9.00	0	1,234,313	9.00
10.00	0	150,856	10.00
11.00	0	941,710	11.00
200.00	0	3,965,697	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151332		Period: From 01/01/2011 To 12/31/2011		Worksheet A-8-3 Part Date/Time Prepared: 5/24/2012 9:40 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					18	1.00
2.00	Line 1 multiplied by 15 hours per week					270	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					81	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	706.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	52.56	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)	26.28	26.28	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	1,989	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					37,134	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)					37,134	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)					37,134	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)					37,134	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)					2,129	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)					2,129	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					2,129	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)					2,129	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: 151332		Period: From 01/01/2011 To 12/31/2011		Worksheet A-8-3 Part	
				Occupational Therapy		Date/Time Prepared: 5/24/2012 9:40 am	
						Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	52.56	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					37,134	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					2,129	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					39,263	63.00
64.00	Total cost of outside supplier services (from your records)					43,651	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					4,388	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					2,129	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					2,129	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					0	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet A-8-3 Part Date/Time Prepared: 5/24/2012 9:40 am		
			Speech Pathology	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)			93	3.00	
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)			0	4.00	
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)			0	5.00	
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)			0	6.00	
7.00	Standard travel expense rate			0.00	7.00	
8.00	Optional travel expense rate per mile			0.00	8.00	
		Supervisors	Therapists	Assistants	Aides	Trainees
		1.00	2.00	3.00	4.00	5.00
9.00	Total hours worked	0.00	628.75	0.00	0.00	0.00
10.00	AHSEA (see instructions)	0.00	63.39	0.00	0.00	0.00
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)	31.70	31.70	0.00		
12.00	Number of travel hours (provider site)	0	0	0		
12.01	Number of travel hours (offsite)	0	0	0		
13.00	Number of miles driven (provider site)	0	0	0		
13.01	Number of miles driven (offsite)	0	0	0		
				1.00		
Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)			0	14.00	
15.00	Therapists (column 2, line 9 times column 2, line 10)			39,856	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)			39,856	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)			39,856	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)			63.39	21.00	
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)			49,444	22.00	
23.00	Total salary equivalency (see instructions)			49,444	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)			2,948	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)			2,948	26.00	
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)			0	27.00	
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)			2,948	28.00	
Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)			0	29.00	
30.00	Assistants (column 3, line 10 times column 3, line 12)			0	30.00	
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)			0	31.00	
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)			0	32.00	
33.00	Standard travel allowance and standard travel expense (line 28)			0	33.00	
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)			0	34.00	
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)			0	35.00	
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)			0	36.00	
37.00	Assistants (line 6 times column 3, line 11)			0	37.00	
38.00	Subtotal (sum of lines 36 and 37)			0	38.00	
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)			0	39.00	
Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)			0	40.00	
41.00	Assistants (column 3, line 12.01 times column 3, line 10)			0	41.00	
42.00	Subtotal (sum of lines 40 and 41)			0	42.00	
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)			0	43.00	
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)			0	44.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)			0	45.00	

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151332				Period: From 01/01/2011 To 12/31/2011	Worksheet A-8-3 Part Date/Time Prepared: 5/24/2012 9:40 am
						Speech Pathology	Cost
						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	63.39	0.00	0.00	0.00	0.00	52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0	54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0	55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					49,444	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35)					0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					49,444	63.00
64.00	Total cost of outside supplier services (from your records)					19,806	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					2,948	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					2,948	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					0	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151332

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

Worksheet B
Part I
Date/Time Prepared:
5/24/2012 9:40 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT	2,471,481	2,471,481				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0		0			2.00
4.00 EMPLOYEE BENEFITS	5,416,101	3,434	0	5,419,535		4.00
5.00 ADMINISTRATIVE & GENERAL	4,646,197	447,517	0	766,893	5,860,607	5.00
6.00 MAINTENANCE & REPAIRS	612,928	15,870	0	126,485	755,283	6.00
7.00 OPERATION OF PLANT	564,882	211,794	0	1,045	777,721	7.00
8.00 LAUNDRY & LINEN SERVICE	92,902	17,170	0	17,176	127,248	8.00
9.00 HOUSEKEEPING	609,323	12,710	0	114,402	736,435	9.00
10.00 DIETARY	201,148	32,718	0	30,943	264,809	10.00
11.00 CAFETERIA	356,460	7,631	0	78,561	442,652	11.00
13.00 NURSING ADMINISTRATION	805,908	12,281	0	221,646	1,039,835	13.00
14.00 CENTRAL SERVICES & SUPPLY	27,633	0	0	7,180	34,813	14.00
16.00 MEDICAL RECORDS & LIBRARY	588,348	61,846	0	146,437	796,631	16.00
17.00 SOCIAL SERVICE	138,644	5,699	0	38,563	182,906	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,306,960	164,339	0	634,037	3,105,336	30.00
31.00 INTENSIVE CARE UNIT	397,161	15,715	0	107,887	520,763	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	162,670	9,062	0	42,757	214,489	43.00
46.00 OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	1,124,730	128,677	0	300,728	1,554,135	50.00
52.00 DELIVERY ROOM & LABOR ROOM	69,227	117,755	0	18,196	205,178	52.00
53.00 ANESTHESIOLOGY	119,142	0	0	26,414	145,556	53.00
54.00 RADIOLOGY-DIAGNOSTIC	1,712,464	111,376	0	328,380	2,152,220	54.00
55.00 ULTRA SOUND	140,353	0	0	23,545	163,898	55.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	1,443,757	80,626	0	280,864	1,805,247	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	80,545	0	0	0	80,545	62.00
65.00 RESPIRATORY THERAPY	613,536	20,878	0	158,337	792,751	65.00
66.00 PHYSICAL THERAPY	578,515	32,813	0	159,429	770,757	66.00
67.00 OCCUPATIONAL THERAPY	236,697	18,314	0	54,171	309,182	67.00
68.00 SPEECH PATHOLOGY	276,131	17,170	0	69,335	362,636	68.00
69.00 ELECTROCARDIOLOGY	175,464	9,300	0	44,234	228,998	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,132,255	29,093	0	0	2,161,348	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	14,700	0	0	0	14,700	72.00
73.00 DRUGS CHARGED TO PATIENTS	2,359,773	27,471	0	207,015	2,594,259	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	302,615	23,680	0	63,792	390,087	90.00
90.01 ONCOLOGY	320,181	10,612	0	59,861	390,654	90.01
90.02 OUTPATIENT CLINIC	99,892	75,367	0	25,784	201,043	90.02
90.03 PROVIDER BASED CLINIC - TCMP	485,591	151,176	0	92,276	729,043	90.03
90.04 PROVIDER BASED CLINIC - DCPC	808,093	75,117	0	211,836	1,095,046	90.04
90.05 PROVIDER BASED CLINIC - WESTPORT	118,230	14,308	0	29,305	161,843	90.05
90.06 CLINIC	302,992	28,735	0	10,953	342,680	90.06
91.00 EMERGENCY	1,424,930	70,348	0	388,866	1,884,144	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	753,223	42,924	0	181,061	977,208	95.00
99.10 CORF	0	0	0	0	0	99.10
99.20 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00 HOME HEALTH AGENCY	1,160,135	31,335	0	298,839	1,490,309	101.00
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET CELL ACQUISITION	0	0	0	0	0	111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	36,251,917	2,134,861	0	5,367,233	35,862,995	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,009	8,048	0	0	13,057	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	324,386	0	0	324,386	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151332

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

Worksheet B
Part I
Date/Time Prepared:
5/24/2012 9:40 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
194.00 MARKETING	473,682	2,099	0	43,989	519,770	194.00
194.01 WOMEN'S HEALTH SERVICES	102,578	2,087	0	8,313	112,978	194.01
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	36,833,186	2,471,481	0	5,419,535	36,833,186	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151332

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

Worksheet B
Part I
Date/Time Prepared:
5/24/2012 9:40 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
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	5,860,607					5.00
6.00	MAINTENANCE & REPAIRS	142,914	898,197				6.00
7.00	OPERATION OF PLANT	147,160	0	924,881			7.00
8.00	LAUNDRY & LINEN SERVICE	24,078	0	8,857	160,183		8.00
9.00	HOUSEKEEPING	139,347	74,265	6,557	10,221	966,825	9.00
10.00	DIETARY	50,107	6,294	16,878	631	0	10.00
11.00	CAFETERIA	83,758	16,184	3,937	0	15,594	11.00
13.00	NURSING ADMINISTRATION	196,757	1,798	6,335	0	4,994	13.00
14.00	CENTRAL SERVICES & SUPPLY	6,587	0	0	0	0	14.00
16.00	MEDICAL RECORDS & LIBRARY	150,738	15,824	31,905	0	9,505	16.00
17.00	SOCIAL SERVICE	34,609	899	2,940	0	1,708	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	587,591	117,961	84,777	60,127	298,474	30.00
31.00	INTENSIVE CARE UNIT	98,538	4,495	8,107	3,153	24,776	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	40,585	27,692	4,675	2,710	19,815	43.00
46.00	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	294,072	29,670	66,380	26,255	1,869	50.00
52.00	DELIVERY ROOM & LABOR ROOM	38,824	11,868	60,746	3,810	109,512	52.00
53.00	ANESTHESIOLOGY	27,542	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	407,241	4,495	57,455	13,361	68,562	54.00
55.00	ULTRA SOUND	31,013	0	0	0	0	55.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	341,587	3,596	41,592	0	36,987	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	15,241	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	150,004	3,596	10,770	2,142	15,143	65.00
66.00	PHYSICAL THERAPY	145,842	98,901	16,927	9,514	23,230	66.00
67.00	OCCUPATIONAL THERAPY	58,503	0	9,448	0	0	67.00
68.00	SPEECH PATHOLOGY	68,618	9,890	8,857	0	12,340	68.00
69.00	ELECTROCARDIOLOGY	43,331	0	4,798	1,251	17,302	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	408,968	0	15,008	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	2,782	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	490,883	10,789	14,172	0	60,346	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	73,812	72,827	12,216	0	0	90.00
90.01	ONCOLOGY	73,919	17,083	5,474	751	16,464	90.01
90.02	OUTPATIENT CLINIC	38,041	4,495	38,880	661	25,517	90.02
90.03	PROVIDER BASED CLINIC - TCMP	137,949	319,181	77,987	4,231	0	90.03
90.04	PROVIDER BASED CLINIC - DCPC	207,204	7,193	38,750	167	53,580	90.04
90.05	PROVIDER BASED CLINIC - WESTPORT	30,624	3,596	7,381	0	0	90.05
90.06	CLINIC	64,842	6,833	14,824	0	23,649	90.06
91.00	EMERGENCY	356,516	0	36,290	18,593	74,329	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	184,906	7,193	22,143	2,026	0	95.00
99.10	CORF	0	0	0	0	0	99.10
99.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	HOME HEALTH AGENCY	281,995	5,395	16,164	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET CELL ACQUISITION	0	0	0	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	5,677,028	882,013	751,230	159,604	913,696	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,471	0	4,152	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	61,380	0	167,340	579	53,129	192.00
194.00	MARKETING	98,350	15,285	1,083	0	0	194.00
194.01	WOMEN'S HEALTH SERVICES	21,378	899	1,076	0	0	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	5,860,607	898,197	924,881	160,183	966,825	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151332

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

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Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
	10.00	11.00	13.00	14.00	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
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY	338,719					10.00
11.00 CAFETERIA	0	562,125				11.00
13.00 NURSING ADMINISTRATION	0	20,949	1,270,668			13.00
14.00 CENTRAL SERVICES & SUPPLY	0	1,924	6,856	50,180		14.00
16.00 MEDICAL RECORDS & LIBRARY	0	35,350	0	0	1,039,953	16.00
17.00 SOCIAL SERVICE	0	4,427	15,780	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	326,054	89,690	319,686	0	41,738	30.00
31.00 INTENSIVE CARE UNIT	12,665	11,537	41,119	0	4,592	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	0	5,340	19,033	0	9,500	43.00
46.00 OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	43,329	154,436	0	105,945	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	2,273	8,100	0	7,427	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	6,571	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	40,581	0	0	231,467	54.00
55.00 ULTRA SOUND	0	0	0	0	26,043	55.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	42,715	4,054	0	175,585	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	5,426	62.00
65.00 RESPIRATORY THERAPY	0	22,052	78,600	0	27,893	65.00
66.00 PHYSICAL THERAPY	0	21,665	77,218	0	26,154	66.00
67.00 OCCUPATIONAL THERAPY	0	6,035	21,508	0	8,135	67.00
68.00 SPEECH PATHOLOGY	0	8,888	31,679	0	7,597	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	30,094	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	50,180	56,473	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	278	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	26,161	93,244	0	107,242	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	2,247	33,535	0	3,757	90.00
90.01 ONCOLOGY	0	8,467	30,178	0	2,889	90.01
90.02 OUTPATIENT CLINIC	0	5,557	19,807	0	2,647	90.02
90.03 PROVIDER BASED CLINIC - TCMP	0	0	0	0	12,012	90.03
90.04 PROVIDER BASED CLINIC - DCPC	0	18,037	0	0	6,263	90.04
90.05 PROVIDER BASED CLINIC - WESTPORT	0	0	0	0	1,048	90.05
90.06 CLINIC	0	8,775	31,275	0	17,265	90.06
91.00 EMERGENCY	0	45,895	131,260	0	82,786	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	0	38,615	0	0	33,126	95.00
99.10 CORF	0	0	0	0	0	99.10
99.20 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00 HOME HEALTH AGENCY	0	41,441	147,706	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET CELL ACQUISITION	0	0	0	0	0	111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	338,719	551,950	1,265,074	50,180	1,039,953	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 MARKETING	0	8,606	0	0	0	194.00
194.01 WOMEN'S HEALTH SERVICES	0	1,569	5,594	0	0	194.01
200.00 Cross Foot Adjustments	0	0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151332

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

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Part I
Date/Time Prepared:
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Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
	10.00	11.00	13.00	14.00	16.00	
202.00 TOTAL (sum lines 118-201)	338,719	562,125	1,270,668	50,180	1,039,953	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151332

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

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Part I
Date/Time Prepared:
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Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	17.00	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
6.00 MAINTENANCE & REPAIRS					6.00
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
16.00 MEDICAL RECORDS & LIBRARY					16.00
17.00 SOCIAL SERVICE	243,269				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS	221,224	5,252,658	0	5,252,658	30.00
31.00 INTENSIVE CARE UNIT	0	729,745	0	729,745	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	42.00
43.00 NURSERY	0	343,839	0	343,839	43.00
46.00 OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	2,276,091	0	2,276,091	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	447,738	0	447,738	52.00
53.00 ANESTHESIOLOGY	0	179,669	0	179,669	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	2,975,382	0	2,975,382	54.00
55.00 ULTRA SOUND	0	220,954	0	220,954	55.00
57.00 CT SCAN	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 LABORATORY	0	2,451,363	0	2,451,363	60.00
60.01 BLOOD LABORATORY	0	0	0	0	60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	101,212	0	101,212	62.00
65.00 RESPIRATORY THERAPY	0	1,102,951	0	1,102,951	65.00
66.00 PHYSICAL THERAPY	0	1,190,208	0	1,190,208	66.00
67.00 OCCUPATIONAL THERAPY	0	412,811	0	412,811	67.00
68.00 SPEECH PATHOLOGY	0	510,505	0	510,505	68.00
69.00 ELECTROCARDIOLOGY	0	325,774	0	325,774	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,691,977	0	2,691,977	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	17,760	0	17,760	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	3,397,096	0	3,397,096	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 CLINIC	0	588,481	0	588,481	90.00
90.01 ONCOLOGY	3,512	549,391	0	549,391	90.01
90.02 OUTPATIENT CLINIC	0	336,648	0	336,648	90.02
90.03 PROVIDER BASED CLINIC - TCMP	0	1,280,403	0	1,280,403	90.03
90.04 PROVIDER BASED CLINIC - DCPC	0	1,426,240	0	1,426,240	90.04
90.05 PROVIDER BASED CLINIC - WESTPORT	0	204,492	0	204,492	90.05
90.06 CLINIC	0	510,143	0	510,143	90.06
91.00 EMERGENCY	6,828	2,636,641	0	2,636,641	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES	0	1,265,217	0	1,265,217	95.00
99.10 CORF	0	0	0	0	99.10
99.20 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
101.00 HOME HEALTH AGENCY	11,705	1,994,715	0	1,994,715	101.00
SPECIAL PURPOSE COST CENTERS					
109.00 PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 ISLET CELL ACQUISITION	0	0	0	0	111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	243,269	35,420,104	0	35,420,104	118.00
NONREIMBURSABLE COST CENTERS					
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,680	0	19,680	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	606,814	0	606,814	192.00
194.00 MARKETING	0	643,094	0	643,094	194.00
194.01 WOMEN'S HEALTH SERVICES	0	143,494	0	143,494	194.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151332

Period:
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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
200.00	Cross Foot Adjustments	17.00	24.00	25.00	26.00		200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	243,269	36,833,186	0	36,833,186		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151332

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

Worksheet B
Part II
Date/Time Prepared:
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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	3,434	0	3,434	4.00
5.00	ADMINISTRATIVE & GENERAL	0	447,517	0	447,517	5.00
6.00	MAINTENANCE & REPAIRS	0	15,870	0	15,870	6.00
7.00	OPERATION OF PLANT	0	211,794	0	211,794	7.00
8.00	LAUNDRY & LINEN SERVICE	0	17,170	0	17,170	8.00
9.00	HOUSEKEEPING	0	12,710	0	12,710	9.00
10.00	DIETARY	0	32,718	0	32,718	10.00
11.00	CAFETERIA	0	7,631	0	7,631	11.00
13.00	NURSING ADMINISTRATION	0	12,281	0	12,281	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
16.00	MEDICAL RECORDS & LIBRARY	0	61,846	0	61,846	16.00
17.00	SOCIAL SERVICE	0	5,699	0	5,699	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	164,339	0	164,339	30.00
31.00	INTENSIVE CARE UNIT	0	15,715	0	15,715	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	42.00
43.00	NURSERY	0	9,062	0	9,062	43.00
46.00	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	128,677	0	128,677	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	117,755	0	117,755	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	111,376	0	111,376	54.00
55.00	ULTRA SOUND	0	0	0	0	55.00
57.00	CT SCAN	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	LABORATORY	0	80,626	0	80,626	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	20,878	0	20,878	65.00
66.00	PHYSICAL THERAPY	0	32,813	0	32,813	66.00
67.00	OCCUPATIONAL THERAPY	0	18,314	0	18,314	67.00
68.00	SPEECH PATHOLOGY	0	17,170	0	17,170	68.00
69.00	ELECTROCARDIOLOGY	0	9,300	0	9,300	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	29,093	0	29,093	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	27,471	0	27,471	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	CLINIC	0	23,680	0	23,680	90.00
90.01	ONCOLOGY	0	10,612	0	10,612	90.01
90.02	OUTPATIENT CLINIC	0	75,367	0	75,367	90.02
90.03	PROVIDER BASED CLINIC - TCMP	0	151,176	0	151,176	90.03
90.04	PROVIDER BASED CLINIC - DCPC	0	75,117	0	75,117	90.04
90.05	PROVIDER BASED CLINIC - WESTPORT	0	14,308	0	14,308	90.05
90.06	CLINIC	0	28,735	0	28,735	90.06
91.00	EMERGENCY	0	70,348	0	70,348	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	42,924	0	42,924	95.00
99.10	CORF	0	0	0	0	99.10
99.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
101.00	HOME HEALTH AGENCY	0	31,335	0	31,335	101.00
SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	ISLET CELL ACQUISITION	0	0	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,134,861	0	2,134,861	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,048	0	8,048	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	324,386	0	324,386	192.00
194.00	MARKETING	0	2,099	0	2,099	194.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151332

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

Worksheet B
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	2.00			
194.01 WOMEN'S HEALTH SERVICES	0	2,087	0	2,087	5	194.01
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0	0	0		0 201.00
202.00 TOTAL (sum lines 118-201)	0	2,471,481	0	2,471,481	3,434	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151332

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
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	448,000					5.00
6.00	MAINTENANCE & REPAIRS	10,924	26,874				6.00
7.00	OPERATION OF PLANT	11,249	0	223,044			7.00
8.00	LAUNDRY & LINEN SERVICE	1,841	0	2,136	21,158		8.00
9.00	HOUSEKEEPING	10,652	2,222	1,581	1,350	28,588	9.00
10.00	DIETARY	3,830	188	4,070	83	0	10.00
11.00	CAFETERIA	6,403	484	949	0	461	11.00
13.00	NURSING ADMINISTRATION	15,040	54	1,528	0	148	13.00
14.00	CENTRAL SERVICES & SUPPLY	504	0	0	0	0	14.00
16.00	MEDICAL RECORDS & LIBRARY	11,522	473	7,694	0	281	16.00
17.00	SOCIAL SERVICE	2,646	27	709	0	50	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	44,928	3,529	20,445	7,943	8,825	30.00
31.00	INTENSIVE CARE UNIT	7,532	135	1,955	416	733	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	3,102	829	1,127	358	586	43.00
46.00	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	22,479	888	16,008	3,468	55	50.00
52.00	DELIVERY ROOM & LABOR ROOM	2,968	355	14,649	503	3,238	52.00
53.00	ANESTHESIOLOGY	2,105	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	31,130	135	13,856	1,765	2,027	54.00
55.00	ULTRA SOUND	2,371	0	0	0	0	55.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	26,111	108	10,030	0	1,094	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,165	0	0	0	0	62.00
65.00	RESPIRATORY THERAPY	11,466	108	2,597	283	448	65.00
66.00	PHYSICAL THERAPY	11,148	2,959	4,082	1,257	687	66.00
67.00	OCCUPATIONAL THERAPY	4,472	0	2,278	0	0	67.00
68.00	SPEECH PATHOLOGY	5,245	296	2,136	0	365	68.00
69.00	ELECTROCARDIOLOGY	3,312	0	1,157	165	512	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	31,262	0	3,619	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	213	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	37,523	323	3,418	0	1,784	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	5,642	2,179	2,946	0	0	90.00
90.01	ONCOLOGY	5,650	511	1,320	99	487	90.01
90.02	OUTPATIENT CLINIC	2,908	135	9,376	87	755	90.02
90.03	PROVIDER BASED CLINIC - TCMP	10,545	9,549	18,807	559	0	90.03
90.04	PROVIDER BASED CLINIC - DCPC	15,839	215	9,345	22	1,584	90.04
90.05	PROVIDER BASED CLINIC - WESTPORT	2,341	108	1,780	0	0	90.05
90.06	CLINIC	4,957	204	3,575	0	699	90.06
91.00	EMERGENCY	27,252	0	8,752	2,456	2,198	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	14,134	215	5,340	268	0	95.00
99.10	CORF	0	0	0	0	0	99.10
99.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	HOME HEALTH AGENCY	21,556	161	3,898	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET CELL ACQUISITION	0	0	0	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	433,967	26,390	181,163	21,082	27,017	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	189	0	1,001	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	4,692	0	40,359	76	1,571	192.00
194.00	MARKETING	7,518	457	261	0	0	194.00
194.01	WOMEN'S HEALTH SERVICES	1,634	27	260	0	0	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	448,000	26,874	223,044	21,158	28,588	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151332

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

Worksheet B
Part II
Date/Time Prepared:
5/24/2012 9:40 am

Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
	10.00	11.00	13.00	14.00	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
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY	40,909					10.00
11.00 CAFETERIA	0	15,978				11.00
13.00 NURSING ADMINISTRATION	0	595	29,787			13.00
14.00 CENTRAL SERVICES & SUPPLY	0	55	161	725		14.00
16.00 MEDICAL RECORDS & LIBRARY	0	1,005	0	0	82,914	16.00
17.00 SOCIAL SERVICE	0	126	370	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	39,379	2,545	7,494	0	3,328	30.00
31.00 INTENSIVE CARE UNIT	1,530	328	964	0	366	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	0	152	446	0	758	43.00
46.00 OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	1,232	3,620	0	8,448	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	65	190	0	592	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	524	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	1,153	0	0	18,446	54.00
55.00 ULTRA SOUND	0	0	0	0	2,077	55.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	1,214	95	0	14,001	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	433	62.00
65.00 RESPIRATORY THERAPY	0	627	1,843	0	2,224	65.00
66.00 PHYSICAL THERAPY	0	616	1,810	0	2,085	66.00
67.00 OCCUPATIONAL THERAPY	0	172	504	0	649	67.00
68.00 SPEECH PATHOLOGY	0	253	743	0	606	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	2,400	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	725	4,503	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	22	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	744	2,186	0	8,551	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	64	786	0	300	90.00
90.01 ONCOLOGY	0	241	707	0	230	90.01
90.02 OUTPATIENT CLINIC	0	158	464	0	211	90.02
90.03 PROVIDER BASED CLINIC - TCMP	0	0	0	0	958	90.03
90.04 PROVIDER BASED CLINIC - DCPC	0	513	0	0	499	90.04
90.05 PROVIDER BASED CLINIC - WESTPORT	0	0	0	0	84	90.05
90.06 CLINIC	0	249	733	0	1,377	90.06
91.00 EMERGENCY	0	1,305	3,077	0	6,601	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	0	1,098	0	0	2,641	95.00
99.10 CORF	0	0	0	0	0	99.10
99.20 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00 HOME HEALTH AGENCY	0	1,178	3,463	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET CELL ACQUISITION	0	0	0	0	0	111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	40,909	15,688	29,656	725	82,914	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 MARKETING	0	245	0	0	0	194.00
194.01 WOMEN'S HEALTH SERVICES	0	45	131	0	0	194.01
200.00 Cross Foot Adjustments	0	0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151332			Period: From 01/01/2011 To 12/31/2011		Worksheet B Part II Date/Time Prepared: 5/24/2012 9:40 am	
Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY			
	10.00	11.00	13.00	14.00	16.00			
202.00 TOTAL (sum lines 118-201)	40,909	15,978	29,787	725	82,914			202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151332

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	17.00	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
6.00 MAINTENANCE & REPAIRS					6.00
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
16.00 MEDICAL RECORDS & LIBRARY					16.00
17.00 SOCIAL SERVICE	9,651				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS	8,777	311,934	0	311,934	30.00
31.00 INTENSIVE CARE UNIT	0	29,742	0	29,742	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	42.00
43.00 NURSERY	0	16,447	0	16,447	43.00
46.00 OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	185,066	0	185,066	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	140,327	0	140,327	52.00
53.00 ANESTHESIOLOGY	0	2,646	0	2,646	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	180,096	0	180,096	54.00
55.00 ULTRASOUND	0	4,463	0	4,463	55.00
57.00 CT SCAN	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 LABORATORY	0	133,457	0	133,457	60.00
60.01 BLOOD LABORATORY	0	0	0	0	60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,598	0	1,598	62.00
65.00 RESPIRATORY THERAPY	0	40,574	0	40,574	65.00
66.00 PHYSICAL THERAPY	0	57,558	0	57,558	66.00
67.00 OCCUPATIONAL THERAPY	0	26,423	0	26,423	67.00
68.00 SPEECH PATHOLOGY	0	26,858	0	26,858	68.00
69.00 ELECTROCARDIOLOGY	0	16,874	0	16,874	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	69,202	0	69,202	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	235	0	235	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	82,131	0	82,131	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 CLINIC	0	35,637	0	35,637	90.00
90.01 ONCOLOGY	139	20,034	0	20,034	90.01
90.02 OUTPATIENT CLINIC	0	89,477	0	89,477	90.02
90.03 PROVIDER BASED CLINIC - TCMP	0	191,653	0	191,653	90.03
90.04 PROVIDER BASED CLINIC - DCPC	0	103,268	0	103,268	90.04
90.05 PROVIDER BASED CLINIC - WESTPORT	0	18,640	0	18,640	90.05
90.06 CLINIC	0	40,536	0	40,536	90.06
91.00 EMERGENCY	271	122,507	0	122,507	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES	0	66,735	0	66,735	95.00
99.10 CORF	0	0	0	0	99.10
99.20 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
101.00 HOME HEALTH AGENCY	464	62,244	0	62,244	101.00
SPECIAL PURPOSE COST CENTERS					
109.00 PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 ISLET CELL ACQUISITION	0	0	0	0	111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	9,651	2,076,362	0	2,076,362	118.00
NONREIMBURSABLE COST CENTERS					
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,238	0	9,238	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	371,084	0	371,084	192.00
194.00 MARKETING	0	10,608	0	10,608	194.00
194.01 WOMEN'S HEALTH SERVICES	0	4,189	0	4,189	194.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151332

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		17.00	24.00	25.00	26.00		
200.00	Cross Foot Adjustments		0	0	0		200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	9,651	2,471,481	0	2,471,481		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151332

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

Worksheet B-1
Date/Time Prepared:
5/24/2012 9:40 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCU. 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	207,281					1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		207,281				2.00
4.00 EMPLOYEE BENEFITS	288	288	19,090,608			4.00
5.00 ADMINISTRATIVE & GENERAL	37,533	37,533	2,701,434	-5,860,607	30,972,579	5.00
6.00 MAINTENANCE & REPAIRS	1,331	1,331	445,551	0	755,283	6.00
7.00 OPERATION OF PLANT	17,763	17,763	3,682	0	777,721	7.00
8.00 LAUNDRY & LINEN SERVICE	1,440	1,440	60,502	0	127,248	8.00
9.00 HOUSEKEEPING	1,066	1,066	402,988	0	736,435	9.00
10.00 DIETARY	2,744	2,744	108,998	0	264,809	10.00
11.00 CAFETERIA	640	640	276,736	0	442,652	11.00
13.00 NURSING ADMINISTRATION	1,030	1,030	780,760	0	1,039,835	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	25,292	0	34,813	14.00
16.00 MEDICAL RECORDS & LIBRARY	5,187	5,187	515,832	0	796,631	16.00
17.00 SOCIAL SERVICE	478	478	135,840	0	182,906	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	13,783	13,783	2,233,428	0	3,105,336	30.00
31.00 INTENSIVE CARE UNIT	1,318	1,318	380,036	0	520,763	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	760	760	150,613	0	214,489	43.00
46.00 OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	10,792	10,792	1,059,331	0	1,554,135	50.00
52.00 DELIVERY ROOM & LABOR ROOM	9,876	9,876	64,096	0	205,178	52.00
53.00 ANESTHESIOLOGY	0	0	93,044	0	145,556	53.00
54.00 RADIOLOGY-DIAGNOSTIC	9,341	9,341	1,156,737	0	2,152,220	54.00
55.00 ULTRA SOUND	0	0	82,938	0	163,898	55.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	6,762	6,762	989,357	0	1,805,247	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	80,545	62.00
65.00 RESPIRATORY THERAPY	1,751	1,751	557,749	0	792,751	65.00
66.00 PHYSICAL THERAPY	2,752	2,752	561,596	0	770,757	66.00
67.00 OCCUPATIONAL THERAPY	1,536	1,536	190,820	0	309,182	67.00
68.00 SPEECH PATHOLOGY	1,440	1,440	244,235	0	362,636	68.00
69.00 ELECTROCARDIOLOGY	780	780	155,818	0	228,998	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,440	2,440	0	0	2,161,348	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	14,700	72.00
73.00 DRUGS CHARGED TO PATIENTS	2,304	2,304	729,223	0	2,594,259	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	1,986	1,986	224,709	0	390,087	90.00
90.01 ONCOLOGY	890	890	210,862	0	390,654	90.01
90.02 OUTPATIENT CLINIC	6,321	6,321	90,826	0	201,043	90.02
90.03 PROVIDER BASED CLINIC - TCMP	12,679	12,679	325,048	0	729,043	90.03
90.04 PROVIDER BASED CLINIC - DCPC	6,300	6,300	746,205	0	1,095,046	90.04
90.05 PROVIDER BASED CLINIC - WESTPORT	1,200	1,200	103,228	0	161,843	90.05
90.06 CLINIC	2,410	2,410	38,582	0	342,680	90.06
91.00 EMERGENCY	5,900	5,900	1,369,802	0	1,884,144	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	3,600	3,600	637,797	0	977,208	95.00
99.10 CORF	0	0	0	0	0	99.10
99.20 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00 HOME HEALTH AGENCY	2,628	2,628	1,052,676	0	1,490,309	101.00
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET CELL ACQUISITION	0	0	0	0	0	111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	179,049	179,049	18,906,371	-5,860,607	30,002,388	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	675	675	0	0	13,057	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	27,206	27,206	0	0	324,386	192.00
194.00 MARKETING	176	176	154,955	0	519,770	194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151332

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

Worksheet B-1
Date/Time Prepared:
5/24/2012 9:40 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
194.01 WOMEN'S HEALTH SERVICES	175	175	29,282	0	112,978	194.01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	2,471,481	0	5,419,535		5,860,607	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	11.923336	0.000000	0.283885		0.189219	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			3,434		448,000	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000180		0.014464	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151332

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

Worksheet B-1

Date/Time Prepared:
5/24/2012 9:40 am

Cost Center Description	MAINTENANCE & REPAIRS (TIME SPENT)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
	6.00	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						5.00
6.00 MAINTENANCE & REPAIRS	4,995					6.00
7.00 OPERATION OF PLANT	0	150,366				7.00
8.00 LAUNDRY & LINEN SERVICE	0	1,440	226,794			8.00
9.00 HOUSEKEEPING	413	1,066	14,472	150,040		9.00
10.00 DIETARY	35	2,744	894	0	14,014	10.00
11.00 CAFETERIA	90	640	0	2,420	0	11.00
13.00 NURSING ADMINISTRATION	10	1,030	0	775	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00 MEDICAL RECORDS & LIBRARY	88	5,187	0	1,475	0	16.00
17.00 SOCIAL SERVICE	5	478	0	265	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	656	13,783	85,128	46,320	13,490	30.00
31.00 INTENSIVE CARE UNIT	25	1,318	4,464	3,845	524	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	154	760	3,837	3,075	0	43.00
46.00 OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	165	10,792	37,173	290	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	66	9,876	5,394	16,995	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	25	9,341	18,917	10,640	0	54.00
55.00 ULTRA SOUND	0	0	0	0	0	55.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	20	6,762	0	5,740	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00 RESPIRATORY THERAPY	20	1,751	3,033	2,350	0	65.00
66.00 PHYSICAL THERAPY	550	2,752	13,470	3,605	0	66.00
67.00 OCCUPATIONAL THERAPY	0	1,536	0	0	0	67.00
68.00 SPEECH PATHOLOGY	55	1,440	0	1,915	0	68.00
69.00 ELECTROCARDIOLOGY	0	780	1,771	2,685	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,440	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	60	2,304	0	9,365	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	405	1,986	0	0	0	90.00
90.01 ONCOLOGY	95	890	1,064	2,555	0	90.01
90.02 OUTPATIENT CLINIC	25	6,321	936	3,960	0	90.02
90.03 PROVIDER BASED CLINIC - TCMP	1,775	12,679	5,991	0	0	90.03
90.04 PROVIDER BASED CLINIC - DCPC	40	6,300	237	8,315	0	90.04
90.05 PROVIDER BASED CLINIC - WESTPORT	20	1,200	0	0	0	90.05
90.06 CLINIC	38	2,410	0	3,670	0	90.06
91.00 EMERGENCY	0	5,900	26,325	11,535	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	40	3,600	2,868	0	0	95.00
99.10 CORF	0	0	0	0	0	99.10
99.20 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00 HOME HEALTH AGENCY	30	2,628	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET CELL ACQUISITION	0	0	0	0	0	111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	4,905	122,134	225,974	141,795	14,014	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	675	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	27,206	820	8,245	0	192.00
194.00 MARKETING	85	176	0	0	0	194.00
194.01 WOMEN'S HEALTH SERVICES	5	175	0	0	0	194.01
200.00 Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151332

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

Worksheet B-1

Date/Time Prepared:
5/24/2012 9:40 am

Cost Center Description	MAINTENANCE & REPAIRS (TIME SPENT)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
	6.00	7.00	8.00	9.00	10.00	
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	898,197	924,881	160,183	966,825	338,719	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	179.819219	6.150865	0.706293	6.443782	24.170044	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	26,874	223,044	21,158	28,588	40,909	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	5.380180	1.483341	0.093292	0.190536	2.919152	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151332

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

Worksheet B-1
Date/Time Prepared:
5/24/2012 9:40 am

Cost Center Description	CAFETERIA (HOURS)	NURSING ADMINISTRATION (NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
	11.00	13.00	14.00	16.00	17.00	
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
6.00 MAINTENANCE & REPAIRS						6.00
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	520,437					11.00
13.00 NURSING ADMINISTRATION	19,395	330,067				13.00
14.00 CENTRAL SERVICES & SUPPLY	1,781	1,781	1,000			14.00
16.00 MEDICAL RECORDS & LIBRARY	32,728	0	0	74,305,113		16.00
17.00 SOCIAL SERVICE	4,099	4,099	0	0	1,247	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	83,041	83,041	0	2,982,163	1,134	30.00
31.00 INTENSIVE CARE UNIT	10,681	10,681	0	328,100	0	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	4,944	4,944	0	678,768	0	43.00
46.00 OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	40,116	40,116	0	7,569,648	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	2,104	2,104	0	530,686	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	469,457	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	37,571	0	0	16,539,401	0	54.00
55.00 ULTRA SOUND	0	0	0	1,860,759	0	55.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	39,547	1,053	0	12,545,361	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	387,700	0	62.00
65.00 RESPIRATORY THERAPY	20,417	20,417	0	1,992,940	0	65.00
66.00 PHYSICAL THERAPY	20,058	20,058	0	1,868,690	0	66.00
67.00 OCCUPATIONAL THERAPY	5,587	5,587	0	581,263	0	67.00
68.00 SPEECH PATHOLOGY	8,229	8,229	0	542,814	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	2,150,169	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,000	4,034,931	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	19,856	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	24,221	24,221	0	7,662,336	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	2,080	8,711	0	268,455	0	90.00
90.01 ONCOLOGY	7,839	7,839	0	206,395	18	90.01
90.02 OUTPATIENT CLINIC	5,145	5,145	0	189,154	0	90.02
90.03 PROVIDER BASED CLINIC - TCMP	0	0	0	858,270	0	90.03
90.04 PROVIDER BASED CLINIC - DCPC	16,699	0	0	447,510	0	90.04
90.05 PROVIDER BASED CLINIC - WESTPORT	0	0	0	74,897	0	90.05
90.06 CLINIC	8,124	8,124	0	1,233,581	0	90.06
91.00 EMERGENCY	42,491	34,096	0	5,914,981	35	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	35,751	0	0	2,366,828	0	95.00
99.10 CORF	0	0	0	0	0	99.10
99.20 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00 HOME HEALTH AGENCY	38,368	38,368	0	0	60	101.00
SPECIAL PURPOSE COST CENTERS						
109.00 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 ISLET CELL ACQUISITION	0	0	0	0	0	111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	511,016	328,614	1,000	74,305,113	1,247	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 MARKETING	7,968	0	0	0	0	194.00
194.01 WOMEN'S HEALTH SERVICES	1,453	1,453	0	0	0	194.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151332

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

Worksheet B-1
Date/Time Prepared:
5/24/2012 9:40 am

Cost Center Description	CAFETERIA (HOURS)	NURSING ADMINISTRATION (NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
	11.00	13.00	14.00	16.00	17.00	
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	562,125	1,270,668	50,180	1,039,953	243,269	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	1.080102	3.849727	50.180000	0.013996	195.083400	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	15,978	29,787	725	82,914	9,651	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.030701	0.090245	0.725000	0.001116	7.739374	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151332

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2012 9:40 am

		Title XVIII		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS		5,252,658	0	0	30.00
31.00	INTENSIVE CARE UNIT		729,745	0	0	31.00
41.00	SUBPROVIDER - IRF		0	0	0	41.00
42.00	SUBPROVIDER		0	0	0	42.00
43.00	NURSERY		343,839	0	0	43.00
46.00	OTHER LONG TERM CARE		0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM		2,276,091	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM		447,738	0	0	52.00
53.00	ANESTHESIOLOGY		179,669	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC		2,975,382	0	0	54.00
55.00	ULTRA SOUND		220,954	0	0	55.00
57.00	CT SCAN		0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00
59.00	CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	LABORATORY		2,451,363	0	0	60.00
60.01	BLOOD LABORATORY		0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS		101,212	0	0	62.00
65.00	RESPIRATORY THERAPY	0	1,102,951	0	0	65.00
66.00	PHYSICAL THERAPY	0	1,190,208	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	412,811	0	0	67.00
68.00	SPEECH PATHOLOGY	0	510,505	0	0	68.00
69.00	ELECTROCARDIOLOGY		325,774	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		2,691,977	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT		17,760	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS		3,397,096	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC		0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
90.00	CLINIC		588,481	0	0	90.00
90.01	ONCOLOGY		549,391	0	0	90.01
90.02	OUTPATIENT CLINIC		336,648	0	0	90.02
90.03	PROVIDER BASED CLINIC - TCMP		1,280,403	0	0	90.03
90.04	PROVIDER BASED CLINIC - DCPC		1,426,240	0	0	90.04
90.05	PROVIDER BASED CLINIC - WESTPORT		204,492	0	0	90.05
90.06	CLINIC		510,143	0	0	90.06
91.00	EMERGENCY		2,636,641	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		1,572,768	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES		1,265,217	0	0	95.00
99.10	CORF		0	0	0	99.10
99.20	OUTPATIENT PHYSICAL THERAPY		0	0	0	99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY		0	0	0	99.30
99.40	OUTPATIENT SPEECH PATHOLOGY		0	0	0	99.40
101.00	HOME HEALTH AGENCY		1,994,715	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION		0	0	0	109.00
110.00	INTESTINAL ACQUISITION		0	0	0	110.00
111.00	ISLET CELL ACQUISITION		0	0	0	111.00
200.00	Subtotal (see instructions)		36,992,872	0	0	200.00
201.00	Less Observation Beds		1,572,768	0	0	201.00
202.00	Total (see instructions)		35,420,104	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/24/2012 9:40 am	
			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	2,982,163		2,982,163		30.00
31.00	INTENSIVE CARE UNIT	328,100		328,100		31.00
41.00	SUBPROVIDER - IRF	0		0		41.00
42.00	SUBPROVIDER	0		0		42.00
43.00	NURSERY	678,768		678,768		43.00
46.00	OTHER LONG TERM CARE	0		0		46.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,432,580	6,137,068	7,569,648	0.300687	50.00
52.00	DELIVERY ROOM & LABOR ROOM	429,418	101,268	530,686	0.843697	52.00
53.00	ANESTHESIOLOGY	109,937	359,520	469,457	0.382717	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,200,091	15,339,310	16,539,401	0.179897	54.00
55.00	ULTRA SOUND	127,980	1,732,779	1,860,759	0.118744	55.00
57.00	CT SCAN	0	0	0	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	LABORATORY	1,514,541	11,030,820	12,545,361	0.195400	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	197,950	189,750	387,700	0.261058	62.00
65.00	RESPIRATORY THERAPY	1,214,110	778,830	1,992,940	0.553429	65.00
66.00	PHYSICAL THERAPY	214,180	1,654,510	1,868,690	0.636921	66.00
67.00	OCCUPATIONAL THERAPY	162,079	419,184	581,263	0.710197	67.00
68.00	SPEECH PATHOLOGY	49,064	493,750	542,814	0.940479	68.00
69.00	ELECTROCARDIOLOGY	202,268	1,947,901	2,150,169	0.151511	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,588,884	2,446,047	4,034,931	0.667168	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	19,856	19,856	0.894440	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,558,630	5,103,706	7,662,336	0.443350	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	CLINIC	0	268,455	268,455	2.192103	90.00
90.01	ONCOLOGY	85	206,310	206,395	2.661843	90.01
90.02	OUTPATIENT CLINIC	38,670	150,484	189,154	1.779756	90.02
90.03	PROVIDER BASED CLINIC - TCMP	46	858,224	858,270	1.491842	90.03
90.04	PROVIDER BASED CLINIC - DCPC	0	447,510	447,510	3.187057	90.04
90.05	PROVIDER BASED CLINIC - WESTPORT	0	74,897	74,897	2.730310	90.05
90.06	CLINIC	928	1,232,653	1,233,581	0.413546	90.06
91.00	EMERGENCY	130,426	5,784,555	5,914,981	0.445756	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,443,909	1,443,909	1.089243	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	2,366,828	2,366,828	0.534562	95.00
99.10	CORF	0	0	0		99.10
99.20	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
101.00	HOME HEALTH AGENCY	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS						
109.00	PANCREAS ACQUISITION	0	0	0		109.00
110.00	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	ISLET CELL ACQUISITION	0	0	0		111.00
200.00	Subtotal (see instructions)	15,160,898	60,588,124	75,749,022		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	15,160,898	60,588,124	75,749,022		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/24/2012 9:40 am
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
41.00	SUBPROVIDER - IRF			41.00
42.00	SUBPROVIDER			42.00
43.00	NURSERY			43.00
46.00	OTHER LONG TERM CARE			46.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.000000		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	ANESTHESIOLOGY	0.000000		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	ULTRA SOUND	0.000000		55.00
57.00	CT SCAN	0.000000		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	LABORATORY	0.000000		60.00
60.01	BLOOD LABORATORY	0.000000		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	RESPIRATORY THERAPY	0.000000		65.00
66.00	PHYSICAL THERAPY	0.000000		66.00
67.00	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	SPEECH PATHOLOGY	0.000000		68.00
69.00	ELECTROCARDIOLOGY	0.000000		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
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
90.01	ONCOLOGY	0.000000		90.01
90.02	OUTPATIENT CLINIC	0.000000		90.02
90.03	PROVIDER BASED CLINIC - TCMP	0.000000		90.03
90.04	PROVIDER BASED CLINIC - DCPC	0.000000		90.04
90.05	PROVIDER BASED CLINIC - WESTPORT	0.000000		90.05
90.06	CLINIC	0.000000		90.06
91.00	EMERGENCY	0.000000		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	0.000000		95.00
99.10	CORF			99.10
99.20	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	OUTPATIENT SPEECH PATHOLOGY			99.40
101.00	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
109.00	PANCREAS ACQUISITION			109.00
110.00	INTESTINAL ACQUISITION			110.00
111.00	ISLET CELL ACQUISITION			111.00
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: 151332

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2012 9:40 am

		Title XIX		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS		5,252,658	0	5,252,658	30.00	
31.00	INTENSIVE CARE UNIT		729,745	0	729,745	31.00	
41.00	SUBPROVIDER - IRF		0	0	0	41.00	
42.00	SUBPROVIDER		0	0	0	42.00	
43.00	NURSERY		343,839	0	343,839	43.00	
46.00	OTHER LONG TERM CARE		0	0	0	46.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM		2,276,091	0	2,276,091	50.00	
52.00	DELIVERY ROOM & LABOR ROOM		447,738	0	447,738	52.00	
53.00	ANESTHESIOLOGY		179,669	0	179,669	53.00	
54.00	RADIOLOGY-DIAGNOSTIC		2,975,382	0	2,975,382	54.00	
55.00	ULTRA SOUND		220,954	0	220,954	55.00	
57.00	CT SCAN		0	0	0	57.00	
58.00	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00	
59.00	CARDIAC CATHETERIZATION		0	0	0	59.00	
60.00	LABORATORY		2,451,363	0	2,451,363	60.00	
60.01	BLOOD LABORATORY		0	0	0	60.01	
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS		101,212	0	101,212	62.00	
65.00	RESPIRATORY THERAPY	0	1,102,951	0	1,102,951	65.00	
66.00	PHYSICAL THERAPY	0	1,190,208	0	1,190,208	66.00	
67.00	OCCUPATIONAL THERAPY	-4,388	408,423	0	408,423	67.00	
68.00	SPEECH PATHOLOGY	0	510,505	0	510,505	68.00	
69.00	ELECTROCARDIOLOGY		325,774	0	325,774	69.00	
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		2,691,977	0	2,691,977	71.00	
72.00	IMPL. DEV. CHARGED TO PATIENT		17,760	0	17,760	72.00	
73.00	DRUGS CHARGED TO PATIENTS		3,397,096	0	3,397,096	73.00	
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC		0	0	0	88.00	
89.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00	
90.00	CLINIC		588,481	0	588,481	90.00	
90.01	ONCOLOGY		549,391	0	549,391	90.01	
90.02	OUTPATIENT CLINIC		336,648	0	336,648	90.02	
90.03	PROVIDER BASED CLINIC - TCMP		1,280,403	0	1,280,403	90.03	
90.04	PROVIDER BASED CLINIC - DCPC		1,426,240	0	1,426,240	90.04	
90.05	PROVIDER BASED CLINIC - WESTPORT		204,492	0	204,492	90.05	
90.06	CLINIC		510,143	0	510,143	90.06	
91.00	EMERGENCY		2,636,641	0	2,636,641	91.00	
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		1,572,768	0	1,572,768	92.00	
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES		1,265,217	0	1,265,217	95.00	
99.10	CORF		0	0	0	99.10	
99.20	OUTPATIENT PHYSICAL THERAPY		0	0	0	99.20	
99.30	OUTPATIENT OCCUPATIONAL THERAPY		0	0	0	99.30	
99.40	OUTPATIENT SPEECH PATHOLOGY		0	0	0	99.40	
101.00	HOME HEALTH AGENCY		1,994,715	0	1,994,715	101.00	
SPECIAL PURPOSE COST CENTERS							
109.00	PANCREAS ACQUISITION		0	0	0	109.00	
110.00	INTESTINAL ACQUISITION		0	0	0	110.00	
111.00	ISLET CELL ACQUISITION		0	0	0	111.00	
200.00	Subtotal (see instructions)	0	36,992,872	0	36,988,484	200.00	
201.00	Less Observation Beds		1,572,768	0	1,572,768	201.00	
202.00	Total (see instructions)	0	35,420,104	0	35,415,716	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151332

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

Worksheet C
Part I
Date/Time Prepared:
5/24/2012 9:40 am

		Title XIX			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,982,163		2,982,163			30.00
31.00	INTENSIVE CARE UNIT	328,100		328,100			31.00
41.00	SUBPROVIDER - IRF	0		0			41.00
42.00	SUBPROVIDER	0		0			42.00
43.00	NURSERY	678,768		678,768			43.00
46.00	OTHER LONG TERM CARE	0		0			46.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	1,432,580	6,137,068	7,569,648	0.300687	0.000000	50.00
52.00	DELIVERY ROOM & LABOR ROOM	429,418	101,268	530,686	0.843697	0.000000	52.00
53.00	ANESTHESIOLOGY	109,937	359,520	469,457	0.382717	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,200,091	15,339,310	16,539,401	0.179897	0.000000	54.00
55.00	ULTRA SOUND	127,980	1,732,779	1,860,759	0.118744	0.000000	55.00
57.00	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	LABORATORY	1,514,541	11,030,820	12,545,361	0.195400	0.000000	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	197,950	189,750	387,700	0.261058	0.000000	62.00
65.00	RESPIRATORY THERAPY	1,214,110	778,830	1,992,940	0.553429	0.000000	65.00
66.00	PHYSICAL THERAPY	214,180	1,654,510	1,868,690	0.636921	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	162,079	419,184	581,263	0.710197	0.000000	67.00
68.00	SPEECH PATHOLOGY	49,064	493,750	542,814	0.940479	0.000000	68.00
69.00	ELECTROCARDIOLOGY	202,268	1,947,901	2,150,169	0.151511	0.000000	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,588,884	2,446,047	4,034,931	0.667168	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	19,856	19,856	0.894440	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,558,630	5,103,706	7,662,336	0.443350	0.000000	73.00
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	0	268,455	268,455	2.192103	0.000000	90.00
90.01	ONCOLOGY	85	206,310	206,395	2.661843	0.000000	90.01
90.02	OUTPATIENT CLINIC	38,670	150,484	189,154	1.779756	0.000000	90.02
90.03	PROVIDER BASED CLINIC - TCMP	46	858,224	858,270	1.491842	0.000000	90.03
90.04	PROVIDER BASED CLINIC - DCPC	0	447,510	447,510	3.187057	0.000000	90.04
90.05	PROVIDER BASED CLINIC - WESTPORT	0	74,897	74,897	2.730310	0.000000	90.05
90.06	CLINIC	928	1,232,653	1,233,581	0.413546	0.000000	90.06
91.00	EMERGENCY	130,426	5,784,555	5,914,981	0.445756	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,443,909	1,443,909	1.089243	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	0	2,366,828	2,366,828	0.534562	0.000000	95.00
99.10	CORF	0	0	0			99.10
99.20	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
101.00	HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS							
109.00	PANCREAS ACQUISITION	0	0	0			109.00
110.00	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	ISLET CELL ACQUISITION	0	0	0			111.00
200.00	Subtotal (see instructions)	15,160,898	60,588,124	75,749,022			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	15,160,898	60,588,124	75,749,022			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/24/2012 9:40 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital
		11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS			30.00
31.00	INTENSIVE CARE UNIT			31.00
41.00	SUBPROVIDER - IRF			41.00
42.00	SUBPROVIDER			42.00
43.00	NURSERY			43.00
46.00	OTHER LONG TERM CARE			46.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.300687		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.843697		52.00
53.00	ANESTHESIOLOGY	0.382717		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.179897		54.00
55.00	ULTRA SOUND	0.118744		55.00
57.00	CT SCAN	0.000000		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	LABORATORY	0.195400		60.00
60.01	BLOOD LABORATORY	0.000000		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.261058		62.00
65.00	RESPIRATORY THERAPY	0.553429		65.00
66.00	PHYSICAL THERAPY	0.636921		66.00
67.00	OCCUPATIONAL THERAPY	0.702648		67.00
68.00	SPEECH PATHOLOGY	0.940479		68.00
69.00	ELECTROCARDIOLOGY	0.151511		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.667168		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.894440		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.443350		73.00
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	2.192103		90.00
90.01	ONCOLOGY	2.661843		90.01
90.02	OUTPATIENT CLINIC	1.779756		90.02
90.03	PROVIDER BASED CLINIC - TCMP	1.491842		90.03
90.04	PROVIDER BASED CLINIC - DCPC	3.187057		90.04
90.05	PROVIDER BASED CLINIC - WESTPORT	2.730310		90.05
90.06	CLINIC	0.413546		90.06
91.00	EMERGENCY	0.445756		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.089243		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	0.534562		95.00
99.10	CORF			99.10
99.20	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	OUTPATIENT SPEECH PATHOLOGY			99.40
101.00	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
109.00	PANCREAS ACQUISITION			109.00
110.00	INTESTINAL ACQUISITION			110.00
111.00	ISLET CELL ACQUISITION			111.00
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: 151332

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

Worksheet C Part II Date/Time Prepared: 5/24/2012 9:40 am

Cost Center Description		Title XIX			Hospital	PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	2,276,091	185,066	2,091,025	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	447,738	140,327	307,411	0	0	52.00
53.00	ANESTHESIOLOGY	179,669	2,646	177,023	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,975,382	180,096	2,795,286	0	0	54.00
55.00	ULTRA SOUND	220,954	4,463	216,491	0	0	55.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	2,451,363	133,457	2,317,906	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	101,212	1,598	99,614	0	0	62.00
65.00	RESPIRATORY THERAPY	1,102,951	40,574	1,062,377	0	0	65.00
66.00	PHYSICAL THERAPY	1,190,208	57,558	1,132,650	0	0	66.00
67.00	OCCUPATIONAL THERAPY	412,811	26,423	386,388	0	0	67.00
68.00	SPEECH PATHOLOGY	510,505	26,858	483,647	0	0	68.00
69.00	ELECTROCARDIOLOGY	325,774	16,874	308,900	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,691,977	69,202	2,622,775	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	17,760	235	17,525	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	3,397,096	82,131	3,314,965	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	588,481	35,637	552,844	0	0	90.00
90.01	ONCOLOGY	549,391	20,034	529,357	0	0	90.01
90.02	OUTPATIENT CLINIC	336,648	89,477	247,171	0	0	90.02
90.03	PROVIDER BASED CLINIC - TCMP	1,280,403	191,653	1,088,750	0	0	90.03
90.04	PROVIDER BASED CLINIC - DCPC	1,426,240	103,268	1,322,972	0	0	90.04
90.05	PROVIDER BASED CLINIC - WESTPORT	204,492	18,640	185,852	0	0	90.05
90.06	CLINIC	510,143	40,536	469,607	0	0	90.06
91.00	EMERGENCY	2,636,641	122,507	2,514,134	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1,572,768	0	1,572,768	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	1,265,217	66,735	1,198,482	0	0	95.00
99.10	CORF	0	0	0	0	0	99.10
99.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	HOME HEALTH AGENCY	1,994,715	62,244	1,932,471	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	ISLET CELL ACQUISITION	0	0	0	0	0	111.00
200.00	Subtotal (sum of lines 50 thru 199)	30,666,630	1,718,239	28,948,391	0	0	200.00
201.00	Less Observation Beds	1,572,768	0	1,572,768	0	0	201.00
202.00	Total (line 200 minus line 201)	29,093,862	1,718,239	27,375,623	0	0	202.00

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

Provider CCN: 151332

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

Worksheet C Part II Date/Time Prepared: 5/24/2012 9:40 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
Title XIX Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	2,276,091	7,569,648	0.300687	50.00
52.00	DELIVERY ROOM & LABOR ROOM	447,738	530,686	0.843697	52.00
53.00	ANESTHESIOLOGY	179,669	469,457	0.382717	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,975,382	16,539,401	0.179897	54.00
55.00	ULTRA SOUND	220,954	1,860,759	0.118744	55.00
57.00	CT SCAN	0	0	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	59.00
60.00	LABORATORY	2,451,363	12,545,361	0.195400	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	101,212	387,700	0.261058	62.00
65.00	RESPIRATORY THERAPY	1,102,951	1,992,940	0.553429	65.00
66.00	PHYSICAL THERAPY	1,190,208	1,868,690	0.636921	66.00
67.00	OCCUPATIONAL THERAPY	412,811	581,263	0.710197	67.00
68.00	SPEECH PATHOLOGY	510,505	542,814	0.940479	68.00
69.00	ELECTROCARDIOLOGY	325,774	2,150,169	0.151511	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,691,977	4,034,931	0.667168	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	17,760	19,856	0.894440	72.00
73.00	DRUGS CHARGED TO PATIENTS	3,397,096	7,662,336	0.443350	73.00
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	588,481	268,455	2.192103	90.00
90.01	ONCOLOGY	549,391	206,395	2.661843	90.01
90.02	OUTPATIENT CLINIC	336,648	189,154	1.779756	90.02
90.03	PROVIDER BASED CLINIC - TCMP	1,280,403	858,270	1.491842	90.03
90.04	PROVIDER BASED CLINIC - DCPC	1,426,240	447,510	3.187057	90.04
90.05	PROVIDER BASED CLINIC - WESTPORT	204,492	74,897	2.730310	90.05
90.06	CLINIC	510,143	1,233,581	0.413546	90.06
91.00	EMERGENCY	2,636,641	5,914,981	0.445756	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1,572,768	1,443,909	1.089243	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES	1,265,217	2,366,828	0.534562	95.00
99.10	CORF	0	0	0.000000	99.10
99.20	OUTPATIENT PHYSICAL THERAPY	0	0	0.000000	99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0.000000	99.30
99.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0.000000	99.40
101.00	HOME HEALTH AGENCY	1,994,715	0	0.000000	101.00
SPECIAL PURPOSE COST CENTERS					
109.00	PANCREAS ACQUISITION	0	0	0.000000	109.00
110.00	INTESTINAL ACQUISITION	0	0	0.000000	110.00
111.00	ISLET CELL ACQUISITION	0	0	0.000000	111.00
200.00	Subtotal (sum of lines 50 thru 199)	30,666,630	0		200.00
201.00	Less Observation Beds	1,572,768	0		201.00
202.00	Total (line 200 minus line 201)	29,093,862	71,759,991		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part II Date/Time Prepared: 5/24/2012 9:40 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	185,066	7,569,648	0.024448	428,904	10,486	50.00
52.00	DELIVERY ROOM & LABOR ROOM	140,327	530,686	0.264426	0	0	52.00
53.00	ANESTHESIOLOGY	2,646	469,457	0.005636	41,880	236	53.00
54.00	RADIOLOGY-DIAGNOSTIC	180,096	16,539,401	0.010889	476,347	5,187	54.00
55.00	ULTRA SOUND	4,463	1,860,759	0.002398	53,179	128	55.00
57.00	CT SCAN	0	0	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	LABORATORY	133,457	12,545,361	0.010638	638,814	6,796	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,598	387,700	0.004122	110,865	457	62.00
65.00	RESPIRATORY THERAPY	40,574	1,992,940	0.020359	719,485	14,648	65.00
66.00	PHYSICAL THERAPY	57,558	1,868,690	0.030801	93,619	2,884	66.00
67.00	OCCUPATIONAL THERAPY	26,423	581,263	0.045458	69,515	3,160	67.00
68.00	SPEECH PATHOLOGY	26,858	542,814	0.049479	9,005	446	68.00
69.00	ELECTROCARDIOLOGY	16,874	2,150,169	0.007848	106,566	836	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	69,202	4,034,931	0.017151	662,555	11,363	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	235	19,856	0.011835	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	82,131	7,662,336	0.010719	1,112,744	11,928	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	CLINIC	35,637	268,455	0.132749	0	0	90.00
90.01	ONCOLOGY	20,034	206,395	0.097066	0	0	90.01
90.02	OUTPATIENT CLINIC	89,477	189,154	0.473038	3,520	1,665	90.02
90.03	PROVIDER BASED CLINIC - TCMP	191,653	858,270	0.223302	0	0	90.03
90.04	PROVIDER BASED CLINIC - DCPC	103,268	447,510	0.230761	0	0	90.04
90.05	PROVIDER BASED CLINIC - WESTPORT	18,640	74,897	0.248875	0	0	90.05
90.06	CLINIC	40,536	1,233,581	0.032860	0	0	90.06
91.00	EMERGENCY	122,507	5,914,981	0.020711	408	8	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,443,909	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	1,589,260	69,393,163		4,527,406	70,228	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/24/2012 9:40 am
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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	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00 ULTRA SOUND	0	0	0	0	0	55.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
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
90.01 ONCOLOGY	0	0	0	0	0	90.01
90.02 OUTPATIENT CLINIC	0	0	0	0	0	90.02
90.03 PROVIDER BASED CLINIC - TCMP	0	0	0	0	0	90.03
90.04 PROVIDER BASED CLINIC - DCPC	0	0	0	0	0	90.04
90.05 PROVIDER BASED CLINIC - WESTPORT	0	0	0	0	0	90.05
90.06 CLINIC	0	0	0	0	0	90.06
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/24/2012 9:40 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	7,569,648	0.000000	0.000000	428,904	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	530,686	0.000000	0.000000	0	52.00
53.00	ANESTHESIOLOGY	0	469,457	0.000000	0.000000	41,880	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	16,539,401	0.000000	0.000000	476,347	54.00
55.00	ULTRA SOUND	0	1,860,759	0.000000	0.000000	53,179	55.00
57.00	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	LABORATORY	0	12,545,361	0.000000	0.000000	638,814	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	387,700	0.000000	0.000000	110,865	62.00
65.00	RESPIRATORY THERAPY	0	1,992,940	0.000000	0.000000	719,485	65.00
66.00	PHYSICAL THERAPY	0	1,868,690	0.000000	0.000000	93,619	66.00
67.00	OCCUPATIONAL THERAPY	0	581,263	0.000000	0.000000	69,515	67.00
68.00	SPEECH PATHOLOGY	0	542,814	0.000000	0.000000	9,005	68.00
69.00	ELECTROCARDIOLOGY	0	2,150,169	0.000000	0.000000	106,566	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,034,931	0.000000	0.000000	662,555	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	19,856	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	7,662,336	0.000000	0.000000	1,112,744	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	CLINIC	0	268,455	0.000000	0.000000	0	90.00
90.01	ONCOLOGY	0	206,395	0.000000	0.000000	0	90.01
90.02	OUTPATIENT CLINIC	0	189,154	0.000000	0.000000	3,520	90.02
90.03	PROVIDER BASED CLINIC - TCMP	0	858,270	0.000000	0.000000	0	90.03
90.04	PROVIDER BASED CLINIC - DCPC	0	447,510	0.000000	0.000000	0	90.04
90.05	PROVIDER BASED CLINIC - WESTPORT	0	74,897	0.000000	0.000000	0	90.05
90.06	CLINIC	0	1,233,581	0.000000	0.000000	0	90.06
91.00	EMERGENCY	0	5,914,981	0.000000	0.000000	408	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,443,909	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	0	69,393,163			4,527,406	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/24/2012 9:40 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	Cost
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	ANESTHESIOLOGY	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	ULTRA SOUND	0	0	0		55.00
57.00	CT SCAN	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	LABORATORY	0	0	0		60.00
60.01	BLOOD LABORATORY	0	0	0		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
65.00	RESPIRATORY THERAPY	0	0	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	SPEECH PATHOLOGY	0	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
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
90.01	ONCOLOGY	0	0	0		90.01
90.02	OUTPATIENT CLINIC	0	0	0		90.02
90.03	PROVIDER BASED CLINIC - TCMP	0	0	0		90.03
90.04	PROVIDER BASED CLINIC - DCPC	0	0	0		90.04
90.05	PROVIDER BASED CLINIC - WESTPORT	0	0	0		90.05
90.06	CLINIC	0	0	0		90.06
91.00	EMERGENCY	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES					95.00
200.00	Total (Lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/24/2012 9:40 am
		Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see instructions)	Charges			
			Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
	1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.300687	0	1,291,161	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.843697	0	0	0	52.00
53.00	ANESTHESIOLOGY	0.382717	0	86,044	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.179897	0	4,503,878	420	54.00
55.00	ULTRA SOUND	0.118744	0	431,492	0	55.00
57.00	CT SCAN	0.000000	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	LABORATORY	0.195400	0	3,366,800	0	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.261058	0	72,899	0	62.00
65.00	RESPIRATORY THERAPY	0.553429	0	366,143	0	65.00
66.00	PHYSICAL THERAPY	0.636921	0	438,065	0	66.00
67.00	OCCUPATIONAL THERAPY	0.710197	0	33,409	0	67.00
68.00	SPEECH PATHOLOGY	0.940479	0	34,321	0	68.00
69.00	ELECTROCARDIOLOGY	0.151511	0	647,103	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.667168	0	434,016	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.894440	0	11,692	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.443350	0	2,499,674	4,899	73.00
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	2.192103	0	11,370	0	90.00
90.01	ONCOLOGY	2.661843	0	131,151	0	90.01
90.02	OUTPATIENT CLINIC	1.779756	0	16,399	821	90.02
90.03	PROVIDER BASED CLINIC - TCMP	1.491842	0	207,708	0	90.03
90.04	PROVIDER BASED CLINIC - DCPC	3.187057	0	89,382	0	90.04
90.05	PROVIDER BASED CLINIC - WESTPORT	2.730310	0	24,036	0	90.05
90.06	CLINIC	0.413546	0	660,364	0	90.06
91.00	EMERGENCY	0.445756	0	1,208,244	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.089243	0	528,604	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0.534562		0		95.00
200.00	Subtotal (see instructions)		0	17,093,955	6,140	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	17,093,955	6,140	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/24/2012 9:40 am
Title XVIII		Hospital	Cost

Cost Center Description	Costs			
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)	
	5.00	6.00	7.00	
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	388,235	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	32,931	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	810,234	76	54.00
55.00 ULTRA SOUND	0	51,237	0	55.00
57.00 CT SCAN	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 LABORATORY	0	657,873	0	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	19,031	0	62.00
65.00 RESPIRATORY THERAPY	0	202,634	0	65.00
66.00 PHYSICAL THERAPY	0	279,013	0	66.00
67.00 OCCUPATIONAL THERAPY	0	23,727	0	67.00
68.00 SPEECH PATHOLOGY	0	32,278	0	68.00
69.00 ELECTROCARDIOLOGY	0	98,043	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	289,562	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	10,458	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	1,108,230	2,172	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00 CLINIC	0	24,924	0	90.00
90.01 ONCOLOGY	0	349,103	0	90.01
90.02 OUTPATIENT CLINIC	0	29,186	1,461	90.02
90.03 PROVIDER BASED CLINIC - TCMP	0	309,868	0	90.03
90.04 PROVIDER BASED CLINIC - DCPC	0	284,866	0	90.04
90.05 PROVIDER BASED CLINIC - WESTPORT	0	65,626	0	90.05
90.06 CLINIC	0	273,091	0	90.06
91.00 EMERGENCY	0	538,582	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	575,778	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 AMBULANCE SERVICES		0		95.00
200.00 Subtotal (see instructions)	0	6,454,510	3,709	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	6,454,510	3,709	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/24/2012 9:40 am		
		Component CCN: 15Z332	Title XVIII		Swing Beds - SNF	
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	0.300687	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.843697	0	0	0	52.00
53.00	ANESTHESIOLOGY	0.382717	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.179897	0	0	0	54.00
55.00	ULTRA SOUND	0.118744	0	0	0	55.00
57.00	CT SCAN	0.000000	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	LABORATORY	0.195400	0	0	0	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.261058	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0.553429	0	0	0	65.00
66.00	PHYSICAL THERAPY	0.636921	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0.710197	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0.940479	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.151511	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.667168	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.894440	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.443350	0	0	0	73.00
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	2.192103	0	0	0	90.00
90.01	ONCOLOGY	2.661843	0	0	0	90.01
90.02	OUTPATIENT CLINIC	1.779756	0	0	0	90.02
90.03	PROVIDER BASED CLINIC - TCMP	1.491842	0	0	0	90.03
90.04	PROVIDER BASED CLINIC - DCPC	3.187057	0	0	0	90.04
90.05	PROVIDER BASED CLINIC - WESTPORT	2.730310	0	0	0	90.05
90.06	CLINIC	0.413546	0	0	0	90.06
91.00	EMERGENCY	0.445756	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.089243	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0.534562		0		95.00
200.00	Subtotal (see instructions)		0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/24/2012 9:40 am
	Component CCN: 15Z332	Title XVIII	Swing Beds - SNF Cost

Cost Center Description	Costs				Cost
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	0	0		50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00 ANESTHESIOLOGY	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00 ULTRA SOUND	0	0	0		55.00
57.00 CT SCAN	0	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00 LABORATORY	0	0	0		60.00
60.01 BLOOD LABORATORY	0	0	0		60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
65.00 RESPIRATORY THERAPY	0	0	0		65.00
66.00 PHYSICAL THERAPY	0	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	0	0	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
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
90.01 ONCOLOGY	0	0	0		90.01
90.02 OUTPATIENT CLINIC	0	0	0		90.02
90.03 PROVIDER BASED CLINIC - RCMP	0	0	0		90.03
90.04 PROVIDER BASED CLINIC - DCPC	0	0	0		90.04
90.05 PROVIDER BASED CLINIC - WESTPORT	0	0	0		90.05
90.06 CLINIC	0	0	0		90.06
91.00 EMERGENCY	0	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES		0			95.00
200.00 Subtotal (see instructions)	0	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part I Date/Time Prepared: 5/24/2012 9:40 am
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Cost Center Description	Title XIX			Hospital	PPS	
	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	311,934	0	311,934	4,551	68.54	30.00
31.00 INTENSIVE CARE UNIT	29,742		29,742	175	169.95	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00 SUBPROVIDER	0	0	0	0	0.00	42.00
43.00 NURSERY	16,447		16,447	618	26.61	43.00
200.00 Total (Lines 30-199)	358,123		358,123	5,344		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part I Date/Time Prepared: 5/24/2012 9:40 am
		Title XIX	Hospital	PPS

Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
	6.00	7.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS	200	13,708		30.00
31.00 INTENSIVE CARE UNIT	0	0		31.00
41.00 SUBPROVIDER - IRF	0	0		41.00
42.00 SUBPROVIDER	0	0		42.00
43.00 NURSERY	0	0		43.00
200.00 Total (lines 30-199)	200	13,708		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part II Date/Time Prepared: 5/24/2012 9:40 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	185,066	7,569,648	0.024448	78,175	1,911	50.00
52.00	DELIVERY ROOM & LABOR ROOM	140,327	530,686	0.264426	73,997	19,567	52.00
53.00	ANESTHESIOLOGY	2,646	469,457	0.005636	59,688	336	53.00
54.00	RADIOLOGY-DIAGNOSTIC	180,096	16,539,401	0.010889	20,622	225	54.00
55.00	ULTRA SOUND	4,463	1,860,759	0.002398	3,584	9	55.00
57.00	CT SCAN	0	0	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	LABORATORY	133,457	12,545,361	0.010638	62,420	664	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,598	387,700	0.004122	5,159	21	62.00
65.00	RESPIRATORY THERAPY	40,574	1,992,940	0.020359	29,120	593	65.00
66.00	PHYSICAL THERAPY	57,558	1,868,690	0.030801	1,165	36	66.00
67.00	OCCUPATIONAL THERAPY	26,423	581,263	0.045458	1,177	54	67.00
68.00	SPEECH PATHOLOGY	26,858	542,814	0.049479	6,352	314	68.00
69.00	ELECTROCARDIOLOGY	16,874	2,150,169	0.007848	3,989	31	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	69,202	4,034,931	0.017151	45,348	778	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	235	19,856	0.011835	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	82,131	7,662,336	0.010719	76,041	815	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	CLINIC	35,637	268,455	0.132749	0	0	90.00
90.01	ONCOLOGY	20,034	206,395	0.097066	0	0	90.01
90.02	OUTPATIENT CLINIC	89,477	189,154	0.473038	0	0	90.02
90.03	PROVIDER BASED CLINIC - TCMP	191,653	858,270	0.223302	0	0	90.03
90.04	PROVIDER BASED CLINIC - DCPC	103,268	447,510	0.230761	0	0	90.04
90.05	PROVIDER BASED CLINIC - WESTPORT	18,640	74,897	0.248875	0	0	90.05
90.06	CLINIC	40,536	1,233,581	0.032860	0	0	90.06
91.00	EMERGENCY	122,507	5,914,981	0.020711	17,600	365	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	99,455	1,443,909	0.068879	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	1,688,715	69,393,163		484,437	25,719	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151332		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part III Date/Time Prepared: 5/24/2012 9:40 am	
Cost Center Description		Title XIX		Hospital		PPS	
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	0	0	0	0	0	43.00
200.00	Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151332		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part III Date/Time Prepared: 5/24/2012 9:40 am	
Cost Center Description		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PPS	
		6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	4,551	0.00	200	0		30.00
31.00	INTENSIVE CARE UNIT	175	0.00	0	0		31.00
41.00	SUBPROVIDER - IRF	0	0.00	0	0		41.00
42.00	SUBPROVIDER	0	0.00	0	0		42.00
43.00	NURSERY	618	0.00	0	0		43.00
200.00	Total (lines 30-199)	5,344		200	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/24/2012 9:40 am
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Cost Center Description	Title XIX				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS								
50.00 OPERATING ROOM	0	0	0	0	0	0	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	0	54.00
55.00 ULTRA SOUND	0	0	0	0	0	0	0	55.00
57.00 CT SCAN	0	0	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	0	0	60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0	0	62.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	0	0	69.00
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
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
90.01 ONCOLOGY	0	0	0	0	0	0	0	90.01
90.02 OUTPATIENT CLINIC	0	0	0	0	0	0	0	90.02
90.03 PROVIDER BASED CLINIC - TCMP	0	0	0	0	0	0	0	90.03
90.04 PROVIDER BASED CLINIC - DCPC	0	0	0	0	0	0	0	90.04
90.05 PROVIDER BASED CLINIC - WESTPORT	0	0	0	0	0	0	0	90.05
90.06 CLINIC	0	0	0	0	0	0	0	90.06
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
OTHER REIMBURSABLE COST CENTERS								
95.00 AMBULANCE SERVICES								95.00
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: 151332

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2012 9:40 am

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	7,569,648	0.000000	0.000000	78,175	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	530,686	0.000000	0.000000	73,997	52.00
53.00	ANESTHESIOLOGY	0	469,457	0.000000	0.000000	59,688	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	16,539,401	0.000000	0.000000	20,622	54.00
55.00	ULTRA SOUND	0	1,860,759	0.000000	0.000000	3,584	55.00
57.00	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	LABORATORY	0	12,545,361	0.000000	0.000000	62,420	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	387,700	0.000000	0.000000	5,159	62.00
65.00	RESPIRATORY THERAPY	0	1,992,940	0.000000	0.000000	29,120	65.00
66.00	PHYSICAL THERAPY	0	1,868,690	0.000000	0.000000	1,165	66.00
67.00	OCCUPATIONAL THERAPY	0	581,263	0.000000	0.000000	1,177	67.00
68.00	SPEECH PATHOLOGY	0	542,814	0.000000	0.000000	6,352	68.00
69.00	ELECTROCARDIOLOGY	0	2,150,169	0.000000	0.000000	3,989	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,034,931	0.000000	0.000000	45,348	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	19,856	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	7,662,336	0.000000	0.000000	76,041	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	CLINIC	0	268,455	0.000000	0.000000	0	90.00
90.01	ONCOLOGY	0	206,395	0.000000	0.000000	0	90.01
90.02	OUTPATIENT CLINIC	0	189,154	0.000000	0.000000	0	90.02
90.03	PROVIDER BASED CLINIC - TCMP	0	858,270	0.000000	0.000000	0	90.03
90.04	PROVIDER BASED CLINIC - DCPC	0	447,510	0.000000	0.000000	0	90.04
90.05	PROVIDER BASED CLINIC - WESTPORT	0	74,897	0.000000	0.000000	0	90.05
90.06	CLINIC	0	1,233,581	0.000000	0.000000	0	90.06
91.00	EMERGENCY	0	5,914,981	0.000000	0.000000	17,600	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,443,909	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	0	69,393,163			484,437	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151332

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

Worksheet D
Part IV
Date/Time Prepared:
5/24/2012 9:40 am

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XIX Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
55.00	ULTRA SOUND	0	0	0	55.00
57.00	CT SCAN	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	LABORATORY	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
65.00	RESPIRATORY THERAPY	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
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
90.01	ONCOLOGY	0	0	0	90.01
90.02	OUTPATIENT CLINIC	0	0	0	90.02
90.03	PROVIDER BASED CLINIC - TCMP	0	0	0	90.03
90.04	PROVIDER BASED CLINIC - DCPC	0	0	0	90.04
90.05	PROVIDER BASED CLINIC - WESTPORT	0	0	0	90.05
90.06	CLINIC	0	0	0	90.06
91.00	EMERGENCY	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (Lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/24/2012 9:40 am
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)		4,917	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,551	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,551	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		295	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		71	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,553	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)		295	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,252,658	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		319,756	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,932,902	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,893,955	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,893,955	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.704554	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)		635.89	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,932,902	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)		1,083.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,683,328	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)		1,683,328	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151332		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1	
Title XVIII		Hospital		Cost		Date/Time Prepared: 5/24/2012 9:40 am	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	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	729,745	175	4,169.97	96	400,317		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)					1,864,381		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,948,026		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)					319,756		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)					319,756		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)						1,451	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,083.92	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						1,572,768	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151332

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

Worksheet D-1
Date/Time Prepared:
5/24/2012 9:40 am

Cost Center Description	Cost	Title XVIII		Hospital	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: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/24/2012 9:40 am
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)		4,917	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,551	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,551	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		71	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		200	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)		618	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			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,252,658	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,252,658	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,893,955	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,893,955	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.815045	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)		635.89	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)		5,252,658	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)		1,154.18	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		230,836	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)		230,836	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/24/2012 9:40 am	
Cost Center Description			Title XIX	Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	343,839	618	556.37	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	729,745	175	4,169.97	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)				222,537	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				453,373	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)				13,708	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				25,719	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				39,427	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				413,946	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)				1,451	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,154.18	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				1,674,715	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151332		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 5/24/2012 9:40 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	311,934	5,252,658	0.059386	1,674,715	99,455	90.00
91.00	Nursing School cost	0	5,252,658	0.000000	1,674,715	0	91.00
92.00	Allied health cost	0	5,252,658	0.000000	1,674,715	0	92.00
93.00	All other Medical Education	0	5,252,658	0.000000	1,674,715	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/24/2012 9:40 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		1,451,879		30.00
31.00	INTENSIVE CARE UNIT		185,280		31.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.300687	428,904	128,966	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.843697	0	0	52.00
53.00	ANESTHESIOLOGY	0.382717	41,880	16,028	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.179897	476,347	85,693	54.00
55.00	ULTRA SOUND	0.118744	53,179	6,315	55.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.195400	638,814	124,824	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.261058	110,865	28,942	62.00
65.00	RESPIRATORY THERAPY	0.553429	719,485	398,184	65.00
66.00	PHYSICAL THERAPY	0.636921	93,619	59,628	66.00
67.00	OCCUPATIONAL THERAPY	0.710197	69,515	49,369	67.00
68.00	SPEECH PATHOLOGY	0.940479	9,005	8,469	68.00
69.00	ELECTROCARDIOLOGY	0.151511	106,566	16,146	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.667168	662,555	442,035	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.894440	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.443350	1,112,744	493,335	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	2.192103	0	0	90.00
90.01	ONCOLOGY	2.661843	0	0	90.01
90.02	OUTPATIENT CLINIC	1.779756	3,520	6,265	90.02
90.03	PROVIDER BASED CLINIC - TCMP	1.491842	0	0	90.03
90.04	PROVIDER BASED CLINIC - DCPC	3.187057	0	0	90.04
90.05	PROVIDER BASED CLINIC - WESTPORT	2.730310	0	0	90.05
90.06	CLINIC	0.413546	0	0	90.06
91.00	EMERGENCY	0.445756	408	182	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.089243	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		4,527,406	1,864,381	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)		4,527,406		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3	
		Component CCN: 15Z332	Date/Time Prepared: 5/24/2012 9:40 am		
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.300687	1,400	421	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.843697	0	0	52.00
53.00	ANESTHESIOLOGY	0.382717	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.179897	16,755	3,014	54.00
55.00	ULTRA SOUND	0.118744	2,530	300	55.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.195400	43,255	8,452	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.261058	4,910	1,282	62.00
65.00	RESPIRATORY THERAPY	0.553429	58,879	32,585	65.00
66.00	PHYSICAL THERAPY	0.636921	55,433	35,306	66.00
67.00	OCCUPATIONAL THERAPY	0.710197	46,097	32,738	67.00
68.00	SPEECH PATHOLOGY	0.940479	1,935	1,820	68.00
69.00	ELECTROCARDIOLOGY	0.151511	2,263	343	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.667168	28,776	19,198	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.894440	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.443350	124,773	55,318	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	2.192103	0	0	90.00
90.01	ONCOLOGY	2.661843	0	0	90.01
90.02	OUTPATIENT CLINIC	1.779756	0	0	90.02
90.03	PROVIDER BASED CLINIC - TCMP	1.491842	0	0	90.03
90.04	PROVIDER BASED CLINIC - DCPC	3.187057	0	0	90.04
90.05	PROVIDER BASED CLINIC - WESTPORT	2.730310	0	0	90.05
90.06	CLINIC	0.413546	0	0	90.06
91.00	EMERGENCY	0.445756	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.089243	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		387,006	190,777	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)		387,006		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/24/2012 9:40 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		134,666		30.00
31.00	INTENSIVE CARE UNIT		8,287		31.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY		132,022		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.300687	78,175	23,506	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.843697	73,997	62,431	52.00
53.00	ANESTHESIOLOGY	0.382717	59,688	22,844	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.179897	20,622	3,710	54.00
55.00	ULTRA SOUND	0.118744	3,584	426	55.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.195400	62,420	12,197	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.261058	5,159	1,347	62.00
65.00	RESPIRATORY THERAPY	0.553429	29,120	16,116	65.00
66.00	PHYSICAL THERAPY	0.636921	1,165	742	66.00
67.00	OCCUPATIONAL THERAPY	0.702648	1,177	827	67.00
68.00	SPEECH PATHOLOGY	0.940479	6,352	5,974	68.00
69.00	ELECTROCARDIOLOGY	0.151511	3,989	604	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.667168	45,348	30,255	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.894440	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.443350	76,041	33,713	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	CLINIC	2.192103	0	0	90.00
90.01	ONCOLOGY	2.661843	0	0	90.01
90.02	OUTPATIENT CLINIC	1.779756	0	0	90.02
90.03	PROVIDER BASED CLINIC - TCMP	1.491842	0	0	90.03
90.04	PROVIDER BASED CLINIC - DCPC	3.187057	0	0	90.04
90.05	PROVIDER BASED CLINIC - WESTPORT	2.730310	0	0	90.05
90.06	CLINIC	0.413546	0	0	90.06
91.00	EMERGENCY	0.445756	17,600	7,845	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.089243	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		484,437	222,537	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)		484,437		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/24/2012 9:40 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			6,458,219 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			6,458,219 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)			6,522,801 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)			92,752 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,696,789 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)			3,733,260 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)			3,733,260 30.00
31.00	Primary payer payments			3,159 31.00
32.00	Subtotal (line 30 minus line 31)			3,730,101 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)			685,906 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			685,906 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			597,506 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			4,416,007 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)			4,416,007 40.00
41.00	Interim payments			4,588,251 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)			-172,244 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151332

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

Worksheet E-1
Part I
Date/Time Prepared:
5/24/2012 9:40 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		3,445,917		3,647,839	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	08/31/2011	98,049	08/31/2011	351,449	3.01	
3.02		12/07/2011	11,983	12/07/2011	77,993	3.02	
3.03			99,945		510,970	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		209,977		940,412	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)		3,655,894		4,588,251	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		35,029		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		172,244	6.02	
7.00	Total Medicare program liability (see instructions)		3,690,923		4,416,007	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: 151332

Period: From 01/01/2011

Worksheet E-1

Component CCN: 15Z332

To 12/31/2011

Part I
Date/Time Prepared:
5/24/2012 9:40 am

Title XVIII

Swing Beds - SNF

Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		439,972		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	08/31/2011	3,001		0	3.01
3.02		12/07/2011	710		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		3,711		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)		443,683		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		66,720		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		510,403		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: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet E-2
Component CCN: 15Z332		Date/Time Prepared: 5/24/2012 9:40 am
Title XVIII	Swing Beds - SNF	Cost
	Part A	Part B
	1.00	2.00

COMPUTATION OF NET COST OF COVERED SERVICES		Part A	Part B	
		1.00	2.00	
1.00	Inpatient routine services - swing bed-SNF (see instructions)	322,954	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)	192,685	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	295	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)	515,639	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	515,639	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)	515,639	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	5,236	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)	510,403	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)	510,403	0	19.00
20.00	Interim payments	443,683	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)	66,720	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part V Date/Time Prepared: 5/24/2012 9:40 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services			3,948,026 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)			3,948,026 4.00
5.00	Primary payer payments			3,257 5.00
6.00	Total cost (line 4 less line 5) . For CAH (see instructions)			3,984,249 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)			3,984,249 19.00
20.00	Deductibles (exclude professional component)			405,000 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			3,579,249 22.00
23.00	Coinsurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			3,579,249 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			111,674 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			111,674 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			100,786 27.00
28.00	Subtotal (sum of lines 24 and 25 or 26)			3,690,923 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)			3,690,923 30.00
31.00	Interim payments			3,655,894 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)			35,029 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: 151332	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part VII Date/Time Prepared: 5/24/2012 9:40 am
		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		0	2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	4.00
5.00	Inpatient primary payer payments		0	5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		274,976	8.00
9.00	Ancillary service charges		484,437	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)		759,413	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)		759,413	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		759,413	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	21.00
PROSPECTIVE PAYMENT AMOUNT				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		0	23.00
24.00	Program capital payments		0	24.00
25.00	Capital exception payments (see instructions)		0	25.00
26.00	Routine and Ancillary service other pass through costs		0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX enter the sum of lines 27 and 21.		0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	31.00
32.00	Deductibles		0	32.00
33.00	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)		0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	40.00
41.00	Interim payments		243,390	41.00
42.00	Balance due provider/program (line 40 minus 41)		-243,390	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: 151332

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

Worksheet G
Date/Time Prepared:
5/24/2012 9:40 am

		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	1,832,691	0	0	0	1.00
2.00	Temporary investments	11,679,903	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	13,512,563	0	0	0	4.00
5.00	Other receivable	826,258	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-6,527,857	0	0	0	6.00
7.00	Inventory	369,118	0	0	0	7.00
8.00	Prepaid expenses	538,724	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	22,231,400	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	46,582,008	0	0	0	15.00
16.00	Accumulated depreciation	-21,757,157	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	24,824,851	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	4,370,982	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,370,982	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	51,427,233	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,326,273	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,516,896	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,843,169	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	2,803,845	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,803,845	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	6,647,014	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	44,780,219				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	44,780,219	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	51,427,233	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151332

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

Worksheet G-1

Date/Time Prepared:
5/24/2012 9:40 am

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		42,678,832	
2.00	Net income (loss) (From Wkst. G-3, line 29)		2,106,397			2.00
3.00	Total (sum of line 1 and line 2)		44,785,229		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		44,785,229		0	11.00
12.00	Deductions (debit adjustments) (specify)	5,010		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)		5,010		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		44,780,219		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151332

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

Worksheet G-1

Date/Time Prepared:
5/24/2012 9:40 am

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
1.00			0		0	1.00
2.00						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
11.00			0		0	11.00
12.00	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			0		0	18.00
19.00			0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151332

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

Worksheet G-2 Parts
Date/Time Prepared:
5/24/2012 9:40 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,660,931		3,660,931	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,660,931		3,660,931	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	328,100		328,100	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)	328,100		328,100	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,989,031		3,989,031	17.00
18.00	Ancillary services	12,719,161	68,642,933	81,362,094	18.00
19.00	Outpatient services	0	175,342	175,342	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,818,936	1,818,936	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	16,708,192	70,637,211	87,345,403	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		41,864,724		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)		41,864,724		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151332

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

Worksheet G-3

Date/Time Prepared:
5/24/2012 9:40 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	87,345,403	1.00
2.00	Less contractual allowances and discounts on patients' accounts	45,316,862	2.00
3.00	Net patient revenues (line 1 minus line 2)	42,028,541	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	41,864,724	4.00
5.00	Net income from service to patients (line 3 minus line 4)	163,817	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	1,230,584	24.00
24.01	NON-OPERATING REVENUE/(EXPENSE)	711,999	24.01
25.00	Total other income (sum of lines 6-24)	1,942,583	25.00
26.00	Total (line 5 plus line 25)	2,106,400	26.00
27.00	OTHER EXPENSES (SPECIFY)	3	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	3	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,106,397	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151332

Period: From 01/01/2011

Worksheet H

HHA CCN: 157153

To 12/31/2011

Date/Time Prepared:
5/24/2012 9:40 am

Home Health Agency I

PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	1.00
2.00	Capital Related - Movable Equipment			0		0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	188,619	0	74,252	0	20,620	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	533,843	0	0	0	0	6.00
7.00	Physical Therapy	152,164	0	0	12,587	0	7.00
8.00	Occupational Therapy	74,082	0	0	0	0	8.00
9.00	Speech Pathology	13,658	0	0	0	0	9.00
10.00	Medical Social Services	4,814	0	0	0	0	10.00
11.00	Home Health Aide	85,496	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)	1,052,676	0	74,252	12,587	20,620	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: 151332

Period: From 01/01/2011

Worksheet H

HHA CCN: 157153

To 12/31/2011

Date/Time Prepared: 5/24/2012 9:40 am

Home Health Agency I

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		Total (sum of col.s. 1 thru 5)	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	283,491	0	283,491	0	283,491	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	533,843	0	533,843	0	533,843	6.00
7.00	Physical Therapy	164,751	0	164,751	0	164,751	7.00
8.00	Occupational Therapy	74,082	0	74,082	0	74,082	8.00
9.00	Speech Pathology	13,658	0	13,658	0	13,658	9.00
10.00	Medical Social Services	4,814	0	4,814	0	4,814	10.00
11.00	Home Health Aide	85,496	0	85,496	0	85,496	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)	1,160,135	0	1,160,135	0	1,160,135	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: 151332	Period: From 01/01/2011	Worksheet H-1 Part I Date/Time Prepared: 5/24/2012 9:40 am
	HHA CCN: 157153	To 12/31/2011	
		Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	
		Bldgs & Fixtures	Movable Equipment			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0		3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	283,491	0	0	0	5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	533,843	0	0	0	6.00
7.00	Physical Therapy	164,751	0	0	0	7.00
8.00	Occupational Therapy	74,082	0	0	0	8.00
9.00	Speech Pathology	13,658	0	0	0	9.00
10.00	Medical Social Services	4,814	0	0	0	10.00
11.00	Home Health Aide	85,496	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,160,135	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST	Provider CCN: 151332	Period: From 01/01/2011	Worksheet H-1 Part I Date/Time Prepared: 5/24/2012 9:40 am
	HHA CCN: 157153	To 12/31/2011	
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	Subtotal (col s. 0-4) 4A.00	Administrative & General 5.00	Total (col s. 4A + 5) 6.00	
GENERAL SERVICE COST CENTERS				
1.00 Capital Related - Bldg. & Fixtures	0			1.00
2.00 Capital Related - Movable Equipment	0			2.00
3.00 Plant Operation & Maintenance	0			3.00
4.00 Transportation				4.00
5.00 Administrative and General	283,491	283,491		5.00
HHA REIMBURSABLE SERVICES				
6.00 Skilled Nursing Care	533,843	172,634	706,477	6.00
7.00 Physical Therapy	164,751	53,278	218,029	7.00
8.00 Occupational Therapy	74,082	23,957	98,039	8.00
9.00 Speech Pathology	13,658	4,417	18,075	9.00
10.00 Medical Social Services	4,814	1,557	6,371	10.00
11.00 Home Health Aide	85,496	27,648	113,144	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	0	0	0	17.00
18.00 Clinic	0	0	0	18.00
19.00 Health Promotion Activities	0	0	0	19.00
20.00 Day Care Program	0	0	0	20.00
21.00 Home Delivered Meals Program	0	0	0	21.00
22.00 Homemaker Service	0	0	0	22.00
23.00 All Others (specify)	0	0	0	23.00
24.00 Total (sum of lines 1-23)	876,644		1,160,135	24.00

COST ALLOCATION - HHA STATISTICAL BASIS	Provider CCN: 151332	Period: From 01/01/2011	Worksheet H-1 Part II Date/Time Prepared: 5/24/2012 9:40 am
	HHA CCN: 157153	To 12/31/2011	
		Home Health Agency I	PPS

	Capital Related Costs				Transportation (MILEAGE)	Reconciliation	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)				
	1.00	2.00	3.00	4.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation (see instructions)	0	0	0	0	0	4.00
5.00	Administrative and General	0	0	0	0	-283,491	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	-283,491	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	0	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		26.00

COST ALLOCATION - HHA STATISTICAL BASIS	Provider CCN: 151332	Period: From 01/01/2011	Worksheet H-1
	HHA CCN: 157153	To 12/31/2011	Part II Date/Time Prepared: 5/24/2012 9:40 am
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		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	876,644	5.00
HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	533,843	6.00
7.00	Physical Therapy	164,751	7.00
8.00	Occupational Therapy	74,082	8.00
9.00	Speech Pathology	13,658	9.00
10.00	Medical Social Services	4,814	10.00
11.00	Home Health Aide	85,496	11.00
12.00	Supplies (see instructions)	0	12.00
13.00	Drugs	0	13.00
14.00	DME	0	14.00
HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	15.00
16.00	Respiratory Therapy	0	16.00
17.00	Private Duty Nursing	0	17.00
18.00	Clinic	0	18.00
19.00	Health Promotion Activities	0	19.00
20.00	Day Care Program	0	20.00
21.00	Home Delivered Meals Program	0	21.00
22.00	Homemaker Service	0	22.00
23.00	All Others (specify)	0	23.00
24.00	Total (sum of lines 1-23)	876,644	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	283,491	25.00
26.00	Unit Cost Multiplier	0.323382	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151332

Period: From 01/01/2011

Worksheet H-2

HHA CCN: 157153

To 12/31/2011

Part I
Date/Time Prepared:
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	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		1.00	2.00			
	0			4.00	4A	
1.00 Administrative and General	0	31,335	0	298,839	330,174	1.00
2.00 Skilled Nursing Care	706,477	0	0	0	706,477	2.00
3.00 Physical Therapy	218,029	0	0	0	218,029	3.00
4.00 Occupational Therapy	98,039	0	0	0	98,039	4.00
5.00 Speech Pathology	18,075	0	0	0	18,075	5.00
6.00 Medical Social Services	6,371	0	0	0	6,371	6.00
7.00 Home Health Aide	113,144	0	0	0	113,144	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	1,160,135	31,335	0	298,839	1,490,309	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: 151332

Period:

Worksheet H-2

HHA CCN: 157153

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

Part I
Date/Time Prepared:
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		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
1.00	Administrative and General	62,475	5,395	16,164	0	0	1.00
2.00	Skilled Nursing Care	133,679	0	0	0	0	2.00
3.00	Physical Therapy	41,255	0	0	0	0	3.00
4.00	Occupational Therapy	18,551	0	0	0	0	4.00
5.00	Speech Pathology	3,420	0	0	0	0	5.00
6.00	Medical Social Services	1,206	0	0	0	0	6.00
7.00	Home Health Aide	21,409	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	281,995	5,395	16,164	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: 151332

Period: From 01/01/2011

Worksheet H-2

HHA CCN: 157153

To 12/31/2011

Part I
Date/Time Prepared:
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Home Health Agency I

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	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
	10.00	11.00	13.00	14.00	16.00	
1.00 Administrative and General	0	41,441	147,706	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	0	41,441	147,706	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: 151332

Period: From 01/01/2011

Worksheet H-2

HHA CCN: 157153

To 12/31/2011

Part I
Date/Time Prepared:
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Home Health Agency I

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		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		17.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	11,705	615,060	0	615,060		1.00
2.00	Skilled Nursing Care	0	840,156	0	840,156	374,546	2.00
3.00	Physical Therapy	0	259,284	0	259,284	115,591	3.00
4.00	Occupational Therapy	0	116,590	0	116,590	51,977	4.00
5.00	Speech Pathology	0	21,495	0	21,495	9,583	5.00
6.00	Medical Social Services	0	7,577	0	7,577	3,378	6.00
7.00	Home Health Aide	0	134,553	0	134,553	59,985	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	11,705	1,994,715	0	1,994,715	615,060	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.					0.445807	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: 151332

Period: From 01/01/2011

Worksheet H-2

HHA CCN: 157153

To 12/31/2011

Part I
Date/Time Prepared:
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		Total HHA Costs	
		28.00	
1.00	Administrative and General		1.00
2.00	Skilled Nursing Care	1,214,702	2.00
3.00	Physical Therapy	374,875	3.00
4.00	Occupational Therapy	168,567	4.00
5.00	Speech Pathology	31,078	5.00
6.00	Medical Social Services	10,955	6.00
7.00	Home Health Aide	194,538	7.00
8.00	Supplies (see instructions)	0	8.00
9.00	Drugs	0	9.00
10.00	DME	0	10.00
11.00	Home Dialysis Aide Services	0	11.00
12.00	Respiratory Therapy	0	12.00
13.00	Private Duty Nursing	0	13.00
14.00	Clinic	0	14.00
15.00	Health Promotion Activities	0	15.00
16.00	Day Care Program	0	16.00
17.00	Home Delivered Meals Program	0	17.00
18.00	Homemaker Service	0	18.00
19.00	All Others (specify)	0	19.00
20.00	Total (sum of lines 1-19) (2)	1,994,715	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 STATISTICAL BASIS

Provider CCN: 151332
HHA CCN: 157153

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

Worksheet H-2
Part II
Date/Time Prepared:
5/24/2012 9:40 am

		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (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	2,628	2,628	1,052,676	0	330,174	1.00
2.00	Skilled Nursing Care	0	0	0	0	706,477	2.00
3.00	Physical Therapy	0	0	0	0	218,029	3.00
4.00	Occupational Therapy	0	0	0	0	98,039	4.00
5.00	Speech Pathology	0	0	0	0	18,075	5.00
6.00	Medical Social Services	0	0	0	0	6,371	6.00
7.00	Home Health Aide	0	0	0	0	113,144	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	2,628	2,628	1,052,676		1,490,309	20.00
21.00	Total cost to be allocated	31,335	0	298,839		281,995	21.00
22.00	Unit cost multiplier	11.923516	0.000000	0.283885		0.189219	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151332
HHA CCN: 157153

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

Worksheet H-2
Part II
Date/Time Prepared:
5/24/2012 9:40 am

				Home Health Agency I		PPS	
		MAINTENANCE & REPAIRS (TIME SPENT)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	30	2,628	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	30	2,628	0	0	0	20.00
21.00	Total cost to be allocated	5,395	16,164	0	0	0	21.00
22.00	Unit cost multiplier	179.833333	6.150685	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151332
HHA CCN: 157153

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

Worksheet H-2
Part II
Date/Time Prepared:
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		CAFETERIA (HOURS)	NURSING ADMINISTRATION (NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		11.00	13.00	14.00	16.00	17.00	
1.00	Administrative and General	38,368	38,368	0	0	60	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	38,368	38,368	0	0	60	20.00
21.00	Total cost to be allocated	41,441	147,706	0	0	11,705	21.00
22.00	Unit cost multiplier	1.080093	3.849719	0.000000	0.000000	195.083333	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 151332 HHA CCN: 157153		Period: From 01/01/2011 To 12/31/2011		Worksheet H-3 Parts I-III Date/Time Prepared: 5/24/2012 9:40 am	
		Title XVIII		Home Health Agency I		PPS	
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	
		0	1.00	2.00	3.00	4.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,214,702		1,214,702	5,459	1.00
2.00	Physical Therapy	3.00	374,875	0	374,875	1,676	2.00
3.00	Occupational Therapy	4.00	168,567	0	168,567	608	3.00
4.00	Speech Pathology	5.00	31,078	0	31,078	104	4.00
5.00	Medical Social Services	6.00	10,955		10,955	35	5.00
6.00	Home Health Aide	7.00	194,538		194,538	2,907	6.00
7.00	Total (sum of lines 1-6)		1,994,715	0	1,994,715	10,789	7.00
				Program Visits			
				Part B			
				Not Subject to Deductibles & Coinsurance		Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	
Limitation Cost Computation							
8.00	Skilled Nursing Care			1,292	1,426		8.00
9.00	Physical Therapy			517	428		9.00
10.00	Occupational Therapy			223	139		10.00
11.00	Speech Pathology			24	15		11.00
12.00	Medical Social Services			15	9		12.00
13.00	Home Health Aide			178	864		13.00
14.00	Total (sum of lines 8-13)			2,249	2,881		14.00
				Total HHA Costs (cols. 1 + 2)		Total Charges (from HHA Record)	
		0	1.00	2.00	3.00	4.00	
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	52,675	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	16.00
				Cost to Charge Ratio		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	0.636921	0	0	1.00
2.00	Occupational Therapy		67.00	0.710197	0	0	2.00
3.00	Speech Pathology		68.00	0.940479	0	0	3.00
4.00	Cost of Medical Supplies		71.00	0.667168	0	0	4.00
5.00	Cost of Drugs		73.00	0.443350	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151332
HHA CCN: 157153

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

Worksheet H-3
Parts I-III
Date/Time Prepared:
5/24/2012 9:40 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Part A	Program Visits			
			Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	5.00	6.00	7.00	8.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
Cost Per Visit Computation						
1.00	Skilled Nursing Care	222.51	1,292	1,426		1.00
2.00	Physical Therapy	223.67	517	428		2.00
3.00	Occupational Therapy	277.25	223	139		3.00
4.00	Speech Pathology	298.83	24	15		4.00
5.00	Medical Social Services	313.00	15	9		5.00
6.00	Home Health Aide	66.92	178	864		6.00
7.00	Total (sum of lines 1-6)		2,249	2,881		7.00
	Cost Center Description	5.00	6.00	7.00	8.00	9.00
Limitation Cost Computation						
8.00	Skilled Nursing Care					8.00
9.00	Physical Therapy					9.00
10.00	Occupational Therapy					10.00
11.00	Speech Pathology					11.00
12.00	Medical Social Services					12.00
13.00	Home Health Aide					13.00
14.00	Total (sum of lines 8-13)					14.00
	Cost Center Description	Ratio (col. 3 ÷ col. 4)	Part A	Program Covered Charges		
		5.00	6.00	Part B		
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
				7.00	8.00	
Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	0.000000	0	52,675	0	15.00
16.00	Cost of Drugs	0.000000	0	0	0	16.00
	Cost Center Description		Transfer to Part I as Indicated			
			4.00			
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy		col. 2, line 2.00			1.00
2.00	Occupational Therapy		col. 2, line 3.00			2.00
3.00	Speech Pathology		col. 2, line 4.00			3.00
4.00	Cost of Medical Supplies		col. 2, line 15.00			4.00
5.00	Cost of Drugs		col. 2, line 16.00			5.00

APPORTIONMENT OF PATIENT SERVICE COSTS	Provider CCN: 151332	Period: From 01/01/2011	Worksheet H-3 Parts I-III Date/Time Prepared: 5/24/2012 9:40 am
	HHA CCN: 157153	To 12/31/2011	
	Title XVII I	Home Health Agency I	PPS

Cost Center Description	Cost of Services			Total Program Cost (sum of col.s. 9-10)	
	Part A	Part B			
		Not Subject to Deductibles & Coi nsurance	Subject to Deductibles & Coi nsurance		
	9.00	10.00	11.00	12.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION					
Cost Per Visit Computation					
1.00	Skilled Nursing Care	287,483	317,299	604,782	1.00
2.00	Physical Therapy	115,637	95,731	211,368	2.00
3.00	Occupational Therapy	61,827	38,538	100,365	3.00
4.00	Speech Pathology	7,172	4,482	11,654	4.00
5.00	Medical Social Services	4,695	2,817	7,512	5.00
6.00	Home Health Aide	11,912	57,819	69,731	6.00
7.00	Total (sum of lines 1-6)	488,726	516,686	1,005,412	7.00
Cost Center Description					
		10.00	11.00	12.00	
Limitation Cost Computation					
8.00	Skilled Nursing Care				8.00
9.00	Physical Therapy				9.00
10.00	Occupational Therapy				10.00
11.00	Speech Pathology				11.00
12.00	Medical Social Services				12.00
13.00	Home Health Aide				13.00
14.00	Total (sum of lines 8-13)				14.00
Cost of Services					
Cost Center Description	Part A	Part B			
		Not Subject to Deductibles & Coi nsurance	Subject to Deductibles & Coi nsurance		
	9.00	10.00	11.00		
Supplies and Drugs Cost Computations					
15.00	Cost of Medical Supplies	0	0	0	15.00
16.00	Cost of Drugs	0	0	0	16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 151332 HHA CCN: 157153	Period: From 01/01/2011 To 12/31/2011	Worksheet H-4 Part I-II Date/Time Prepared: 5/24/2012 9:40 am
		Title XVII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
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
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		328,365	372,053
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	0
13.00	Total PPS Reimbursement - LUPA Episodes		8,519	10,210
14.00	Total PPS Reimbursement - PEP Episodes		2,711	2,988
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	0
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		339,595	385,251
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		339,595	385,251
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		339,595	385,251
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		339,595	385,251
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		339,595	385,251
32.00	Interim payments (see instructions)		339,595	385,251
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 32 and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	0

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

Provider CCN: 151332
HHA CCN: 157153

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

Worksheet H-5
Date/Time Prepared:
5/24/2012 9:40 am
PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		339,595		385,250	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		1	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		1	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)		339,595		385,251	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)		339,595		385,251	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00