

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: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet 5 Parts I-III Date/Time Prepared: 2/9/2012 10:28 am
--	----------------------	---	--

PART I - COST REPORT STATUS

Provider use only	1. <input type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 2/9/2012 Time: 10:28 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN
		10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GIBSON GENERAL HOSPITAL for the cost reporting period beginning 10/31/2010 and ending 09/30/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 2/9/2012 Time: 10:28 am
zDPcn8j7YkinuV.EtpEg8OWtdIa140
xw7q10HufH6.EoB4xc02KnaKzz:8ch
yUSe0Jwgtg04GoiU
PI: Date: 2/9/2012 Time: 10:28 am
2zOkB8RRjHAPRL2PxDVvs77dQYGB0X0
NVGSy00ZvO.:N.mdgjom7rIry81QMz
2TtLRwc0d10xowak

(Signed) Ron Harrington
Officer or Administrator of Provider(s)

VP + CFO
Title

02/22/2012
Date

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	192,211	294,109	0	1,371,502 1.00
2.00	Subprovider - IPF	0	0	0	0	2.00
3.00	Subprovider - IRF	0	0	0	0	3.00
4.00	SUBPROVIDER I	0	0	0	0	4.00
5.00	Swing bed - SNF	0	34,313	0	0	5.00
6.00	Swing bed - NF	0	0	0	0	6.00
7.00	Skilled Nursing Facility	0	0	0	0	7.00
8.00	Nursing Facility	0	0	0	0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0	0	9.00
10.00	RURAL HEALTH CLINIC I	0	0	0	0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	11.00
12.00	CMHC I	0	0	0	0	12.00
200.00	Total	0	226,524	294,109	0	1,371,502 200.00

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.

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: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet S Parts I-III Date/Time Prepared: 2/9/2012 10:28 am
--	----------------------	---	--

PART I - COST REPORT STATUS

Provider use only

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

Date: 2/9/2012 Time: 10:28 am

Contractor use only

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

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

10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. 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 GIBSON GENERAL HOSPITAL for the cost reporting period beginning 10/31/2010 and ending 09/30/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

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

Title _____

Date _____

Cost Center Description	Title V 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	192,211	294,109	0	1,371,502	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	34,313	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
7.00 Skilled Nursing Facility	0	0	0		0	7.00
8.00 Nursing Facility	0	0	0		0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0		0	11.00
12.00 CMHC I	0	0	0		0	12.00
200.00 Total	0	226,524	294,109	0	1,371,502	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.

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: 151319
Period: From 10/31/2010 To 09/30/2011
Worksheet 5
Parts I-III
Date/Time Prepared: 2/9/2012 10:28 am

PART I - COST REPORT STATUS

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

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

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

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

Date: 2/9/2012 Time: 10:28 am

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance sheet and Statement of Revenue and Expenses prepared by GIBSON GENERAL HOSPITAL for the cost reporting period beginning 10/31/2010 and ending 09/30/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 2/9/2012 Time: 10:28 am
zDPcnBj7Ykinuv.EtpEg80WtdIa140
xw7Q10HufH6.EoB4xc02KnaKzz:8ch
yuse0Jwgtg04Goiu
PI: Date: 2/9/2012 Time: 10:28 am
2zokB8RRjHAPRL2Pxdvs77dQYGB0x0
NVG5y00ZVO.:N.mdgjom7rIrY81Qmz
2TtLRwc0d10x0wAK

(Signed)

Officer or Administrator of Provider(s)

Title

Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	192,211	294,109	0	1,371,502	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 SUBPROVIOER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	34,313	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	226,524	294,109	0	1,371,502	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.

Health Financial Systems

In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet S-2 Part I Date/Time Prepared: 2/9/2012 10:27 am			
		Beginning: 1.00		Ending: 2.00			
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	XVIII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N		46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.					58.00	
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00	
		Y/N	IME Average	Direct GME Average			
		1.00	2.00	3.00			
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00		61.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)		0.00			62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)		0.00			62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings							
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N				63.00	
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
		1.00	2.00	3.00			
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.							
64.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		64.00
		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	
65.00	Enter in column 1 the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet S-2 Part I Date/Time Prepared: 2/9/2012 10:27 am		
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	0.00	0.00	0.000000		67.00
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		
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
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		
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)(ii)? 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	Y	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		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		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		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet S-2 Part I Date/Time Prepared: 2/9/2012 10:27 am	
		V 1.00	XIX 2.00		
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
				1.00	2.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.	N			115.00
116.00	Is this a facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		0		118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.		0		119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N			140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:		Contractor's Number:	
142.00	Street:	PO Box:			
143.00	City:	State:		Zip Code:	
				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet S-2 Part I Date/Time Prepared: 2/9/2012 10:27 am
---	----------------------	---	---

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.	1.00 N	2.00	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	
155.00	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)	N	N	155.00
156.00	Hospital	N	N	156.00
157.00	Subprovider - IPF	N	N	157.00
158.00	Subprovider - IRF	N	N	158.00
159.00	Subprovider - Other	N	N	159.00
160.00	SNF	N	N	160.00
161.00	HHA	N	N	161.00
	CMHC		N	161.00

	Multicampus		1.00						
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.		N	165.00					
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	Name 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 5.00	0.00	166.00

	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		1.00	
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
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: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet 5-2 Part II Date/Time Prepared: 2/9/2012 10:27 am
		Y/N 1.00	Date 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 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C	03/01/2011
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N 1.00	Legal Oper. 2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
		Y/N 1.00		
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		
Description		Y/N	Date	
0		1.00	2.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	01/04/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet S-2 Part II Date/Time Prepared: 2/9/2012 10:27 am
21.00	Description 0 Was the cost report prepared only using the provider's records? If yes, see instructions.	Part A		21.00
		Y/N 1.00 N	Date 2.00	
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N		23.00
24.00	were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	A		33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N		35.00
		Y/N 1.00	Date 2.00	
Home Office Costs				
36.00	were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	A		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	A		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	A		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	A		40.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet S-2
Part II
Date/Time Prepared:
2/9/2012 10:27 am

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	01/04/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for other? Describe the other adjustments:	N		20.00
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
2/9/2012 10:27 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	20	7,300	47,184.00	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)		20	7,300	47,184.00	7.00
8.00 INTENSIVE CARE UNIT	31.00	5	1,825	4,680.00	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					13.00
14.00 Total (see instructions)		25	9,125	51,864.00	14.00
15.00 CAH visits					15.00
16.00 SUBPROVIDER - IPF					16.00
17.00 SUBPROVIDER - IRF					17.00
18.00 SUBPROVIDER					18.00
19.00 SKILLED NURSING FACILITY	44.00	45	16,425		19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE					21.00
22.00 HOME HEALTH AGENCY	101.00				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00 HOSPICE					24.00
25.00 CMHC - CMHC					25.00
26.00 RURAL HEALTH CLINIC					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25
27.00 Total (sum of lines 14-26)		70			27.00
28.00 Observation Bed Days					28.00
29.00 Ambulance Trips					29.00
30.00 Employee discount days (see instruction)					30.00
31.00 Employee discount days - IRF					31.00
32.00 Labor & delivery days (see instructions)					32.00
33.00 LTCH non-covered days					33.00

Cost Center Description	I/P Days / O/P Visits / Trips				Total All Patients	
	Title V	Title XVIII	Title XIX			
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	1,261	104	1,966	1.00	
2.00 HMO		62	0		2.00	
3.00 HMO IPF		0	0		3.00	
4.00 HMO IRF		0	0		4.00	
5.00 Hospital Adults & Peds. Swing Bed SNF	0	523	0	523	5.00	
6.00 Hospital Adults & Peds. Swing Bed NF	0		100	100	6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,784	204	2,589	7.00	
8.00 INTENSIVE CARE UNIT	0	132	0	195	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	1,916	204	2,784	14.00	
15.00 CAH visits	0	0	0	0	15.00	
16.00 SUBPROVIDER - IPF					16.00	
17.00 SUBPROVIDER - IRF					17.00	
18.00 SUBPROVIDER					18.00	
19.00 SKILLED NURSING FACILITY	0	1,273	9,104	13,813	19.00	
20.00 NURSING FACILITY					20.00	
21.00 OTHER LONG TERM CARE					21.00	
22.00 HOME HEALTH AGENCY	0	2,999	105	4,315	22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00	
24.00 HOSPICE					24.00	
25.00 CMHC - CMHC					25.00	
26.00 RURAL HEALTH CLINIC					26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25	
27.00 Total (sum of lines 14-26)					27.00	
28.00 Observation Bed Days	0		0	438	28.00	
29.00 Ambulance Trips		0			29.00	
30.00 Employee discount days (see instruction)				0	30.00	
31.00 Employee discount days - IRF				0	31.00	
32.00 Labor & delivery days (see instructions)			0	0	32.00	
33.00 LTCH non-covered days		0			33.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA		Provider CCN: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet S-3 Part I Date/Time Prepared: 2/9/2012 10:27 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	357	1.00
2.00 HMO					15	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	240.25	0.00	0	357	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00	29.22	0.00			19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00	4.92	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	274.39	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

Cost Center Description	Discharges		
	Title XIX	Total All Patients	
	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	34	587	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)	34	587	14.00
15.00 CAH visits			15.00
16.00 SUBPROVIDER - IPF			16.00
17.00 SUBPROVIDER - IRF			17.00
18.00 SUBPROVIDER			18.00
19.00 SKILLED NURSING FACILITY			19.00
20.00 NURSING FACILITY			20.00
21.00 OTHER LONG TERM CARE			21.00
22.00 HOME HEALTH AGENCY			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)			23.00
24.00 HOSPICE			24.00
25.00 CMHC - CMHC			25.00
26.00 RURAL HEALTH CLINIC			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER			26.25
27.00 Total (sum of lines 14-26)			27.00
28.00 Observation Bed Days			28.00
29.00 Ambulance Trips			29.00
30.00 Employee discount days (see instruction)			30.00
31.00 Employee discount days - IRF			31.00
32.00 Labor & delivery days (see instructions)			32.00
33.00 LTCH non-covered days			33.00

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	142,260	3.00
4.00	Prior Year Pension Service Cost	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	1,942,595	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	130,332	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	952,979	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	51,941	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total wage Related cost (Sum of lines 1 -23)	3,220,107	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOME HEALTH AGENCY STATISTICAL DATA	Provider CCN: 151319 Component CCN: 157445	Period: From 10/31/2010 To 09/30/2011	Worksheet S-4 Date/Time Prepared: 2/9/2012 10:27 am
		Home Health Agency I	PPS

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

1.00	HOME HEALTH AGENCY STATISTICAL DATA	0	0	0	0	0	1.00
2.00	Home Health Aide Hours	0.00	0.00	0.00	0.00	0.00	2.00
	Unduplicated Census Count (see instructions)						

		Number of Employees (Full Time Equivalent)			
	Enter the number of hours in your normal work week	Staff	Contract	Total	
		0	1.00	2.00	3.00

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

HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		15999				20.00

		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	

PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	1,396	75	32	5	1,508	21.00
22.00	Skilled Nursing Visit Charges	180,587	9,702	4,140	647	195,076	22.00
23.00	Physical Therapy Visits	696	23	6	1	726	23.00
24.00	Physical Therapy Visit Charges	91,677	3,030	790	132	95,629	24.00
25.00	Occupational Therapy Visits	164	18	0	0	182	25.00
26.00	Occupational Therapy Visit Charges	21,602	2,371	0	0	23,973	26.00
27.00	Speech Pathology Visits	96	24	0	0	120	27.00
28.00	Speech Pathology Visit Charges	12,645	3,161	0	0	15,806	28.00
29.00	Medical Social Service Visits	5	0	0	0	5	29.00
30.00	Medical Social Service Visit Charges	878	0	0	0	878	30.00
31.00	Home Health Aide Visits	420	35	3	0	458	31.00
32.00	Home Health Aide Visit Charges	30,400	2,533	217	0	33,150	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,777	175	41	6	2,999	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	337,789	20,797	5,147	779	364,512	35.00
36.00	Total Number of Episodes (standard/non outlier)	142		15	1	158	36.00
37.00	Total Number of Outlier Episodes		3		0	3	37.00
38.00	Total Non-Routine Medical Supply Charges	2,724	29	181	0	2,934	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet S-7

Date/Time Prepared:
2/9/2012 10:27 am

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

	Group	SNF Days		Swing Bed Days	SNF	Total (sum of col. 2 + 3)	
		1.00	2.00			3.00	4.00
3.00	RUX	0	0	0	0	0	3.00
4.00	RUL	0	0	0	0	0	4.00
5.00	RVX	0	0	0	0	0	5.00
6.00	RVL	0	0	0	0	0	6.00
7.00	RHX	0	0	0	0	0	7.00
8.00	RHL	0	0	0	0	0	8.00
9.00	RMX	6	0	0	0	6	9.00
10.00	RML	0	0	0	0	0	10.00
11.00	RLX	0	0	0	0	0	11.00
12.00	RUC	0	0	0	0	0	12.00
13.00	RUB	0	0	0	0	0	13.00
14.00	RUA	0	0	0	0	0	14.00
15.00	RVC	14	0	0	0	14	15.00
16.00	RVB	40	0	0	0	40	16.00
17.00	RVA	30	0	0	0	30	17.00
18.00	RHC	55	0	0	0	55	18.00
19.00	RHB	143	0	0	0	143	19.00
20.00	RHA	450	0	0	0	450	20.00
21.00	RMC	126	0	0	0	126	21.00
22.00	RMB	84	0	0	0	84	22.00
23.00	RMA	109	0	0	0	109	23.00
24.00	RLB	0	0	0	0	0	24.00
25.00	RLA	0	0	0	0	0	25.00
26.00	ES3	0	0	0	0	0	26.00
27.00	ES2	0	0	0	0	0	27.00
28.00	ES1	0	0	0	0	0	28.00
29.00	HE2	0	0	0	0	0	29.00
30.00	HE1	0	0	0	0	0	30.00
31.00	HD2	15	0	0	0	15	31.00
32.00	HD1	13	0	0	0	13	32.00
33.00	HC2	8	0	0	0	8	33.00
34.00	HC1	7	0	0	0	7	34.00
35.00	HB2	0	0	0	0	0	35.00
36.00	HB1	0	0	0	0	0	36.00
37.00	LE2	0	0	0	0	0	37.00
38.00	LE1	0	0	0	0	0	38.00
39.00	LD2	13	0	0	0	13	39.00
40.00	LD1	64	0	0	0	64	40.00
41.00	LC2	0	0	0	0	0	41.00
42.00	LC1	0	0	0	0	0	42.00
43.00	LB2	0	0	0	0	0	43.00
44.00	LB1	35	0	0	0	35	44.00
45.00	CE2	0	0	0	0	0	45.00
46.00	CE1	14	0	0	0	14	46.00
47.00	CD2	0	0	0	0	0	47.00
48.00	CD1	0	0	0	0	0	48.00
49.00	CC2	0	0	0	0	0	49.00
50.00	CC1	12	0	0	0	12	50.00
51.00	CB2	0	0	0	0	0	51.00
52.00	CB1	0	0	0	0	0	52.00
53.00	CA2	0	0	0	0	0	53.00
54.00	CA1	8	0	0	0	8	54.00
55.00	SE3	0	0	0	0	0	55.00
56.00	SE2	0	0	0	0	0	56.00
57.00	SE1	0	0	0	0	0	57.00
58.00	SSC	0	0	0	0	0	58.00
59.00	SSB	0	0	0	0	0	59.00
60.00	SSA	0	0	0	0	0	60.00
61.00	IB2	0	0	0	0	0	61.00
62.00	IB1	0	0	0	0	0	62.00
63.00	IA2	0	0	0	0	0	63.00
64.00	IA1	0	0	0	0	0	64.00
65.00	BB2	0	0	0	0	0	65.00
66.00	BB1	0	0	0	0	0	66.00
67.00	BA2	0	0	0	0	0	67.00
68.00	BA1	0	0	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		Provider CCN: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet S-7 Date/Time Prepared: 2/9/2012 10:27 am	
	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1.00	2.00	3.00	4.00	
69.00	PE2	0	0	0	69.00
70.00	PE1	0	0	0	70.00
71.00	PD2	0	0	0	71.00
72.00	PD1	0	0	0	72.00
73.00	PC2	0	0	0	73.00
74.00	PC1	0	0	0	74.00
75.00	PB2	0	0	0	75.00
76.00	PB1	0	0	0	76.00
77.00	PA2	0	0	0	77.00
78.00	PA1	0	0	0	78.00
199.00	AAA	27	0	27	199.00
200.00	TOTAL	1,273	0	1,273	200.00

	CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)
	1.00	2.00

SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	15999	15999
	Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?
	1.00	2.00	3.00

A notice published in the Federal Register volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

202.00	Staffing	0	0.00	202.00
203.00	Recruitment	0	0.00	203.00
204.00	Retention of employees	0	0.00	204.00
205.00	Training	0	0.00	205.00
206.00	OTHER (SPECIFY)	0	0.00	206.00
207.00	Total SNF revenue (worksheet G-2, Part I, line 7, column 3)	2,109,602		207.00

1.00 Wage Index Factor						0.0000	1.00
	Group	Base Rate Prior to 10/1	Actual Rate for Services Prior to 10/1	Days for Services Prior to 10/1	Base Rate on/After 10/1		
	1.00	2.00	3.00	4.00	5.00		
3.00	RUX	266.82	266.82	0	266.82	3.00	
4.00	RUL	260.04	260.04	0	260.04	4.00	
5.00	RVX	241.42	241.42	0	241.42	5.00	
6.00	RVL	214.30	214.30	0	214.30	6.00	
7.00	RHX	221.85	221.85	0	221.85	7.00	
8.00	RHL	195.70	195.70	0	195.70	8.00	
9.00	RMX	205.09	205.09	0	205.09	9.00	
10.00	RML	187.66	187.66	0	187.66	10.00	
11.00	RLX	182.17	182.17	0	182.17	11.00	
12.00	RUC	194.65	194.65	0	194.65	12.00	
13.00	RUB	194.65	194.65	0	194.65	13.00	
14.00	RUA	157.36	157.36	0	157.36	14.00	
15.00	RVC	169.25	169.25	0	169.25	15.00	
16.00	RVB	143.58	143.58	0	143.58	16.00	
17.00	RVA	143.10	143.10	0	143.10	17.00	
18.00	RHC	149.69	149.69	0	149.69	18.00	
19.00	RHB	133.22	133.22	0	133.22	19.00	
20.00	RHA	115.30	115.30	0	115.30	20.00	
21.00	RMC	133.41	133.41	0	133.41	21.00	
22.00	RMB	123.73	123.73	0	123.73	22.00	
23.00	RMA	99.51	99.51	0	99.51	23.00	
24.00	RLB	132.28	132.28	0	132.28	24.00	
25.00	RLA	80.95	80.95	0	80.95	25.00	
26.00	ES3	202.92	202.92	0	202.92	26.00	
27.00	ES2	158.84	158.84	0	158.84	27.00	
28.00	ES1	141.89	141.89	0	141.89	28.00	

	Group	Base Rate Prior to 10/1	Actual Rate for Services Prior to 10/1	Days for Services Prior to 10/1	Base Rate On/After 10/1	
	1.00	2.00	3.00	4.00	5.00	
29.00	HE2	137.04	137.04	0	137.04	29.00
30.00	HE1	113.80	113.80	0	113.80	30.00
31.00	HD2	128.33	128.33	0	128.33	31.00
32.00	HD1	107.02	107.02	0	107.02	32.00
33.00	HC2	121.06	121.06	0	121.06	33.00
34.00	HC1	101.20	101.20	0	101.20	34.00
35.00	HB2	119.61	119.61	0	119.61	35.00
36.00	HB1	100.24	100.24	0	100.24	36.00
37.00	LE2	124.45	124.45	0	124.45	37.00
38.00	LE1	104.11	104.11	0	104.11	38.00
39.00	LD2	119.61	119.61	0	119.61	39.00
40.00	LD1	100.24	100.24	0	100.24	40.00
41.00	LC2	105.08	105.08	0	105.08	41.00
42.00	LC1	88.61	88.61	0	88.61	42.00
43.00	LB2	99.75	99.75	0	99.75	43.00
44.00	LB1	84.74	84.74	0	84.74	44.00
45.00	CE2	110.89	110.89	0	110.89	45.00
46.00	CE1	102.17	102.17	0	102.17	46.00
47.00	CD2	105.08	105.08	0	105.08	47.00
48.00	CD1	96.36	96.36	0	96.36	48.00
49.00	CC2	92.00	92.00	0	92.00	49.00
50.00	CC1	85.22	85.22	0	85.22	50.00
51.00	CB2	85.22	85.22	0	85.22	51.00
52.00	CB1	78.93	78.93	0	78.93	52.00
53.00	CA2	72.14	72.14	0	72.14	53.00
54.00	CA1	67.30	67.30	0	67.30	54.00
55.00	SE3	0.00	0.00	0	0.00	55.00
56.00	SE2	0.00	0.00	0	0.00	56.00
57.00	SE1	0.00	0.00	0	0.00	57.00
58.00	SSC	0.00	0.00	0	0.00	58.00
59.00	SSB	0.00	0.00	0	0.00	59.00
60.00	SSA	0.00	0.00	0	0.00	60.00
61.00	IB2	0.00	0.00	0	0.00	61.00
62.00	IB1	0.00	0.00	0	0.00	62.00
63.00	IA2	0.00	0.00	0	0.00	63.00
64.00	IA1	0.00	0.00	0	0.00	64.00
65.00	BB2	76.50	76.50	0	76.50	65.00
66.00	BB1	73.11	73.11	0	73.11	66.00
67.00	BA2	63.42	63.42	0	63.42	67.00
68.00	BA1	60.52	60.52	0	60.52	68.00
69.00	PE2	102.17	102.17	0	102.17	69.00
70.00	PE1	97.33	97.33	0	97.33	70.00
71.00	PD2	96.36	96.36	0	96.36	71.00
72.00	PD1	91.52	91.52	0	91.52	72.00
73.00	PC2	82.80	82.80	0	82.80	73.00
74.00	PC1	78.93	78.93	0	78.93	74.00
75.00	PB2	70.21	70.21	0	70.21	75.00
76.00	PB1	67.30	67.30	0	67.30	76.00
77.00	PA2	58.10	58.10	0	58.10	77.00
78.00	PA1	55.68	55.68	0	55.68	78.00
199.00	AAA	0.00	0.00	0	0.00	199.00
200.00	TOTAL			0		200.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet 5-7

Date/Time Prepared:
2/9/2012 10:27 am

	Actual Rate for Services On/After 10/1	Days for Services On/After 10/1	total	
	6.00	7.00	8.00	
3.00	266.82	0	0	3.00
4.00	260.04	0	0	4.00
5.00	241.42	0	0	5.00
6.00	214.30	0	0	6.00
7.00	221.85	0	0	7.00
8.00	195.70	0	0	8.00
9.00	205.09	0	0	9.00
10.00	187.66	0	0	10.00
11.00	182.17	0	0	11.00
12.00	194.65	0	0	12.00
13.00	194.65	0	0	13.00
14.00	157.36	0	0	14.00
15.00	169.25	0	0	15.00
16.00	143.58	0	0	16.00
17.00	143.10	0	0	17.00
18.00	149.69	0	0	18.00
19.00	133.22	0	0	19.00
20.00	115.30	0	0	20.00
21.00	133.41	0	0	21.00
22.00	123.73	0	0	22.00
23.00	99.51	0	0	23.00
24.00	132.28	0	0	24.00
25.00	80.95	0	0	25.00
26.00	202.92	0	0	26.00
27.00	158.84	0	0	27.00
28.00	141.89	0	0	28.00
29.00	137.04	0	0	29.00
30.00	113.80	0	0	30.00
31.00	128.33	0	0	31.00
32.00	107.02	0	0	32.00
33.00	121.06	0	0	33.00
34.00	101.20	0	0	34.00
35.00	119.61	0	0	35.00
36.00	100.24	0	0	36.00
37.00	124.45	0	0	37.00
38.00	104.11	0	0	38.00
39.00	119.61	0	0	39.00
40.00	100.24	0	0	40.00
41.00	105.08	0	0	41.00
42.00	88.61	0	0	42.00
43.00	99.75	0	0	43.00
44.00	84.74	0	0	44.00
45.00	110.89	0	0	45.00
46.00	102.17	0	0	46.00
47.00	105.08	0	0	47.00
48.00	96.36	0	0	48.00
49.00	92.00	0	0	49.00
50.00	85.22	0	0	50.00
51.00	85.22	0	0	51.00
52.00	78.93	0	0	52.00
53.00	72.14	0	0	53.00
54.00	67.30	0	0	54.00
55.00	0.00	0	0	55.00
56.00	0.00	0	0	56.00
57.00	0.00	0	0	57.00
58.00	0.00	0	0	58.00
59.00	0.00	0	0	59.00
60.00	0.00	0	0	60.00
61.00	0.00	0	0	61.00
62.00	0.00	0	0	62.00
63.00	0.00	0	0	63.00
64.00	0.00	0	0	64.00
65.00	76.50	0	0	65.00
66.00	73.11	0	0	66.00
67.00	63.42	0	0	67.00
68.00	60.52	0	0	68.00
69.00	102.17	0	0	69.00
70.00	97.33	0	0	70.00
71.00	96.36	0	0	71.00
72.00	91.52	0	0	72.00
73.00	82.80	0	0	73.00
74.00	78.93	0	0	74.00
75.00	70.21	0	0	75.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet S-7
Date/Time Prepared:
2/9/2012 10:27 am

	Actual Rate for Services On/After 10/1	Days For Services On/After 10/1	Total	
	6.00	7.00	8.00	
76.00	67.30	0	0	76.00
77.00	58.10	0	0	77.00
78.00	55.68	0	0	78.00
199.00	0.00	0	0	199.00
200.00 TOTAL		0	0	200.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet S-10

Date/Time Prepared:
2/9/2012 10:27 am

		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)	0.470169	1.00
Medicaid (see instructions for each line)			
2.00	Net revenue from Medicaid	1,105,439	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	A	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	6,187,704	6.00
7.00	Medicaid cost (line 1 times line 6)	2,909,267	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,803,828	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)	1,803,828	19.00
		Uninsured patients	Insured patients
		1.00	2.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	548,140	1,296,921
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	257,718	609,772
22.00	Partial payment by patients approved for charity care	20,640	20,172
23.00	Cost of charity care (line 21 minus line 22)	237,078	589,600
		Total (col. 1 + col. 2)	3.00
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,945,933	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	403,907	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	2,542,026	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	1,195,182	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	2,021,860	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,825,688	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet A	
Date/Time Prepared: 2/9/2012 10:27 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		
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT		2,720,174	2,720,174	-1,040,203	1,679,971	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		0	0	1,711,519	1,711,519	2.00
4.00	EMPLOYEE BENEFITS	132,241	-518,546	-386,305	735,392	349,087	4.00
5.00	ADMINISTRATIVE & GENERAL	1,620,748	3,298,421	4,919,169	-105,791	4,813,378	5.00
7.00	OPERATION OF PLANT	290,511	948,240	1,238,751	-25,015	1,213,736	7.00
8.00	LAUNDRY & LINEN SERVICE	53,350	70,188	123,538	-3,521	120,017	8.00
9.00	HOUSEKEEPING	310,054	182,836	492,890	-19,317	473,573	9.00
10.00	DIETARY	399,240	371,295	770,535	-445,620	324,915	10.00
11.00	CAFETERIA	0	0	0	420,191	420,191	11.00
13.00	NURSING ADMINISTRATION	37,468	27,659	65,127	-126	65,001	13.00
16.00	MEDICAL RECORDS & LIBRARY	213,838	194,888	408,726	-11,734	396,992	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,134,841	493,129	1,627,970	-110,425	1,517,545	30.00
31.00	INTENSIVE CARE UNIT	269,974	80,761	350,735	-16,731	334,004	31.00
44.00	SKILLED NURSING FACILITY	1,144,553	475,251	1,619,804	-77,706	1,542,098	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	384,904	1,277,904	1,662,808	-462,441	1,200,367	50.00
54.00	RADIOLOGY-DIAGNOSTIC	645,748	690,729	1,336,477	-41,405	1,295,072	54.00
54.03	NUCLEAR MEDICINE-DIAGNOSTIC	0	147,689	147,689	-2	147,687	54.03
60.00	LABORATORY	640,313	846,933	1,487,246	-68,869	1,418,377	60.00
65.00	RESPIRATORY THERAPY	320,304	380,578	700,882	-76,507	624,375	65.00
66.00	PHYSICAL THERAPY	645,468	203,517	848,985	-43,920	805,065	66.00
67.00	OCCUPATIONAL THERAPY	242,181	78,138	320,319	-13,187	307,132	67.00
68.00	SPEECH PATHOLOGY	129,075	52,226	181,301	-8,189	173,112	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	-1,845	-1,845	232,713	230,868	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	288,520	288,520	72.00
73.00	DRUGS CHARGED TO PATIENTS	227,787	552,810	780,597	-45,958	734,639	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	158,300	197,912	356,212	-21,532	334,680	90.00
90.01	DIABETES	72,467	24,974	97,441	-2,287	95,154	90.01
90.02	OP PSYCH	49,609	76,297	125,906	-2,217	123,689	90.02
91.00	EMERGENCY	780,467	548,066	1,328,533	-61,689	1,266,844	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	CARDIAC REHAB	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	258,253	135,592	393,845	-16,372	377,473	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE		354,701	354,701	-354,701	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	10,161,694	13,910,517	24,072,211	312,870	24,385,081	118.00
NONREIMBURSABLE COST CENTERS							
194.00	MOB	3,531,599	2,577,823	6,109,422	-189,512	5,919,910	194.00
194.01	FOUNDATION	53,348	62,844	116,192	-123,358	-7,166	194.01
194.02	ASC	0	852,735	852,735	0	852,735	194.02
200.00	TOTAL (SUM OF LINES 118-199)	13,746,641	17,403,919	31,150,560	0	31,150,560	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet A

Date/Time Prepared:
2/9/2012 10:27 am

Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For Allocation	
	6.00	7.00	
GENERAL SERVICE COST CENTERS			
1.00 NEW CAP REL COSTS-BLDG & FIXT	-691,297	988,674	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	-60,919	1,650,600	2.00
4.00 EMPLOYEE BENEFITS	108,449	457,536	4.00
5.00 ADMINISTRATIVE & GENERAL	-1,452,400	3,360,978	5.00
7.00 OPERATION OF PLANT	-9,491	1,204,245	7.00
8.00 LAUNDRY & LINEN SERVICE	0	120,017	8.00
9.00 HOUSEKEEPING	0	473,573	9.00
10.00 DIETARY	0	324,915	10.00
11.00 CAFETERIA	-179,720	240,471	11.00
13.00 NURSING ADMINISTRATION	0	65,001	13.00
16.00 MEDICAL RECORDS & LIBRARY	-8,355	388,637	16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS	0	1,517,545	30.00
31.00 INTENSIVE CARE UNIT	0	334,004	31.00
44.00 SKILLED NURSING FACILITY	0	1,542,098	44.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	-451,906	748,461	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	1,295,072	54.00
54.03 NUCLEAR MEDICINE-DIAGNOSTIC	0	147,687	54.03
60.00 LABORATORY	0	1,418,377	60.00
65.00 RESPIRATORY THERAPY	-30,323	594,052	65.00
66.00 PHYSICAL THERAPY	0	805,065	66.00
67.00 OCCUPATIONAL THERAPY	0	307,132	67.00
68.00 SPEECH PATHOLOGY	0	173,112	68.00
69.00 ELECTROCARDIOLOGY	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	230,868	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	288,520	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	734,639	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00 CLINIC	0	334,680	90.00
90.01 DIABETES	0	95,154	90.01
90.02 OP PSYCH	-60,865	62,824	90.02
91.00 EMERGENCY	0	1,266,844	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00 CARDIAC REHAB	0	0	93.00
OTHER REIMBURSABLE COST CENTERS			
101.00 HOME HEALTH AGENCY	0	377,473	101.00
SPECIAL PURPOSE COST CENTERS			
113.00 INTEREST EXPENSE	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-2,836,827	21,548,254	118.00
NONREIMBURSABLE COST CENTERS			
194.00 MOB	0	5,919,910	194.00
194.01 FOUNDATION	0	-7,166	194.01
194.02 ASC	0	852,735	194.02
200.00 TOTAL (SUM OF LINES 118-199)	-2,836,827	28,313,733	200.00

	Increases				
	Cost Center 2.00	Line # 3.00	Salary 4.00	Other 5.00	
A - INSURANCE					
1.00	NEW CAP REL COSTS-MVBLE	2.00	0	22,667	1.00
	EQUIP				
	TOTALS		0	22,667	
B - DEPRECIATION					
1.00	NEW CAP REL COSTS-MVBLE	2.00	0	1,014,760	1.00
	EQUIP				
	TOTALS		0	1,014,760	
D - CAFETERIA					
1.00	CAFETERIA	11.00	217,715	202,476	1.00
	TOTALS		217,715	202,476	
E - MED SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	232,713	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	288,520	2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	177	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
16.00		0.00	0	0	16.00
20.00		0.00	0	0	20.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
	TOTALS		0	521,410	
F - RENTAL EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE	2.00	0	316,977	1.00
	EQUIP				
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
24.00		0.00	0	0	24.00
27.00		0.00	0	0	27.00
	TOTALS		0	316,977	
H - BUSINESS HEALTH SER					
1.00	EMPLOYEE BENEFITS	4.00	30,915	22,600	1.00
	TOTALS		30,915	22,600	
I - INTEREST					
1.00		0.00	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE	2.00	0	354,339	2.00
	EQUIP				
3.00	ADMINISTRATIVE & GENERAL	5.00	0	362	3.00
	TOTALS		0	354,701	
J - PROPERTY TAX					
1.00	NEW CAP REL COSTS-MVBLE	2.00	0	2,776	1.00
	EQUIP				
	TOTALS		0	2,776	
K - QUALITY SERVICES					
1.00	ADMINISTRATIVE & GENERAL	5.00	27,665	3,333	1.00
	TOTALS		27,665	3,333	
L - HEALTH INSURANCE					
1.00	EMPLOYEE BENEFITS	4.00	0	681,877	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
28.00		0.00	0	0		28.00
30.00		0.00	0	0		30.00
	TOTALS		0	681,877		
500.00	Grand Total: Increases		276,295	3,143,577		500.00

Health Financial Systems
RECLASSIFICATIONS

In Lieu of Form CMS-2552-10

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet A-6

Date/Time Prepared:
2/9/2012 10:27 am

		Decreases			wkst. A-7 Ref.		
Cost Center		Line #	Salary	Other			
6.00		7.00	8.00	9.00	10.00		
A - INSURANCE							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	22,667	9		1.00
	TOTALS		0	22,667			
B - DEPRECIATION							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,014,760	9		1.00
	TOTALS		0	1,014,760			
D - CAFETERIA							
1.00	DIETARY	10.00	217,715	202,476	0		1.00
	TOTALS		217,715	202,476			
E - MED SUPPLIES							
1.00		0.00	0	0	0		1.00
2.00	DIETARY	10.00	0	58	0		2.00
3.00		0.00	0	0	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	1,658	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	269	0		5.00
6.00	SKILLED NURSING FACILITY	44.00	0	1,013	0		6.00
7.00	OPERATING ROOM	50.00	0	414,267	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,434	0		8.00
9.00	NUCLEAR MEDICINE-DIAGNOSTIC	54.03	0	2	0		9.00
10.00	LABORATORY	60.00	0	785	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	15,386	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	4,641	0		12.00
13.00	OCCUPATIONAL THERAPY	67.00	0	15	0		13.00
16.00	DRUGS CHARGED TO PATIENTS	73.00	0	21	0		16.00
20.00	EMERGENCY	91.00	0	6,549	0		20.00
22.00	HOME HEALTH AGENCY	101.00	0	600	0		22.00
23.00	MOB	194.00	0	74,712	0		23.00
	TOTALS		0	521,410			
F - RENTAL EXPENSE							
1.00		0.00	0	0	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	36,540	0		2.00
3.00	OPERATION OF PLANT	7.00	0	752	0		3.00
5.00	HOUSEKEEPING	9.00	0	45	0		5.00
6.00	DIETARY	10.00	0	4,350	0		6.00
9.00	ADULTS & PEDIATRICS	30.00	0	14,407	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	5,217	0		10.00
11.00	SKILLED NURSING FACILITY	44.00	0	270	0		11.00
12.00	OPERATING ROOM	50.00	0	24,624	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,007	0		13.00
15.00	LABORATORY	60.00	0	31,320	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	49,689	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	22,140	0		17.00
21.00	DRUGS CHARGED TO PATIENTS	73.00	0	45,408	0		21.00
22.00	CLINIC	90.00	0	5,488	0		22.00
24.00	EMERGENCY	91.00	0	10,435	0		24.00
27.00	MOB	194.00	0	61,285	0		27.00
	TOTALS		0	316,977			
H - BUSINESS HEALTH SER							
1.00	MOB	194.00	30,915	22,600	0		1.00
	TOTALS		30,915	22,600			
I - INTEREST							
1.00	INTEREST EXPENSE	113.00	0	354,701	0		1.00
2.00		0.00	0	0	10		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	354,701			
J - PROPERTY TAX							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	2,776	9		1.00
	TOTALS		0	2,776			
K - QUALITY SERVICES							
1.00	ADULTS & PEDIATRICS	30.00	27,665	3,333	0		1.00
	TOTALS		27,665	3,333			
L - HEALTH INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	100,788	0		1.00
2.00	OPERATION OF PLANT	7.00	0	24,263	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	3,521	0		3.00
4.00	HOUSEKEEPING	9.00	0	19,272	0		4.00
5.00	DIETARY	10.00	0	21,021	0		5.00
7.00	NURSING ADMINISTRATION	13.00	0	126	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	11,734	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	63,362	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	11,245	0		10.00

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet A-6
Date/Time Prepared:
2/9/2012 10:27 am

		Decreases					
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
6.00	7.00	8.00	9.00	10.00			
11.00	SKILLED NURSING FACILITY	44.00	0	76,423	0	11.00	
12.00	OPERATING ROOM	50.00	0	23,550	0	12.00	
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	34,964	0	13.00	
15.00	LABORATORY	60.00	0	36,764	0	15.00	
16.00	RESPIRATORY THERAPY	65.00	0	11,432	0	16.00	
17.00	PHYSICAL THERAPY	66.00	0	17,139	0	17.00	
18.00	OCCUPATIONAL THERAPY	67.00	0	13,172	0	18.00	
19.00	SPEECH PATHOLOGY	68.00	0	8,189	0	19.00	
22.00	DRUGS CHARGED TO PATIENTS	73.00	0	529	0	22.00	
23.00	CLINIC	90.00	0	16,044	0	23.00	
24.00	DIABETES	90.01	0	2,287	0	24.00	
25.00	OP PSYCH	90.02	0	2,217	0	25.00	
26.00	EMERGENCY	91.00	0	44,705	0	26.00	
28.00	HOME HEALTH AGENCY	101.00	0	15,772	0	28.00	
30.00	FOUNDATION	194.01	0	123,358	0	30.00	
	TOTALS		0	681,877			
500.00	Grand Total: Decreases		276,295	3,143,577		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/9/2012 10:27 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	421,244	232,449	0	232,449	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	18,092,390	0	0	0	87,147	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	12,405,055	225,382	0	225,382	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	30,918,689	457,831	0	457,831	87,147	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	30,918,689	457,831	0	457,831	87,147	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	2,720,174	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,720,174	0	0	0	0	3.00
COMPUTATION OF RATIOS							
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/9/2012 10:27 am

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	653,693	0		1.00		
2.00	Land Improvements	0	0		2.00		
3.00	Buildings and Fixtures	18,005,243	0		3.00		
4.00	Building Improvements	0	0		4.00		
5.00	Fixed Equipment	0	0		5.00		
6.00	Movable Equipment	12,630,437	0		6.00		
7.00	HIT designated Assets	0	0		7.00		
8.00	Subtotal (sum of lines 1-7)	31,289,373	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	31,289,373	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	2,720,174		1.00		
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00		
3.00	Total (sum of lines 1-2)	0	2,720,174		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	988,674	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,040,203	610,397	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,028,877	610,397	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet A-7 Parts I-III Date/Time Prepared: 2/9/2012 10:27 am
---	----------------------	---	--

SUMMARY OF CAPITAL

Cost Center Description	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	988,674	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,650,600	2.00
3.00 Total (sum of lines 1-2)	0	0	0	0	2,639,274	3.00

	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted		Line #			
			1.00	2.00			3.00	4.00
1.00			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	1.00		
2.00	B	-60,919	0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	2.00		
3.00		0	0		0.00	3.00		
4.00		0	0		0.00	4.00		
5.00		0	0		0.00	5.00		
6.00		0	0		0.00	6.00		
7.00	A	-9,491	0	OPERATION OF PLANT	7.00	7.00		
8.00		0	0		0.00	8.00		
9.00		0	0		0.00	9.00		
10.00	A-8-2	-543,094	0		10.00	10.00		
11.00		0	0		0.00	11.00		
12.00	A-8-1	0	0		12.00	12.00		
13.00		0	0		0.00	13.00		
14.00	B	-179,720	0	CAFETERIA	11.00	14.00		
15.00	B	-600	0	ADMINISTRATIVE & GENERAL	5.00	15.00		
16.00		0	0		0.00	16.00		
17.00		0	0		0.00	17.00		
18.00	B	-8,355	0	MEDICAL RECORDS & LIBRARY	16.00	18.00		
19.00		0	0		0.00	19.00		
20.00		0	0		0.00	20.00		
21.00		0	0		0.00	21.00		
22.00		0	0		0.00	22.00		
23.00	A-8-3	0	0	RESPIRATORY THERAPY	65.00	23.00		
24.00	A-8-3	0	0	PHYSICAL THERAPY	66.00	24.00		
25.00		0	0	*** Cost Center Deleted ***	114.00	25.00		
26.00		0	0	NEW CAP REL COSTS-BLDG & FIXT	1.00	26.00		
27.00		0	0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	27.00		
28.00		0	0	*** Cost Center Deleted ***	19.00	28.00		
29.00		0	0		0.00	29.00		
30.00	A-8-3	0	0	OCCUPATIONAL THERAPY	67.00	30.00		
31.00	A-8-3	0	0	SPEECH PATHOLOGY	68.00	31.00		
32.00		0	0		0.00	32.00		
33.00	B	-47,303	0	ADMINISTRATIVE & GENERAL	5.00	33.00		
33.01		0	0		0.00	33.01		
33.02	A	-43,056	0	ADMINISTRATIVE & GENERAL	5.00	33.02		
33.03	A	-248,727	0	ADMINISTRATIVE & GENERAL	5.00	33.03		
34.00	A	108,449	0	EMPLOYEE BENEFITS	4.00	34.00		
35.00		0	0		0.00	35.00		
36.00	A	-1,112,714	0	ADMINISTRATIVE & GENERAL	5.00	36.00		
37.00	A	-691,297	0	NEW CAP REL COSTS-BLDG & FIXT	1.00	37.00		
38.00		0	0		0.00	38.00		
39.00		0	0		0.00	39.00		
40.00		0	0		0.00	40.00		
41.00		0	0		0.00	41.00		
42.00		0	0		0.00	42.00		
43.00		0	0		0.00	43.00		
44.00		0	0		0.00	44.00		
45.00		0	0		0.00	45.00		
50.00		-2,836,827				50.00		
TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)								

	5.00	Ref.	
1.00 Investment income - buildings and fixtures (chapter 2)	0		1.00
2.00 Investment income - movable equipment (chapter 2)	10		2.00
3.00 Investment income - other (chapter 2)	0		3.00
4.00 Trade, quantity, and time discounts (chapter 8)	0		4.00
5.00 Refunds and rebates of expenses (chapter 8)	0		5.00
6.00 Rental of provider space by suppliers (chapter 8)	0		6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	0		7.00
8.00 Television and radio service (chapter 21)	0		8.00
9.00 Parking lot (chapter 21)	0		9.00
10.00 Provider-based physician adjustment	0		10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	0		11.00
12.00 Related organization transactions (chapter 10)	0		12.00
13.00 Laundry and linen service	0		13.00
14.00 Cafeteria-employees and guests	0		14.00
15.00 Rental of quarters to employee and others	0		15.00
16.00 Sale of medical and surgical supplies to other than patients	0		16.00
17.00 Sale of drugs to other than patients	0		17.00
18.00 Sale of medical records and abstracts	0		18.00
19.00 Nursing school (tuition, fees, books, etc.)	0		19.00
20.00 Vending machines	0		20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)	0		21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0		22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			25.00
26.00 Depreciation - buildings and fixtures	0		26.00
27.00 Depreciation - movable equipment	0		27.00
28.00 Non-physician Anesthetist			28.00
29.00 Physicians' assistant	0		29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)			30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	0		32.00
33.00 MISC INCOME	0		33.00
33.01	0		33.01
33.02 PHYSICIAN RECRUITING	0		33.02
33.03 ADVERTISING	0		33.03
34.00 EMPLOYEE DISCOUNT	0		34.00
35.00	0		35.00
36.00 ASC SETTLEMENT	0		36.00
37.00 NURSING HOME WRITE DOWN	9		37.00
38.00	0		38.00
39.00	0		39.00
40.00	0		40.00
41.00	0		41.00
42.00	0		42.00
43.00	0		43.00
44.00	0		44.00
45.00	0		45.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet A-8-2

Date/Time Prepared:
2/9/2012 10:27 am

	1.00	2.00	3.00	4.00	
1.00	50.00	OR	451,906	451,906	1.00
2.00	65.00	RT	80,523	30,323	2.00
3.00	90.00	GERI PSYCH	27,516	0	3.00
4.00	90.02	OP PSYCH	60,865	60,865	4.00
5.00	91.00	ER	161,500	0	5.00
6.00	0.00		0	0	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00	TOTAL (lines 1.00 through 199.00)		782,310	543,094	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet A-8-2

Date/Time Prepared:
2/9/2012 10:27 am

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	0	0	0	0	0	1.00
2.00	50,200	0	0	0	0	2.00
3.00	27,516	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	161,500	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	239,216					200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet A-8-2

Date/Time Prepared:
2/9/2012 10:27 am

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet A-8-2

Date/Time Prepared:
2/9/2012 10:27 am

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	451,906	1.00
2.00	0	30,323	2.00
3.00	0	0	3.00
4.00	0	60,865	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	543,094	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet B
Part I
Date/Time Prepared:
2/9/2012 10:27 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	988,674	988,674			1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,650,600		1,650,600		2.00
4.00	EMPLOYEE BENEFITS	457,536	6,399	10,682	474,617	4.00
5.00	ADMINISTRATIVE & GENERAL	3,360,978	55,829	93,207	57,597	3,567,611 5.00
7.00	OPERATION OF PLANT	1,204,245	132,819	221,745	10,151	1,568,960 7.00
8.00	LAUNDRY & LINEN SERVICE	120,017	18,071	30,170	1,864	170,122 8.00
9.00	HOUSEKEEPING	473,573	9,641	16,097	10,834	510,145 9.00
10.00	DIETARY	324,915	48,207	80,483	6,343	459,948 10.00
11.00	CAFETERIA	240,471	0	0	7,607	248,078 11.00
13.00	NURSING ADMINISTRATION	65,001	3,101	5,177	1,309	74,588 13.00
16.00	MEDICAL RECORDS & LIBRARY	388,637	17,165	28,657	7,472	441,931 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,517,545	100,761	168,221	38,686	1,825,213 30.00
31.00	INTENSIVE CARE UNIT	334,004	29,307	48,928	9,433	421,672 31.00
44.00	SKILLED NURSING FACILITY	1,542,098	98,632	164,666	39,992	1,845,388 44.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	748,461	56,440	94,228	13,449	912,578 50.00
54.00	RADIOLOGY-DIAGNOSTIC	1,295,072	36,721	61,305	22,563	1,415,661 54.00
54.03	NUCLEAR MEDICINE-DIAGNOSTIC	147,687	4,586	7,656	0	159,929 54.03
60.00	LABORATORY	1,418,377	21,292	35,547	22,373	1,497,589 60.00
65.00	RESPIRATORY THERAPY	594,052	14,282	23,844	11,192	643,370 65.00
66.00	PHYSICAL THERAPY	805,065	34,897	58,261	22,553	920,776 66.00
67.00	OCCUPATIONAL THERAPY	307,132	8,921	14,893	8,462	339,408 67.00
68.00	SPEECH PATHOLOGY	173,112	677	1,130	4,510	179,429 68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	230,868	39,188	65,425	0	335,481 71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	288,520	0	0	0	288,520 72.00
73.00	DRUGS CHARGED TO PATIENTS	734,639	12,349	20,617	7,959	775,564 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	334,680	23,476	39,193	5,531	402,880 90.00
90.01	DIABETES	95,154	15,265	25,485	2,532	138,436 90.01
90.02	OP PSYCH	62,824	2,195	3,664	1,733	70,416 90.02
91.00	EMERGENCY	1,266,844	96,961	161,877	27,270	1,552,952 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
93.00	CARDIAC REHAB	0	0	0	0	0 93.00
OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	377,473	4,728	7,893	9,024	399,118 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0 113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	21,548,254	891,910	1,489,051	350,439	21,165,763 118.00
NONREIMBURSABLE COST CENTERS						
194.00	MOB	5,919,910	81,259	135,663	122,314	6,259,146 194.00
194.01	FOUNDATION	-7,166	15,505	25,886	1,864	36,089 194.01
194.02	ASC	852,735	0	0	0	852,735 194.02
200.00	Gross Foot Adjustments					0 200.00
201.00	Negative Cost Centers					0 201.00
202.00	TOTAL (sum lines 118-201)	28,313,733	988,674	1,650,600	474,617	28,313,733 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet B
Part I
Date/Time Prepared:
2/9/2012 10:27 am

Cost Center Description		ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 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	3,567,611					5.00
7.00	OPERATION OF PLANT	226,194	1,795,154				7.00
8.00	LAUNDRY & LINEN SERVICE	24,526	40,876	235,524			8.00
9.00	HOUSEKEEPING	73,547	21,809	10,299	615,800		9.00
10.00	DIETARY	66,310	109,043	3,202	38,759	677,262	10.00
11.00	CAFETERIA	35,765	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	10,753	7,014	0	2,493	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	63,712	38,826	0	13,801	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	263,137	227,915	80,531	81,012	227,027	30.00
31.00	INTENSIVE CARE UNIT	60,792	66,291	1,194	23,563	0	31.00
44.00	SKILLED NURSING FACILITY	266,046	223,101	71,042	79,300	450,235	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	131,565	127,666	16,970	45,378	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC	204,093	83,061	10,346	29,524	0	54.00
54.03	NUCLEAR MEDICINE-DIAGNOSTIC	23,057	10,373	0	3,687	0	54.03
60.00	LABORATORY	215,904	48,162	0	17,119	0	60.00
65.00	RESPIRATORY THERAPY	92,753	32,306	5,037	11,483	0	65.00
66.00	PHYSICAL THERAPY	132,746	78,936	16,831	28,058	0	66.00
67.00	OCCUPATIONAL THERAPY	48,932	20,179	0	7,172	0	67.00
68.00	SPEECH PATHOLOGY	25,868	1,531	0	544	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	48,366	88,643	0	31,508	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	41,595	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	111,812	27,934	0	9,929	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	58,082	53,102	0	18,875	0	90.00
90.01	DIABETES	19,958	34,528	0	12,273	0	90.01
90.02	OP PSYCH	10,152	4,964	0	1,765	0	90.02
91.00	EMERGENCY	223,886	219,322	20,072	77,957	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	CARDIAC REHAB	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	57,540	10,694	0	3,801	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,537,091	1,576,276	235,524	538,001	677,262	118.00
NONREIMBURSABLE COST CENTERS							
194.00	MOB	902,380	183,806	0	65,333	0	194.00
194.01	FOUNDATION	5,203	35,072	0	12,466	0	194.01
194.02	ASC	122,937	0	0	0	0	194.02
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)	3,567,611	1,795,154	235,524	615,800	677,262	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet B
Part I
Date/Time Prepared:
2/9/2012 10:27 am

Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	11.00	13.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA	283,843					11.00
13.00 NURSING ADMINISTRATION	559	95,407				13.00
16.00 MEDICAL RECORDS & LIBRARY	13,436	0	571,706			16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	49,124	31,998	125,830	2,911,787	0	30.00
31.00 INTENSIVE CARE UNIT	8,777	5,717	2,735	590,741	0	31.00
44.00 SKILLED NURSING FACILITY	58,421	38,053	19,148	3,050,734	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	10,637	0	61,547	1,306,341	0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	24,332	0	77,960	1,844,977	0	54.00
54.03 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	197,046	0	54.03
60.00 LABORATORY	26,031	0	47,870	1,852,675	0	60.00
65.00 RESPIRATORY THERAPY	11,476	0	21,883	818,308	0	65.00
66.00 PHYSICAL THERAPY	22,152	0	42,399	1,241,898	0	66.00
67.00 OCCUPATIONAL THERAPY	7,098	0	0	422,789	0	67.00
68.00 SPEECH PATHOLOGY	3,258	0	0	210,630	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,899	0	0	505,897	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	330,115	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	6,118	0	0	931,357	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	1,879	0	1,368	536,186	0	90.00
90.01 DIABETES	2,379	1,550	0	209,124	0	90.01
90.02 OP PSYCH	6,618	0	0	93,915	0	90.02
91.00 EMERGENCY	27,770	18,089	169,598	2,309,646	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 CARDIAC REHAB	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	0	0	0	471,153	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	281,964	95,407	570,338	19,835,319	0	118.00
NONREIMBURSABLE COST CENTERS						
194.00 MOB	0	0	1,368	7,412,033	0	194.00
194.01 FOUNDATION	1,879	0	0	90,709	0	194.01
194.02 ASC	0	0	0	975,672	0	194.02
200.00 Cross Foot Adjustments	0	0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	283,843	95,407	571,706	28,313,733	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet B
Part I
Date/Time Prepared:
2/9/2012 10:27 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	EMPLOYEE BENEFITS		4.00
5.00	ADMINISTRATIVE & GENERAL		5.00
7.00	OPERATION OF PLANT		7.00
8.00	LAUNDRY & LINEN SERVICE		8.00
9.00	HOUSEKEEPING		9.00
10.00	DIETARY		10.00
11.00	CAFETERIA		11.00
13.00	NURSING ADMINISTRATION		13.00
16.00	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	2,911,787	30.00
31.00	INTENSIVE CARE UNIT	590,741	31.00
44.00	SKILLED NURSING FACILITY	3,050,734	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	1,306,341	50.00
54.00	RADIOLOGY-DIAGNOSTIC	1,844,977	54.00
54.03	NUCLEAR MEDICINE-DIAGNOSTIC	197,046	54.03
60.00	LABORATORY	1,852,675	60.00
65.00	RESPIRATORY THERAPY	818,308	65.00
66.00	PHYSICAL THERAPY	1,241,898	66.00
67.00	OCCUPATIONAL THERAPY	422,789	67.00
68.00	SPEECH PATHOLOGY	210,630	68.00
69.00	ELECTROCARDIOLOGY	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	505,897	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	330,115	72.00
73.00	DRUGS CHARGED TO PATIENTS	931,357	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	536,186	90.00
90.01	DIABETES	209,124	90.01
90.02	OP PSYCH	93,915	90.02
91.00	EMERGENCY	2,309,646	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
93.00	CARDIAC REHAB	0	93.00
OTHER REIMBURSABLE COST CENTERS			
101.00	HOME HEALTH AGENCY	471,153	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	19,835,319	118.00
NONREIMBURSABLE COST CENTERS			
194.00	MOB	7,412,033	194.00
194.01	FOUNDATION	90,709	194.01
194.02	ASC	975,672	194.02
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	28,313,733	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet B
Part II
Date/Time Prepared:
2/9/2012 10:27 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	2A	4.00	
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	6,399	10,682	17,081	4.00
5.00	ADMINISTRATIVE & GENERAL	0	55,829	93,207	149,036	2,072
7.00	OPERATION OF PLANT	0	132,819	221,745	354,564	365
8.00	LAUNDRY & LINEN SERVICE	0	18,071	30,170	48,241	67
9.00	HOUSEKEEPING	0	9,641	16,097	25,738	390
10.00	DIETARY	0	48,207	80,483	128,690	228
11.00	CAFETERIA	0	0	0	0	274
13.00	NURSING ADMINISTRATION	0	3,101	5,177	8,278	47
16.00	MEDICAL RECORDS & LIBRARY	0	17,165	28,657	45,822	269
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	100,761	168,221	268,982	1,392
31.00	INTENSIVE CARE UNIT	0	29,307	48,928	78,235	339
44.00	SKILLED NURSING FACILITY	0	98,632	164,666	263,298	1,439
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	56,440	94,228	150,668	484
54.00	RADIOLOGY-DIAGNOSTIC	0	36,721	61,305	98,026	812
54.03	NUCLEAR MEDICINE-DIAGNOSTIC	0	4,586	7,656	12,242	0
60.00	LABORATORY	0	21,292	35,547	56,839	805
65.00	RESPIRATORY THERAPY	0	14,282	23,844	38,126	403
66.00	PHYSICAL THERAPY	0	34,897	58,261	93,158	811
67.00	OCCUPATIONAL THERAPY	0	8,921	14,893	23,814	304
68.00	SPEECH PATHOLOGY	0	677	1,130	1,807	162
69.00	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	39,188	65,425	104,613	0
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	DRUGS CHARGED TO PATIENTS	0	12,349	20,617	32,966	286
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	23,476	39,193	62,669	199
90.01	DIABETES	0	15,265	25,485	40,750	91
90.02	OP PSYCH	0	2,195	3,664	5,859	62
91.00	EMERGENCY	0	96,961	161,877	258,838	981
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	CARDIAC REHAB	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	4,728	7,893	12,621	325
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	891,910	1,489,051	2,380,961	12,607
NONREIMBURSABLE COST CENTERS						
194.00	MOB	0	81,259	135,663	216,922	4,407
194.01	FOUNDATION	0	15,505	25,886	41,391	67
194.02	ASC	0	0	0	0	0
200.00	Cross Foot Adjustments	0	0	0	0	0
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118-201)	0	988,674	1,650,600	2,639,274	17,081

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet B
Part II
Date/Time Prepared:
2/9/2012 10:27 am

Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL	151,108					5.00
7.00 OPERATION OF PLANT	9,580	364,509				7.00
8.00 LAUNDRY & LINEN SERVICE	1,039	8,300	57,647			8.00
9.00 HOUSEKEEPING	3,115	4,428	2,521	36,192		9.00
10.00 DIETARY	2,808	22,141	784	2,278	156,929	10.00
11.00 CAFETERIA	1,515	0	0	0	0	11.00
13.00 NURSING ADMINISTRATION	455	1,424	0	147	0	13.00
16.00 MEDICAL RECORDS & LIBRARY	2,698	7,884	0	811	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	11,145	46,280	19,710	4,759	52,605	30.00
31.00 INTENSIVE CARE UNIT	2,575	13,460	292	1,385	0	31.00
44.00 SKILLED NURSING FACILITY	11,268	45,301	17,388	4,661	104,324	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	5,572	25,923	4,154	2,667	0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	8,644	16,866	2,532	1,735	0	54.00
54.03 NUCLEAR MEDICINE-DIAGNOSTIC	977	2,106	0	217	0	54.03
60.00 LABORATORY	9,144	9,779	0	1,006	0	60.00
65.00 RESPIRATORY THERAPY	3,928	6,560	1,233	675	0	65.00
66.00 PHYSICAL THERAPY	5,622	16,028	4,120	1,649	0	66.00
67.00 OCCUPATIONAL THERAPY	2,072	4,097	0	422	0	67.00
68.00 SPEECH PATHOLOGY	1,096	311	0	32	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,048	17,999	0	1,852	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	1,762	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	4,736	5,672	0	584	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	2,460	10,782	0	1,109	0	90.00
90.01 DIABETES	845	7,011	0	721	0	90.01
90.02 OP PSYCH	430	1,008	0	104	0	90.02
91.00 EMERGENCY	9,482	44,534	4,913	4,582	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00 CARDIAC REHAB	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	2,437	2,172	0	223	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	107,453	320,066	57,647	31,619	156,929	118.00
NONREIMBURSABLE COST CENTERS						
194.00 MOB	38,228	37,322	0	3,840	0	194.00
194.01 FOUNDATION	220	7,121	0	733	0	194.01
194.02 ASC	5,207	0	0	0	0	194.02
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)	151,108	364,509	57,647	36,192	156,929	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet 8
Part II
Date/Time Prepared:
2/9/2012 10:27 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		11.00	13.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	1,789					11.00
13.00	NURSING ADMINISTRATION	4	10,355				13.00
16.00	MEDICAL RECORDS & LIBRARY	85	0	57,569			16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	310	3,473	12,671	421,327	0	30.00
31.00	INTENSIVE CARE UNIT	55	620	275	97,236	0	31.00
44.00	SKILLED NURSING FACILITY	366	4,131	1,928	454,104	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	67	0	6,198	195,733	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC	153	0	7,850	136,618	0	54.00
54.03	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	15,542	0	54.03
60.00	LABORATORY	164	0	4,820	82,557	0	60.00
65.00	RESPIRATORY THERAPY	72	0	2,204	53,201	0	65.00
66.00	PHYSICAL THERAPY	140	0	4,269	125,797	0	66.00
67.00	OCCUPATIONAL THERAPY	45	0	0	30,754	0	67.00
68.00	SPEECH PATHOLOGY	21	0	0	3,429	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	12	0	0	126,524	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,762	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	39	0	0	44,283	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	12	0	138	77,369	0	90.00
90.01	DIABETES	15	168	0	49,601	0	90.01
90.02	OP PSYCH	42	0	0	7,505	0	90.02
91.00	EMERGENCY	175	1,963	17,078	342,546	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	CARDIAC REHAB	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	0	0	0	17,778	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,777	10,355	57,431	2,283,666	0	118.00
NONREIMBURSABLE COST CENTERS							
194.00	MOB	0	0	138	300,857	0	194.00
194.01	FOUNDATION	12	0	0	49,544	0	194.01
194.02	ASC	0	0	0	5,207	0	194.02
200.00	Cross Foot Adjustments				0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,789	10,355	57,569	2,639,274	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet B
Part II
Date/time Prepared:
2/9/2012 10:27 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	EMPLOYEE BENEFITS		4.00
5.00	ADMINISTRATIVE & GENERAL		5.00
7.00	OPERATION OF PLANT		7.00
8.00	LAUNDRY & LINEN SERVICE		8.00
9.00	HOUSEKEEPING		9.00
10.00	DIETARY		10.00
11.00	CAFETERIA		11.00
13.00	NURSING ADMINISTRATION		13.00
16.00	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	421,327	30.00
31.00	INTENSIVE CARE UNIT	97,236	31.00
44.00	SKILLED NURSING FACILITY	454,104	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	195,733	50.00
54.00	RADIOLOGY-DIAGNOSTIC	136,618	54.00
54.03	NUCLEAR MEDICINE-DIAGNOSTIC	15,542	54.03
60.00	LABORATORY	82,557	60.00
65.00	RESPIRATORY THERAPY	53,201	65.00
66.00	PHYSICAL THERAPY	125,797	66.00
67.00	OCCUPATIONAL THERAPY	30,754	67.00
68.00	SPEECH PATHOLOGY	3,429	68.00
69.00	ELECTROCARDIOLOGY	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	126,524	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	1,762	72.00
73.00	DRUGS CHARGED TO PATIENTS	44,283	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	77,369	90.00
90.01	DIABETES	49,601	90.01
90.02	OP PSYCH	7,505	90.02
91.00	EMERGENCY	342,546	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
93.00	CARDIAC REHAB	0	93.00
OTHER REIMBURSABLE COST CENTERS			
101.00	HOME HEALTH AGENCY	17,778	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,283,666	118.00
NONREIMBURSABLE COST CENTERS			
194.00	MOB	300,857	194.00
194.01	FOUNDATION	49,544	194.01
194.02	ASC	5,207	194.02
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	2,639,274	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet B-1

Date/Time Prepared:
2/9/2012 10:27 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	90,546					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		90,546				2.00
4.00	EMPLOYEE BENEFITS	586	586	13,583,485			4.00
5.00	ADMINISTRATIVE & GENERAL	5,113	5,113	1,648,413	-3,567,611	24,746,122	5.00
7.00	OPERATION OF PLANT	12,164	12,164	290,511	0	1,568,960	7.00
8.00	LAUNDRY & LINEN SERVICE	1,655	1,655	53,350	0	170,122	8.00
9.00	HOUSEKEEPING	883	883	310,054	0	510,145	9.00
10.00	DIETARY	4,415	4,415	181,525	0	459,948	10.00
11.00	CAFETERIA	0	0	217,715	0	248,078	11.00
13.00	NURSING ADMINISTRATION	284	284	37,468	0	74,588	13.00
16.00	MEDICAL RECORDS & LIBRARY	1,572	1,572	213,838	0	441,931	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	9,228	9,228	1,107,176	0	1,825,213	30.00
31.00	INTENSIVE CARE UNIT	2,684	2,684	269,974	0	421,672	31.00
44.00	SKILLED NURSING FACILITY	9,033	9,033	1,144,553	0	1,845,388	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	5,169	5,169	384,904	0	912,578	50.00
54.00	RADIOLOGY-DIAGNOSTIC	3,363	3,363	645,748	0	1,415,661	54.00
54.03	NUCLEAR MEDICINE-DIAGNOSTIC	420	420	0	0	159,929	54.03
60.00	LABORATORY	1,950	1,950	640,313	0	1,497,589	60.00
65.00	RESPIRATORY THERAPY	1,308	1,308	320,304	0	643,370	65.00
66.00	PHYSICAL THERAPY	3,196	3,196	645,468	0	920,776	66.00
67.00	OCCUPATIONAL THERAPY	817	817	242,181	0	339,408	67.00
68.00	SPEECH PATHOLOGY	62	62	129,075	0	179,429	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,589	3,589	0	0	335,481	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	288,520	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,131	1,131	227,787	0	775,564	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	2,150	2,150	158,300	0	402,880	90.00
90.01	DIABETES	1,398	1,398	72,467	0	138,436	90.01
90.02	OP PSYCH	201	201	49,609	0	70,416	90.02
91.00	EMERGENCY	8,880	8,880	780,467	0	1,552,952	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	CARDIAC REHAB	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	433	433	258,253	0	399,118	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	81,684	81,684	10,029,453	-3,567,611	17,598,152	118.00
NONREIMBURSABLE COST CENTERS							
194.00	MOB	7,442	7,442	3,500,684	0	6,259,146	194.00
194.01	FOUNDATION	1,420	1,420	53,348	0	36,089	194.01
194.02	ASC	0	0	0	0	852,735	194.02
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)	988,674	1,650,600	474,617		3,567,611	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	10.919025	18.229408	0.034941		0.144168	203.00
204.00	Cost to be allocated (per wkst. B, Part II)			17,081		151,108	204.00
205.00	Unit cost multiplier (wkst. B, Part II)			0.001257		0.006106	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet B-1

Date/Time Prepared:
2/9/2012 10:27 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
<u>GENERAL SERVICE COST CENTERS</u>							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT	72,683					7.00
8.00	LAUNDRY & LINEN SERVICE	1,655	578,825				8.00
9.00	HOUSEKEEPING	883	25,312	70,145			9.00
10.00	DIETARY	4,415	7,870	4,415	61,734		10.00
11.00	CAFETERIA	0	0	0	0	295,298	11.00
13.00	NURSING ADMINISTRATION	284	0	284	0	582	13.00
16.00	MEDICAL RECORDS & LIBRARY	1,572	0	1,572	0	13,978	16.00
<u>INPATIENT ROUTINE SERVICE COST CENTERS</u>							
30.00	ADULTS & PEDIATRICS	9,228	197,911	9,228	20,694	51,106	30.00
31.00	INTENSIVE CARE UNIT	2,684	2,935	2,684	0	9,131	31.00
44.00	SKILLED NURSING FACILITY	9,033	174,593	9,033	41,040	60,778	44.00
<u>ANCILLARY SERVICE COST CENTERS</u>							
50.00	OPERATING RDOM	5,169	41,705	5,169	0	11,066	50.00
54.00	RADIOLOGY-DIAGNOSTIC	3,363	25,426	3,363	0	25,314	54.00
54.03	NUCLEAR MEDICINE-DIAGNOSTIC	420	0	420	0	0	54.03
60.00	LABORATORY	1,950	0	1,950	0	27,082	60.00
65.00	RESPIRATORY THERAPY	1,308	12,380	1,308	0	11,939	65.00
66.00	PHYSICAL THERAPY	3,196	41,365	3,196	0	23,046	66.00
67.00	OCCUPATIONAL THERAPY	817	0	817	0	7,384	67.00
68.00	SPEECH PATHOLOGY	62	0	62	0	3,390	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,589	0	3,589	0	1,976	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,131	0	1,131	0	6,365	73.00
<u>OUTPATIENT SERVICE COST CENTERS</u>							
90.00	CLINIC	2,150	0	2,150	0	1,955	90.00
90.01	DIABETES	1,398	0	1,398	0	2,475	90.01
90.02	OP PSYCH	201	0	201	0	6,885	90.02
91.00	EMERGENCY	8,880	49,328	8,880	0	28,891	91.00
92.00	OBSERVATION BEDS (NDN-DISTINCT PART)						92.00
93.00	CARDIAC REHAB	0	0	0	0	0	93.00
<u>OTHER REIMBURSABLE COST CENTERS</u>							
101.00	HOME HEALTH AGENCY	433	0	433	0	0	101.00
<u>SPECIAL PURPOSE COST CENTERS</u>							
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	63,821	578,825	61,283	61,734	293,343	118.00
<u>NONREIMBURSABLE COST CENTERS</u>							
194.00	MOB	7,442	0	7,442	0	0	194.00
194.01	FOUNDATION	1,420	0	1,420	0	1,955	194.01
194.02	ASC	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,795,154	235,524	615,800	677,262	283,843	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	24.698403	0.406900	8.778958	10.970648	0.961209	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	364,509	57,647	36,192	156,929	1,789	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	5.015052	0.099593	0.515960	2.542019	0.006058	205.00

Cost Center Description		NURSING ADMINISTRATION (NRSE FTE'S)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		13.00	16.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	EMPLOYEE BENEFITS			4.00
5.00	ADMINISTRATIVE & GENERAL			5.00
7.00	OPERATION OF PLANT			7.00
8.00	LAUNDRY & LINEN SERVICE			8.00
9.00	HOUSEKEEPING			9.00
10.00	DIETARY			10.00
11.00	CAFETERIA			11.00
13.00	NURSING ADMINISTRATION	152,381		13.00
16.00	MEDICAL RECORDS & LIBRARY	0	418	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	51,106	92	30.00
31.00	INTENSIVE CARE UNIT	9,131	2	31.00
44.00	SKILLED NURSING FACILITY	60,778	14	44.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	45	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	57	54.00
54.03	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	54.03
60.00	LABORATORY	0	35	60.00
65.00	RESPIRATORY THERAPY	0	16	65.00
66.00	PHYSICAL THERAPY	0	31	66.00
67.00	OCCUPATIONAL THERAPY	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0	1	90.00
90.01	DIABETES	2,475	0	90.01
90.02	OP PSYCH	0	0	90.02
91.00	EMERGENCY	28,891	124	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	CARDIAC REHAB	0	0	93.00
OTHER REIMBURSABLE COST CENTERS				
101.00	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	152,381	417	118.00
NONREIMBURSABLE COST CENTERS				
194.00	MOB	0	1	194.00
194.01	FOUNDATION	0	0	194.01
194.02	ASC	0	0	194.02
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)	95,407	571,706	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.626108	1,367.717703	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	10,355	57,569	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.067955	137.724880	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet C Part I Date/Time Prepared: 2/9/2012 10:27 am
--	----------------------	---	---

Cost Center Description	Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Hospital		Total Costs	
			Costs			
			Total Costs	RCE Disallowance		
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS		2,911,787		0	30.00
31.00	INTENSIVE CARE UNIT		590,741		0	31.00
44.00	SKILLED NURSING FACILITY		3,050,734		0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM		1,306,341		0	50.00
54.00	RADIOLOGY-DIAGNOSTIC		1,844,977		0	54.00
54.03	NUCLEAR MEDICINE-DIAGNOSTIC		197,046		0	54.03
60.00	LABORATORY		1,852,675		0	60.00
65.00	RESPIRATORY THERAPY	0	818,308		0	65.00
66.00	PHYSICAL THERAPY	0	1,241,898		0	66.00
67.00	OCCUPATIONAL THERAPY	0	422,789		0	67.00
68.00	SPEECH PATHOLOGY	0	210,630		0	68.00
69.00	ELECTROCARDIOLOGY		0		0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		505,897		0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS		330,115		0	72.00
73.00	DRUGS CHARGED TO PATIENTS		931,357		0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC		536,186		0	90.00
90.01	DIABETES		209,124		0	90.01
90.02	OP PSYCH		93,915		0	90.02
91.00	EMERGENCY		2,309,646		0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		433,633		0	92.00
93.00	CARDIAC REHAB		0		0	93.00
OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY		471,153		0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	0	20,268,952		0	200.00
201.00	Less Observation Beds		433,633		0	201.00
202.00	Total (see instructions)	0	19,835,319		0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet C
Part I
Date/Time Prepared:
2/9/2012 10:27 am

Cost Center Description	Title XVIII			Hospital	Cost	
	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,678,653		1,678,653		30.00
31.00	INTENSIVE CARE UNIT	257,823		257,823		31.00
44.00	SKILLED NURSING FACILITY	2,106,413		2,106,413		44.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	736,878	2,660,266	3,397,144	0.384541	50.00
54.00	RADIOLOGY-DIAGNOSTIC	283,722	9,337,938	9,621,660	0.191752	54.00
54.03	NUCLEAR MEDICINE-DIAGNOSTIC	32,995	265,229	298,224	0.660732	54.03
60.00	LABORATORY	901,508	6,169,790	7,071,298	0.261999	60.00
65.00	RESPIRATORY THERAPY	558,034	1,505,900	2,063,934	0.396480	65.00
66.00	PHYSICAL THERAPY	689,925	2,819,848	3,509,773	0.353840	66.00
67.00	OCCUPATIONAL THERAPY	271,772	1,180,936	1,452,708	0.291035	67.00
68.00	SPEECH PATHOLOGY	69,067	573,053	642,120	0.328023	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	885,599	566,546	1,452,145	0.348379	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	617,390	59,627	677,017	0.487602	72.00
73.00	DRUGS CHARGED TO PATIENTS	833,089	1,295,774	2,128,863	0.437490	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	209,935	209,935	2.554057	90.00
90.01	DIABETES	0	23,434	23,434	8.923957	90.01
90.02	OP PSYCH	0	0	0	0.000000	90.02
91.00	EMERGENCY	8,396	6,230,723	6,239,119	0.370188	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	10,753	268,878	279,631	1.550733	92.00
93.00	CARDIAC REHAB	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	9,942,017	33,167,877	43,109,894		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	9,942,017	33,167,877	43,109,894		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet C
Part I
Date/Time Prepared:
2/9/2012 10:27 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
44.00	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000			50.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.03	NUCLEAR MEDICINE-DIAGNOSTIC	0.000000			54.03
60.00	LABORATORY	0.000000			60.00
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 PATIENTS	0.000000			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0.000000			90.00
90.01	DIABETES	0.000000			90.01
90.02	OP PSYCH	0.000000			90.02
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
93.00	CARDIAC REHAB	0.000000			93.00
OTHER REIMBURSABLE COST CENTERS					
101.00	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
113.00	INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet C
Part I
Date/Time Prepared:
2/9/2012 10:27 am

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE			
				Total Costs	Disallowance		Total Costs
1.00	2.00	3.00	4.00	5.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,911,787		2,911,787	0	2,911,787	30.00
31.00	INTENSIVE CARE UNIT	590,741		590,741	0	590,741	31.00
44.00	SKILLED NURSING FACILITY	3,050,734		3,050,734	0	3,050,734	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	1,306,341		1,306,341	0	1,306,341	50.00
54.00	RADIOLOGY-DIAGNOSTIC	1,844,977		1,844,977	0	1,844,977	54.00
54.03	NUCLEAR MEDICINE-DIAGNOSTIC	197,046		197,046	0	197,046	54.03
60.00	LABORATORY	1,852,675		1,852,675	0	1,852,675	60.00
65.00	RESPIRATORY THERAPY	818,308	0	818,308	0	818,308	65.00
66.00	PHYSICAL THERAPY	1,241,898	0	1,241,898	0	1,241,898	66.00
67.00	OCCUPATIONAL THERAPY	422,789	0	422,789	0	422,789	67.00
68.00	SPEECH PATHOLOGY	210,630	0	210,630	0	210,630	68.00
69.00	ELECTROCARDIOLOGY	0		0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	505,897		505,897	0	505,897	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	330,115		330,115	0	330,115	72.00
73.00	DRUGS CHARGED TO PATIENTS	931,357		931,357	0	931,357	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	536,186		536,186	0	536,186	90.00
90.01	DIABETES	209,124		209,124	0	209,124	90.01
90.02	OP PSYCH	93,915		93,915	0	93,915	90.02
91.00	EMERGENCY	2,309,646		2,309,646	0	2,309,646	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	433,633		433,633	0	433,633	92.00
93.00	CARDIAC REHAB	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	471,153		471,153		471,153	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	20,268,952	0	20,268,952	0	20,268,952	200.00
201.00	Less Observation Beds	433,633		433,633		433,633	201.00
202.00	Total (see instructions)	19,835,319	0	19,835,319	0	19,835,319	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet C
Part I
Date/Time Prepared:
2/9/2012 10:27 am

Cost Center Description	Title XIX			Hospital	PPS		
	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,678,653		1,678,653			30.00
31.00	INTENSIVE CARE UNIT	257,823		257,823			31.00
44.00	SKILLED NURSING FACILITY	2,106,413		2,106,413			44.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	736,878	2,660,266	3,397,144	0.384541	0.000000	50.00
54.00	RADIOLOGY-DIAGNOSTIC	283,722	9,337,938	9,621,660	0.191752	0.000000	54.00
54.03	NUCLEAR MEDICINE-DIAGNOSTIC	32,995	265,229	298,224	0.660732	0.000000	54.03
60.00	LABORATORY	901,508	6,169,790	7,071,298	0.261999	0.000000	60.00
65.00	RESPIRATORY THERAPY	558,034	1,505,900	2,063,934	0.396480	0.000000	65.00
66.00	PHYSICAL THERAPY	689,925	2,819,848	3,509,773	0.353840	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	271,772	1,180,936	1,452,708	0.291035	0.000000	67.00
68.00	SPEECH PATHOLOGY	69,067	573,053	642,120	0.328023	0.000000	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	885,599	566,546	1,452,145	0.348379	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	617,390	59,627	677,017	0.487602	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	833,089	1,295,774	2,128,863	0.437490	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	0	209,935	209,935	2.554057	0.000000	90.00
90.01	DIABETES	0	23,434	23,434	8.923957	0.000000	90.01
90.02	OP PSYCH	0	0	0	0.000000	0.000000	90.02
91.00	EMERGENCY	8,396	6,230,723	6,239,119	0.370188	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	10,753	268,878	279,631	1.550733	0.000000	92.00
93.00	CARDIAC REHAB	0	0	0	0.000000	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	9,942,017	33,167,877	43,109,894			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	9,942,017	33,167,877	43,109,894			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet C Part I Date/Time Prepared: 2/9/2012 10:27 am
	Title XIX	Hospital	PPS

Cost Center Description	PPS Inpatient Ratio		
	11.00		
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS			30.00
31.00 INTENSIVE CARE UNIT			31.00
44.00 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	0.384541		50.00
54.00 RADIOLOGY-DIAGNOSTIC	0.191752		54.00
54.03 NUCLEAR MEDICINE-DIAGNOSTIC	0.660732		54.03
60.00 LABORATORY	0.261999		60.00
65.00 RESPIRATORY THERAPY	0.396480		65.00
66.00 PHYSICAL THERAPY	0.353840		66.00
67.00 OCCUPATIONAL THERAPY	0.291035		67.00
68.00 SPEECH PATHOLOGY	0.328023		68.00
69.00 ELECTROCARDIOLOGY	0.000000		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.348379		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0.487602		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.437490		73.00
OUTPATIENT SERVICE COST CENTERS			
90.00 CLINIC	2.554057		90.00
90.01 DIABETES	8.923957		90.01
90.02 OP PSYCH	0.000000		90.02
91.00 EMERGENCY	0.370188		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.550733		92.00
93.00 CARDIAC REHAB	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS			
101.00 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS			
113.00 INTEREST EXPENSE			113.00
200.00 Subtotal (see instructions)			200.00
201.00 Less observation beds			201.00
202.00 Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 151319 Period: From 10/31/2010 To 09/30/2011 Worksheet D Part II Date/Time Prepared: 2/9/2012 10:27 am

Cost Center Description		Title XVIII			Hospital		Cost
		Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	195,733	3,397,144	0.057617	359,641	20,721	50.00
54.00	RADIOLOGY-DIAGNOSTIC	136,618	9,621,660	0.014199	154,608	2,195	54.00
54.03	NUCLEAR MEDICINE-DIAGNOSTIC	15,542	298,224	0.052115	23,298	1,214	54.03
60.00	LABORATORY	82,557	7,071,298	0.011675	494,266	5,771	60.00
65.00	RESPIRATORY THERAPY	53,201	2,063,934	0.025777	229,162	5,907	65.00
66.00	PHYSICAL THERAPY	125,797	3,509,773	0.035842	140,519	5,036	66.00
67.00	OCCUPATIONAL THERAPY	30,754	1,452,708	0.021170	35,030	742	67.00
68.00	SPEECH PATHOLOGY	3,429	642,120	0.005340	24,814	133	68.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	126,524	1,452,145	0.087129	264,317	23,030	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	1,762	677,017	0.002603	606,371	1,578	72.00
73.00	DRUGS CHARGED TO PATIENTS	44,783	2,128,863	0.020801	260,997	5,429	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	77,369	209,935	0.368538	0	0	90.00
90.01	DIABETES	49,601	23,434	2.116625	0	0	90.01
90.02	OP PSYCH	7,505	0	0.000000	0	0	90.02
91.00	EMERGENCY	342,546	6,239,119	0.054903	2,966	163	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	279,631	0.000000	73	0	92.00
93.00	CARDIAC REHAB	0	0	0.000000	0	0	93.00
200.00	Total (lines 50-199)	1,293,221	39,067,005		2,596,062	71,919	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS
 Provider CCN: 151319
 Period: From 10/31/2010 To 09/30/2011
 Worksheet D Part IV
 Date/Time Prepared: 2/9/2012 10:27 am

Cost Center Description	Title XVIII				Hospital	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0	0	0	0	0	0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
54.03 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	0	54.03
60.00 LABORATORY	0	0	0	0	0	0	60.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00 CLINIC	0	0	0	0	0	0	90.00
90.01 DIABETES	0	0	0	0	0	0	90.01
90.02 OP PSYCH	0	0	0	0	0	0	90.02
91.00 EMERGENCY	0	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
93.00 CARDIAC REHAB	0	0	0	0	0	0	93.00
200.00 Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet D
Part IV
Date/Time Prepared:
2/9/2012 10:27 am

Cost Center Description		Title XVIII			Hospital		Cost
		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	3,397,144	0.000000	0.000000	359,641	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	9,621,660	0.000000	0.000000	154,608	54.00
54.03	NUCLEAR MEDICINE-DIAGNOSTIC	0	298,224	0.000000	0.000000	23,298	54.03
60.00	LABORATORY	0	7,071,298	0.000000	0.000000	494,266	60.00
65.00	RESPIRATORY THERAPY	0	2,063,934	0.000000	0.000000	229,162	65.00
66.00	PHYSICAL THERAPY	0	3,509,773	0.000000	0.000000	140,519	66.00
67.00	OCCUPATIONAL THERAPY	0	1,452,708	0.000000	0.000000	35,030	67.00
68.00	SPEECH PATHOLOGY	0	642,120	0.000000	0.000000	24,814	68.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,452,145	0.000000	0.000000	264,317	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	677,017	0.000000	0.000000	606,371	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	2,128,863	0.000000	0.000000	260,997	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	0	209,935	0.000000	0.000000	0	90.00
90.01	DIABETES	0	23,434	0.000000	0.000000	0	90.01
90.02	OP PSYCH	0	0	0.000000	0.000000	0	90.02
91.00	EMERGENCY	0	6,239,119	0.000000	0.000000	2,966	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	279,631	0.000000	0.000000	73	92.00
93.00	CARDIAC REHAB	0	0	0.000000	0.000000	0	93.00
200.00	Total (lines 50-199)	0	39,067,005			2,596,062	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS
 Provider CCN: 151319
 Period: From 10/31/2010 To 09/30/2011
 Worksheet D Part IV
 Date/Time Prepared: 2/9/2012 10:27 am

Cost Center Description	Title XVIII			Hospital	Cost	
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.03 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.03
60.00 LABORATORY	0	0	0	0	0	60.00
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 PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	0	0	0	0	90.00
90.01 DIABETES	0	0	0	0	0	90.01
90.02 OP PSYCH	0	0	0	0	0	90.02
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 CARDIAC REHAB	0	0	0	0	0	93.00
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: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet D Part IV Date/Time Prepared: 2/9/2012 10:27 am
--	----------------------	---	--

Cost Center Description	Title XVIII		Hospital	Cost
	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
	23.00	24.00		
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	0		50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.03 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		54.03
60.00 LABORATORY	0	0		60.00
65.00 RESPIRATORY THERAPY	0	0		65.00
66.00 PHYSICAL THERAPY	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0		68.00
69.00 ELECTROCARDIOLOGY	0	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 CLINIC	0	0		90.00
90.01 DIABETES	0	0		90.01
90.02 OP PSYCH	0	0		90.02
91.00 EMERGENCY	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00 CARDIAC REHAB	0	0		93.00
200.00 Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet D
Part V
Date/Time Prepared:
2/9/2012 10:27 am

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Hospital	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)		
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0.384541	0	737,313	0		50.00
54.00 RADIOLOGY-DIAGNOSTIC	0.191752	0	2,386,925	0		54.00
54.03 NUCLEAR MEDICINE-DIAGNOSTIC	0.660732	0	95,140	0		54.03
60.00 LABORATORY	0.261999	0	1,952,845	0		60.00
65.00 RESPIRATORY THERAPY	0.396480	0	446,432	0		65.00
66.00 PHYSICAL THERAPY	0.353840	0	932,543	0		66.00
67.00 OCCUPATIONAL THERAPY	0.291035	0	206,788	0		67.00
68.00 SPEECH PATHOLOGY	0.328023	0	107,426	0		68.00
69.00 ELECTROCARDIOLOGY	0.000000	0	0	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.348379	0	78,030	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0.487602	0	55,776	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.437490	0	262,432	2,762		73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	2.554057	0	207,994	0		90.00
90.01 DIABETES	8.923957	0	6,462	0		90.01
90.02 OP PSYCH	0.000000	0	0	0		90.02
91.00 EMERGENCY	0.370188	0	1,232,205	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.550733	0	113,004	0		92.00
93.00 CARDIAC REHAB	0.000000	0	0	0		93.00
200.00 Subtotal (see instructions)		0	8,821,315	2,762		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	8,821,315	2,762		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 2/9/2012 10:27 am
--	----------------------	---	---

Cost Center Description	Title XVIII			Hospital	Cost
	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	283,527	0		50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	457,698	0		54.00
54.03 NUCLEAR MEDICINE-DIAGNOSTIC	0	62,862	0		54.03
60.00 LABORATORY	0	511,643	0		60.00
65.00 RESPIRATORY THERAPY	0	177,001	0		65.00
66.00 PHYSICAL THERAPY	0	329,971	0		66.00
67.00 OCCUPATIONAL THERAPY	0	60,183	0		67.00
68.00 SPEECH PATHOLOGY	0	35,238	0		68.00
69.00 ELECTROCARDIOLOGY	0	0	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	27,184	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	27,196	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	114,811	1,208		73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	0	531,229	0		90.00
90.01 DIABETES	0	57,667	0		90.01
90.02 OP PSYCH	0	0	0		90.02
91.00 EMERGENCY	0	456,148	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	175,239	0		92.00
93.00 CARDIAC REHAB	0	0	0		93.00
200.00 Subtotal (see instructions)	0	3,307,597	1,208		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	3,307,597	1,208		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151319 Component CCN: 152319	Period: From 10/31/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 2/9/2012 10:27 am
--	---	---	---

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)	
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.384541	0	0	0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0.191752	0	0	0	54.00
54.03 NUCLEAR MEDICINE-DIAGNOSTIC	0.660732	0	0	0	54.03
60.00 LABORATORY	0.261999	0	0	0	60.00
65.00 RESPIRATORY THERAPY	0.396480	0	0	0	65.00
66.00 PHYSICAL THERAPY	0.353840	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0.291035	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0.328023	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.348379	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0.487602	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.437490	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	2.554057	0	0	0	90.00
90.01 DIABETES	8.923957	0	0	0	90.01
90.02 OP PSYCH	0.000000	0	0	0	90.02
91.00 EMERGENCY	0.370188	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.550733	0	0	0	92.00
93.00 CARDIAC REHAB	0.000000	0	0	0	93.00
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: 151319 Component CCN: 152319	Period: From 10/31/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 2/9/2012 10:27 am
--	---	---	---

Cost Center Description	Costs			Swing Beds - SNF	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
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.03 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0		54.03
60.00 LABORATORY	0	0	0		60.00
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 PATIENTS	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	0	0	0		90.00
90.01 DIABETES	0	0	0		90.01
90.02 OP PSYCH	0	0	0		90.02
91.00 EMERGENCY	0	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00 CARDIAC REHAB	0	0	0		93.00
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/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151319
Component CCN: 155093

Period:
From 10/31/2010
To 09/30/2011

Worksheet D
Part IV
Date/Time Prepared:
2/9/2012 10:27 am
PPS

Title XVIII

Skilled Nursing Facility

Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.03 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.03
60.00 LABORATORY	0	0	0	0	0	60.00
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 PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	0	0	0	0	90.00
90.01 DIABETES	0	0	0	0	0	90.01
90.02 OP PSYCH	0	0	0	0	0	90.02
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 CARDIAC REHAB	0	0	0	0	0	93.00
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: 151319 Component CCN: 155093	Period: From 10/31/2010 To 09/30/2011	Worksheet D Part IV Date/Time Prepared: 2/9/2012 10:27 am
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	3,397,144	0.000000	0.000000	0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	9,621,660	0.000000	0.000000	10,096	54.00
54.03 NUCLEAR MEDICINE-DIAGNOSTIC	0	298,224	0.000000	0.000000	1,694	54.03
60.00 LABORATORY	0	7,071,298	0.000000	0.000000	79,144	60.00
65.00 RESPIRATORY THERAPY	0	2,063,934	0.000000	0.000000	27,112	65.00
66.00 PHYSICAL THERAPY	0	3,509,773	0.000000	0.000000	298,989	66.00
67.00 OCCUPATIONAL THERAPY	0	1,452,708	0.000000	0.000000	144,716	67.00
68.00 SPEECH PATHOLOGY	0	642,120	0.000000	0.000000	28,560	68.00
69.00 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,452,145	0.000000	0.000000	8,904	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	677,017	0.000000	0.000000	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	2,128,863	0.000000	0.000000	50,770	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	209,935	0.000000	0.000000	0	90.00
90.01 DIABETES	0	23,434	0.000000	0.000000	0	90.01
90.02 OP PSYCH	0	0	0.000000	0.000000	0	90.02
91.00 EMERGENCY	0	6,239,119	0.000000	0.000000	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	279,631	0.000000	0.000000	0	92.00
93.00 CARDIAC REHAB	0	0	0.000000	0.000000	0	93.00
200.00 Total (lines 50-199)	0	39,067,005			649,985	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151319 Component CCN:155093	Period: From 10/31/2010 To 09/30/2011	Worksheet D Part IV Date/Time Prepared: 2/9/2012 10:27 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)	Title XVIII		PSA Adj. Nursing School
				Skilled Nursing Facility	PSA Adj. Non Physician Anesthetist Cost	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	0
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0
54.03 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	0
60.00 LABORATORY	0	0	0	0	0	0
65.00 RESPIRATORY THERAPY	0	0	0	0	0	0
66.00 PHYSICAL THERAPY	0	0	0	0	0	0
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	0
68.00 SPEECH PATHOLOGY	0	0	0	0	0	0
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	0
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	0	0	0	0	0
90.01 DIABETES	0	0	0	0	0	0
90.02 OP PSYCH	0	0	0	0	0	0
91.00 EMERGENCY	0	0	0	0	0	0
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0
93.00 CARDIAC REHAB	0	0	0	0	0	0
200.00 Total (lines 50-199)	0	0	0	0	0	0

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151319
Component CCN: 155093

Period:
From 10/31/2010
To 09/30/2011

Worksheet D
Part IV
Date/Time Prepared:
2/9/2012 10:27 am

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.03	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	54.03
60.00	LABORATORY	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0	0	90.00
90.01	DIABETES	0	0	90.01
90.02	OP PSYCH	0	0	90.02
91.00	EMERGENCY	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	CARDIAC REHAB	0	0	93.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet D
Part I
Date/Time Prepared:
2/9/2012 10:27 am

Cost Center Description	Title XIX			Hospital	PPS		
	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	421,327	76,942	344,385	2,404	143.25	30.00
31.00	INTENSIVE CARE UNIT	97,236		97,236	195	498.65	31.00
44.00	SKILLED NURSING FACILITY	454,104		454,104	13,813	32.88	44.00
200.00	Total (lines 30-199)	972,667		895,725	16,412		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet D
Part II
Date/Time Prepared:
2/9/2012 10:27 am

Cost Center Description	Title XIX			Hospital	PPS	
	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	195,733	3,397,144	0.057617	97,935	5,643	50.00
54.00 RADIOLOGY-DIAGNOSTIC	136,618	9,621,660	0.014199	14,315	203	54.00
54.03 NUCLEAR MEDICINE-DIAGNOSTIC	15,542	298,224	0.052115	3,315	173	54.03
60.00 LABORATORY	82,557	7,071,298	0.011675	42,172	492	60.00
65.00 RESPIRATORY THERAPY	53,201	2,063,934	0.025777	47,597	1,227	65.00
66.00 PHYSICAL THERAPY	125,797	3,509,773	0.035842	3,555	127	66.00
67.00 OCCUPATIONAL THERAPY	30,754	1,452,708	0.021170	529	11	67.00
68.00 SPEECH PATHOLOGY	3,429	642,120	0.005340	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	126,524	1,452,145	0.087129	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	1,762	677,017	0.002603	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	44,283	2,128,863	0.020801	36,142	752	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	77,369	209,935	0.368538	0	0	90.00
90.01 DIABETES	49,601	23,434	2.116625	0	0	90.01
90.02 OP PSYCH	7,505	0	0.000000	0	0	90.02
91.00 EMERGENCY	342,546	6,239,119	0.054903	319	18	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	76,764	279,631	0.274519	0	0	92.00
93.00 CARDIAC REHAB	0	0	0.000000	0	0	93.00
200.00 Total (lines 50-199)	1,369,985	39,067,005		245,879	8,646	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151319		Period: From 10/31/2010 To 09/30/2011		Worksheet D Part III Date/Time Prepared: 2/9/2012 10:27 am	
Cost Center Description	Nursing School 1.00	Title XIX		Hospital		PPS	
		Allied Health Cost 2.00	All Other Medical Education Cost 3.00	Swing-Bed Adjustment Amount (see instructions) 4.00	Total Costs (sum of cols. 1 through 3, minus col. 4) 5.00		
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
44.00	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00	Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet D Part III Date/Time Prepared: 2/9/2012 10:27 am
---	----------------------	---	---

Cost Center Description	Total Patient Days	Title XIX		Hospital		PPS
		Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
	6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,404	0.00	104	0	0	30.00
31.00 INTENSIVE CARE UNIT	195	0.00	0	0	0	31.00
44.00 SKILLED NURSING FACILITY	13,813	0.00	9,104	0	0	44.00
200.00 Total (lines 30-199)	16,412		9,208	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet D Part III Date/Time Prepared: 2/9/2012 10:27 am
Cost Center Description		PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		12.00	13.00	
30.00	ADULTS & PEDIATRICS	0	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30-199)	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet D
Part IV
Date/Time Prepared:
2/9/2012 10:27 am

Cost Center Description	Title XIX				Hospital	PPS	Total Cost (sum of col 1 through col. 4) 5.00
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
	1.00	2.00	3.00	4.00			
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0	0	0	0	0	0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
54.03 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	0	54.03
60.00 LABORATORY	0	0	0	0	0	0	60.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00 CLINIC	0	0	0	0	0	0	90.00
90.01 DIABETES	0	0	0	0	0	0	90.01
90.02 OP PSYCH	0	0	0	0	0	0	90.02
91.00 EMERGENCY	0	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
93.00 CARDIAC REHAB	0	0	0	0	0	0	93.00
200.00 Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet D
Part IV
Date/Time Prepared:
2/9/2012 10:27 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	3,397,144	0.000000	0.000000	97,935	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	9,621,660	0.000000	0.000000	14,315	54.00
54.03 NUCLEAR MEDICINE-DIAGNOSTIC	0	298,224	0.000000	0.000000	3,315	54.03
60.00 LABORATORY	0	7,071,298	0.000000	0.000000	42,172	60.00
65.00 RESPIRATORY THERAPY	0	2,063,934	0.000000	0.000000	47,597	65.00
66.00 PHYSICAL THERAPY	0	3,509,773	0.000000	0.000000	3,555	66.00
67.00 OCCUPATIONAL THERAPY	0	1,452,708	0.000000	0.000000	529	67.00
68.00 SPEECH PATHOLOGY	0	642,120	0.000000	0.000000	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,452,145	0.000000	0.000000	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	677,017	0.000000	0.000000	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	2,128,863	0.000000	0.000000	36,142	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	209,935	0.000000	0.000000	0	90.00
90.01 DIABETES	0	23,434	0.000000	0.000000	0	90.01
90.02 OP PSYCH	0	0	0.000000	0.000000	0	90.02
91.00 EMERGENCY	0	6,239,119	0.000000	0.000000	319	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	279,631	0.000000	0.000000	0	92.00
93.00 CARDIAC REHAB	0	0	0.000000	0.000000	0	93.00
200.00 Total (lines 50-199)	0	39,067,005			245,879	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 151319 Period: From 10/31/2010 To 09/30/2011 Worksheet D Part IV Date/Time Prepared: 2/9/2012 10:27 am

Cost Center Description	Title XIX			Hospital	PPS	
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.03 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.03
60.00 LABORATORY	0	0	0	0	0	60.00
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 PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	0	0	0	0	90.00
90.01 DIABETES	0	0	0	0	0	90.01
90.02 OP PSYCH	0	0	0	0	0	90.02
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 CARDIAC REHAB	0	0	0	0	0	93.00
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: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet D
Part IV
Date/Time Prepared:
2/9/2012 10:27 am

Cost Center Description	Title XIX		Hospital	PPS
	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
	23.00	24.00		
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	0		50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.03 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		54.03
60.00 LABORATORY	0	0		60.00
65.00 RESPIRATORY THERAPY	0	0		65.00
66.00 PHYSICAL THERAPY	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0		68.00
69.00 ELECTROCARDIOLOGY	0	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 CLINIC	0	0		90.00
90.01 DIABETES	0	0		90.01
90.02 OP PSYCH	0	0		90.02
91.00 EMERGENCY	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00 CARDIAC REHAB	0	0		93.00
200.00 Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 2/9/2012 10:27 am		
		Title XIX	Hospital	PPS		
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
	1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.384541	0	0	393,187	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0.191752	0	0	1,220,309	54.00
54.03	NUCLEAR MEDICINE-DIAGNOSTIC	0.660732	0	0	9,469	54.03
60.00	LABORATORY	0.261999	0	0	788,634	60.00
65.00	RESPIRATORY THERAPY	0.396480	0	0	128,110	65.00
66.00	PHYSICAL THERAPY	0.353840	0	0	132,501	66.00
67.00	OCCUPATIONAL THERAPY	0.291035	0	0	120,143	67.00
68.00	SPEECH PATHOLOGY	0.328023	0	0	200,870	68.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.348379	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.487602	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.437490	0	0	146,248	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	2.554057	0	0	0	90.00
90.01	DIABETES	8.923957	0	0	1,258	90.01
90.02	OP PSYCH	0.000000	0	0	0	90.02
91.00	EMERGENCY	0.370188	0	0	1,349,828	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.550733	0	0	0	92.00
93.00	CARDIAC REHAB	0.000000	0	0	0	93.00
200.00	Subtotal (see instructions)		0	0	4,490,557	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	4,490,557	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 2/9/2012 10:27 am
--	----------------------	---	---

Cost Center Description	Costs			Hospital	PPS
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	0	151,197		50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	233,997		54.00
54.03 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	6,256		54.03
60.00 LABORATORY	0	0	206,621		60.00
65.00 RESPIRATORY THERAPY	0	0	50,793		65.00
66.00 PHYSICAL THERAPY	0	0	46,884		66.00
67.00 OCCUPATIONAL THERAPY	0	0	34,966		67.00
68.00 SPEECH PATHOLOGY	0	0	65,890		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 PATIENTS	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	63,982		73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	0	0	0		90.00
90.01 DIABETES	0	0	11,226		90.01
90.02 OP PSYCH	0	0	0		90.02
91.00 EMERGENCY	0	0	499,690		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00 CARDIAC REHAB	0	0	0		93.00
200.00 Subtotal (see instructions)	0	0	1,371,502		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges					201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	1,371,502		202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet D-1

Date/Time Prepared:
2/9/2012 10:27 am

Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,027 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,404 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)			2,404 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			523 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			100 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)			1,261 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)			523 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			139.61 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			139.61 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,911,787 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)			13,961 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)			531,747 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,380,040 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			1,940,165 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			1,940,165 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			1.226720 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)			807.06 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			2,380,040 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)			990.03 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,248,428 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)			1,248,428 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet D-1

Date/Time Prepared:
2/9/2012 10:27 am

Cost Center Description	Title XVIII				Hospital Program Days	Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 + col. 2)			Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00		4.00	5.00	
42.00 NURSERY (title V & XIX only)							42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	590,741	195	3,029.44		132	399,886	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)						974,893	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						2,623,207	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)						517,786	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)						517,786	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)						438	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						990.03	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						433,633	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet D-1 Date/Time Prepared: 2/9/2012 10:27 am
---	----------------------	---	---

Cost Center Description	Cost	Title XVIII		Hospital	Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		Routine Cost (from line 27)	column 1 + column 2				
	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	0	90.00
91.00 Nursing School cost	0	0	0.000000	0	0	0	91.00
92.00 Allied health cost	0	0	0.000000	0	0	0	92.00
93.00 All other Medical Education	0	0	0.000000	0	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet D-1
Component CCN: 155093	Title XVIII	Date/Time Prepared: 2/9/2012 10:27 am
	Skilled Nursing Facility	PPS

Cost Center Description		1.00	
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	13,813	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,813	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)	13,813	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,273	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	139.61	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	139.61	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,050,734	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)	3,050,734	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed charges)	2,109,602	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	2,109,602	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.446118	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)	152.73	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,050,734	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151319
Component CCN: 155093

Period:
From 10/31/2010
To 09/30/2011

Worksheet D-1
Date/Time Prepared:
2/9/2012 10:27 am

Title XVIII

Skilled Nursing
Facility

PPS

Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT						43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)						48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)						50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)						51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges						54.00
55.00 Target amount per discharge						55.00
56.00 Target amount (line 54 x line 55)						56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00 Bonus payment (see instructions)						58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00 Relief payment (see instructions)						62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00 skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					3,050,734	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					220.86	71.00
72.00 Program routine service cost (line 9 x line 71)					281,155	72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					281,155	74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00 Program capital-related costs (line 9 x line 76)					0	77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00 Inpatient routine service cost per diem limitation					0.00	81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00 Reasonable inpatient routine service costs (see instructions)					281,155	83.00
84.00 Program inpatient ancillary services (see instructions)					217,132	84.00
85.00 Utilization review - physician compensation (see instructions)					0	85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					498,287	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151319 Component CCN:155093		Period: From 10/31/2010 To 09/30/2011		Worksheet D-1 Date/Time Prepared: 2/9/2012 10:27 am	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description	Cost	Routine Cost (From line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet D-1 Date/Time Prepared: 2/9/2012 10:27 am
---	----------------------	---	---

Cost Center Description	Title XIX	Hospital	PPS
			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,027 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,404 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)		2,404 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		523 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		100 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)		104 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		100 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0 14.00
15.00	Total nursery days (title V or XIX only)		0 15.00
16.00	Nursery days (title V or XIX only)		0 16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		139.61 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		139.61 20.00
21.00	Total general inpatient routine service cost (see instructions)		2,911,787 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)		13,961 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)		531,747 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,380,040 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,940,165 28.00
29.00	Private room charges (excluding swing-bed charges)		0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)		1,940,165 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.226720 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)		807.06 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,380,040 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)		990.03 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		102,963 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)		102,963 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet D-1

Date/Time Prepared:
2/9/2012 10:27 am

Cost Center Description	Title XIX			Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	590,741	195	3,029.44	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					89,857	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					192,820	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)					14,898	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					8,646	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					23,544	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					169,276	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)					13,961	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)					13,961	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)					438	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					990.03	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					433,633	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet D-1 Date/Time Prepared: 2/9/2012 10:27 am
---	----------------------	---	---

Cost Center Description	Cost 1.00	Title XIX		Hospital Total Observation Bed Cost (from line 89) 4.00	PPS Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) 5.00	
		Routine Cost (from line 27) 2.00	column 1 + column 2 3.00			
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	421,327	2,380,040	0.177025	433,633	76,764	90.00
91.00 Nursing School cost	0	2,380,040	0.000000	433,633	0	91.00
92.00 Allied health cost	0	2,380,040	0.000000	433,633	0	92.00
93.00 All other Medical Education	0	2,380,040	0.000000	433,633	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet D-3 Date/Time Prepared: 2/9/2012 10:27 am
--	----------------------	---	---

Cost Center Description	Title XVIII	Hospital		
	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS		823,563		30.00
31.00 INTENSIVE CARE UNIT		185,932		31.00
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0.384541	359,641	138,297	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0.191752	154,608	29,646	54.00
54.03 NUCLEAR MEDICINE-DIAGNOSTIC	0.660732	23,298	15,394	54.03
60.00 LABORATORY	0.261999	494,266	129,497	60.00
65.00 RESPIRATORY THERAPY	0.396480	229,162	90,858	65.00
66.00 PHYSICAL THERAPY	0.353840	140,519	49,721	66.00
67.00 OCCUPATIONAL THERAPY	0.291035	35,030	10,195	67.00
68.00 SPEECH PATHOLOGY	0.328023	24,814	8,140	68.00
69.00 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.348379	264,317	92,082	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0.487602	606,371	295,668	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.437490	260,997	114,184	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 CLINIC	2.554057	0	0	90.00
90.01 DIABETES	8.923957	0	0	90.01
90.02 OP PSYCH	0.000000	0	0	90.02
91.00 EMERGENCY	0.370188	2,966	1,098	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.550733	73	113	92.00
93.00 CARDIAC REHAB	0.000000	0	0	93.00
200.00 Total (sum of lines 50-94 and 96-98)		2,596,062	974,893	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00 Net Charges (line 200 minus line 201)		2,596,062		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151319 Component CCN: 152319	Period: From 10/31/2010 To 09/30/2011	Worksheet D-3 Date/Time Prepared: 2/9/2012 10:27 am
Cost Center Description		Ratio of Cost To Charges	Swing Beds - SNF Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2) Cost
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		297,762	30.00
31.00	INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.384541	689	265 50.00
54.00	RADIOLOGY-DIAGNOSTIC	0.191752	11,881	2,278 54.00
54.03	NUCLEAR MEDICINE-DIAGNOSTIC	0.660732	1,211	800 54.03
60.00	LABORATORY	0.261999	90,116	23,610 60.00
65.00	RESPIRATORY THERAPY	0.396480	48,377	19,181 65.00
66.00	PHYSICAL THERAPY	0.353840	122,369	43,299 66.00
67.00	OCCUPATIONAL THERAPY	0.291035	37,707	10,974 67.00
68.00	SPEECH PATHOLOGY	0.328023	5,530	1,814 68.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0 69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.348379	65,075	22,671 71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.487602	0	0 72.00
73.00	DRUGS CHARGED TO PATIENTS	0.437490	71,923	31,466 73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	2.554057	0	0 90.00
90.01	DIABETES	8.923957	0	0 90.01
90.02	OP PSYCH	0.000000	0	0 90.02
91.00	EMERGENCY	0.370188	0	0 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.550733	93	144 92.00
93.00	CARDIAC REHAB	0.000000	0	0 93.00
200.00	Total (sum of lines 50-94 and 96-98)		454,971	156,502 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net charges (line 200 minus line 201)		454,971	156,502 202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet D-3
	Component CCN:155093		Date/Time Prepared: 2/9/2012 10:27 am
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS		0		30.00
31.00 INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0.384541	0	0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0.191752	10,096	1,936	54.00
54.03 NUCLEAR MEDICINE-DIAGNOSTIC	0.660732	1,694	1,119	54.03
60.00 LABORATORY	0.261999	79,144	20,736	60.00
65.00 RESPIRATORY THERAPY	0.396480	27,112	10,749	65.00
66.00 PHYSICAL THERAPY	0.353840	298,989	105,794	66.00
67.00 OCCUPATIONAL THERAPY	0.291035	144,716	42,117	67.00
68.00 SPEECH PATHOLOGY	0.328023	28,560	9,368	68.00
69.00 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.348379	8,904	3,102	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0.487602	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.437490	50,770	22,211	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 CLINIC	2.554057	0	0	90.00
90.01 DIABETES	8.923957	0	0	90.01
90.02 OP PSYCH	0.000000	0	0	90.02
91.00 EMERGENCY	0.370188	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.550733	0	0	92.00
93.00 CARDIAC REHAB	0.000000	0	0	93.00
200.00 Total (sum of lines 50-94 and 96-98)		649,985	217,132	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00 Net charges (line 200 minus line 201)		649,985		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet D-3 Date/Time Prepared: 2/9/2012 10:27 am
--	----------------------	---	---

Cost Center Description	Title XIX	Hospital	PPS	
	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS		103,473		30.00
31.00 INTENSIVE CARE UNIT		8,975		31.00
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0.384541	97,935	37,660	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0.191752	14,315	2,745	54.00
54.03 NUCLEAR MEDICINE-DIAGNOSTIC	0.660732	3,315	2,190	54.03
60.00 LABORATORY	0.261999	42,172	11,049	60.00
65.00 RESPIRATORY THERAPY	0.396480	47,597	18,871	65.00
66.00 PHYSICAL THERAPY	0.353840	3,555	1,258	66.00
67.00 OCCUPATIONAL THERAPY	0.291035	529	154	67.00
68.00 SPEECH PATHOLOGY	0.328023	0	0	68.00
69.00 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.348379	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0.487602	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.437490	36,142	15,812	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 CLINIC	2.554057	0	0	90.00
90.01 DIABETES	8.923957	0	0	90.01
90.02 OP PSYCH	0.000000	0	0	90.02
91.00 EMERGENCY	0.370188	319	118	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.550733	0	0	92.00
93.00 CARDIAC REHAB	0.000000	0	0	93.00
200.00 Total (sum of lines 50-94 and 96-98)		245,879	89,857	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00 Net Charges (line 200 minus line 201)		245,879		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 2/9/2012 10:27 am
		Title XVIII	Hospital	Cost
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		3,308,805	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		3,308,805	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)		3,341,893	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)		45,554	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,365,069	26.00
27.00	Subtotal ((lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23) (for CAH, see instructions)		1,931,270	27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,931,270	30.00
31.00	Primary payer payments		1,375	31.00
32.00	Subtotal (line 30 minus line 31)		1,929,895	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)		340,555	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		340,555	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		2,270,450	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		2,270,450	40.00
41.00	Interim payments		1,976,341	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)		294,109	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 2/9/2012 10:27 am
	Title XVIII	Hospital	Cost
			Overrides 1.00
WORKSHEET OVERRIDE VALUES			
112.00	override of Ancillary service charges (line 12)		0 112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151319 Component CCN:155093	Period: From 10/31/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 2/9/2012 10:27 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
<u>Reasonable charges</u>				
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
<u>Customary charges</u>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)			26.00
27.00	Subtotal ((lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23) (for CAH, see instructions)		0	27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R			38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		0	40.00
41.00	Interim payments		0	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151319 Component CCN:155093	Period: From 10/31/2010 To 09/30/2011	Worksheet E Part 8 Date/Time Prepared: 2/9/2012 10:27 am
	Title XVIII	Skilled Nursing Facility	PPS
			Overrides 1.00
112.00			0112.00

WORKSHEET OVERRIDE VALUES

112.00 override of Ancillary service charges (line 12)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet E-1
Part I
Date/Time Prepared:
2/9/2012 10:27 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		2,195,222		2,041,068	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	04/21/2011	4,271		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0	04/21/2011	64,727	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		4,271		-64,727	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or Wkst. E-3, line and column as appropriate)		2,199,493		1,976,341	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		192,211		294,109	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		2,391,704		2,270,450	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: 151319
Component CCN: 152319

Period:
From 10/31/2010
To 09/30/2011

Worksheet E-1
Part I
Date/Time Prepared:
2/9/2012 10:27 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		633,344		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) Program to Provider						3.00
3.01	ADJUSTMENTS TO PROVIDER	04/21/2011	6,913		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		6,913		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)		640,257		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) Program to Provider						5.00
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		34,313		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		674,570		0		7.00
				Contractor Number	Date (Mo/Day/Yr)		
			0	1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151319
Component CCN: 155093

Period:
From 10/31/2010
To 09/30/2011

Worksheet E-1
Part I
Date/Time Prepared:
2/9/2012 10:27 am

Title XVIII

Skilled Nursing
Facility

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		348,263		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		348,263		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		348,263		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: 151319

Period: From 10/31/2010

Worksheet E-2

Component CCN: 152319

To 09/30/2011

Date/Time Prepared: 2/9/2012 10:27 am

		Swing Beds - SNF		
		Cost		
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	522,964	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)	158,067	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	523	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)	681,031	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	681,031	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)	681,031	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	6,461	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)	674,570	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)	674,570	0	19.00
20.00	Interim payments	640,257	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)	34,313	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: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet E-3 Part V Date/Time Prepared: 2/9/2012 10:27 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		2,623,207		1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)		0		2.00
3.00	Organ acquisition		0		3.00
4.00	Subtotal (sum of lines 1 thru 3)		2,623,207		4.00
5.00	Primary payer payments		3,900		5.00
6.00	Total cost (line 4 less line 5) . For CAH (see instructions)		2,645,539		6.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
7.00	Routine service charges		0		7.00
8.00	Ancillary service charges		0		8.00
9.00	Organ acquisition charges, net of revenue		0		9.00
10.00	Total reasonable charges		0		10.00
Customary charges					
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0		11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0		12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000		13.00
14.00	Total customary charges (see instructions)		0		14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0		15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0		16.00
17.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)		0		17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
18.00	Direct graduate medical education payments (from worksheet E-4, line 49)		0		18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		2,645,539		19.00
20.00	Deductibles (exclude professional component)		315,772		20.00
21.00	Excess reasonable cost (from line 16)		0		21.00
22.00	Subtotal (line 19 minus line 20)		2,329,767		22.00
23.00	Coinsurance		1,415		23.00
24.00	Subtotal (line 22 minus line 23)		2,328,352		24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		63,352		25.00
26.00	Adjusted reimbursable bad debts (see instructions)		63,352		26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		27.00
28.00	Subtotal (sum of lines 24 and 25 or 26)		2,391,704		28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		29.00
29.99	Recovery of Accelerated Depreciation		0		29.99
30.00	Subtotal (line 28, plus or minus lines 29)		2,391,704		30.00
31.00	Interim payments		2,199,493		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)		192,211		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: 151319	Period: From 10/31/2010	Worksheet E-3
	Component CCN: 155093	To 09/30/2011	Part VI Date/Time Prepared: 2/9/2012 10:27 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES			
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)			
1.00	Resource Utilization Group Payment (RUGS)	439,402	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	439,402	4.00
COMPUTATION OF NET COST OF COVERED SERVICES			
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	91,139	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Allowable reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)	348,263	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14)	348,263	15.00
16.00	Interim payments	348,263	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus the sum of lines 16 and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet E-3 Part VII Date/Time Prepared: 2/9/2012 10:27 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		1,371,502	2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1,371,502	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)		1,371,502	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		0	8.00
9.00	Ancillary service charges		4,736,436	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)		4,736,436	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)		4,736,436	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		3,364,934	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)		1,371,502	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.		1,371,502	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)		1,371,502	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)		1,371,502	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		1,371,502	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)		1,371,502	40.00
41.00	Interim payments		0	41.00
42.00	Balance due provider/program (line 40 minus 41)		1,371,502	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: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet G

Date/Time Prepared:
2/9/2012 10:27 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	2,520,947	0	0	0	1.00
2.00 Temporary investments	0	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	6,152,151	0	0	0	4.00
5.00 Other receivable	495,963	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-3,225,703	0	0	0	6.00
7.00 Inventory	638,110	0	0	0	7.00
8.00 Prepaid expenses	185,743	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)	6,767,211	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	31,289,373	0	0	0	15.00
16.00 Accumulated depreciation	-18,470,352	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)	12,819,021	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	4,407,524	0	0	0	31.00
32.00 Deposits on leases	135,859	0	0	0	32.00
33.00 Due from owners/officers	52,394	0	0	0	33.00
34.00 Other assets	45,317	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	4,641,094	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	24,227,326	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	1,637,260	0	0	0	37.00
38.00 Salaries, wages, and fees payable	1,347,774	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	1,204,264	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	271,703	0	0	0	43.00
44.00 Other current liabilities	5,415	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	4,466,416	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	230,593	0	0	0	46.00
47.00 Notes payable	9,207,358	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	0	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	9,437,951	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	13,904,367	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	10,322,959	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	10,322,959	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	24,227,326	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet G-1

Date/Time Prepared:
2/9/2012 10:27 am

	General Fund		Special Purpose Fund			
	1.00	2.00	3.00	4.00		
1.00 Fund balances at beginning of period		11,880,568			0	1.00
2.00 Net income (loss) (from Wkst. G-3, line 29)		-3,460,013				2.00
3.00 Total (sum of line 1 and line 2)		8,420,555			0	3.00
4.00 Additions (credit adjustments) (specify)	1,902,404					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)		1,902,404			0	10.00
11.00 Subtotal (line 3 plus line 10)		10,322,959			0	11.00
12.00 Deductions (debit adjustments) (specify)	0				0	12.00
13.00	0				0	13.00
14.00	0				0	14.00
15.00	0				0	15.00
16.00	0				0	16.00
17.00	0				0	17.00
18.00 Total deductions (sum of lines 12-17)		0			0	18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		10,322,959			0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet G-1

Date/Time Prepared:
2/9/2012 10:27 am

	Endowment Fund		Plant Fund		
	5.00	6.00	7.00	8.00	
	1.00		0		
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: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet G-2 Parts

Date/Time Prepared:
2/9/2012 10:27 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,940,165		1,940,165	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	2,109,602		2,109,602	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,049,767		4,049,767	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	278,944		278,944	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)	278,944		278,944	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,328,711		4,328,711	17.00
18.00	Ancillary services	5,867,036	32,903,052	38,770,088	18.00
19.00	Outpatient services	0	231,610	231,610	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		482,835	482,835	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	ASC	105	1,211,792	1,211,897	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	10,195,852	34,829,289	45,025,141	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		31,150,560		29.00
30.00	PHYSICIAN BAD DEBT	147,585			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)		147,585		36.00
37.00	INDUSTRIAL MEDICINE EXPENSE	3,528,963			37.00
38.00	NON OPERATING EXPENSE	2,703,408			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)		6,232,371		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		25,065,774		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet G-3

Date/Time Prepared:
2/9/2012 10:27 am

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	45,025,141	1.00
2.00	Less contractual allowances and discounts on patients' accounts	21,697,435	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,327,706	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	25,065,774	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,738,068	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	475,219	24.00
24.01	NET INDUSTRIAL MEDICINE	225,898	24.01
24.02		0	24.02
25.00	Total other income (sum of lines 6-24)	701,117	25.00
26.00	Total (line 5 plus line 25)	-1,036,951	26.00
27.00	NET NON OPERATING REVENUE	1,433,716	27.00
27.01	NON OPERATING INCOME	989,346	27.01
27.02		0	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	2,423,062	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-3,460,013	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151319
HHA CCN: 157445

Period:
From 10/31/2010
To 09/30/2011

Worksheet H
Date/Time Prepared:
2/9/2012 10:27 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	43,122	13,891	29,572	0	22,228 5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	157,670	50,790	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	57,461	18,510	0	0	0 11.00
12.00	Supplies (see instructions)	0	0	0	601	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)	258,253	83,191	29,572	601	22,228 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: 151319 HHA CCN: 157445		Period: From 10/31/2010 To 09/30/2011		Worksheet H Date/Time Prepared: 2/9/2012 10:27 am	
				Home Health Agency I		PPS	
		Total (sum of cols. 1 thru 5)	Reclassificati on	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	108,813	-16,372	92,441	0	92,441	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	208,460	0	208,460	0	208,460	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	75,971	0	75,971	0	75,971	11.00
12.00	Supplies (see instructions)	601	0	601	0	601	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)	393,845	-16,372	377,473	0	377,473	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: 151319	Period: From 10/31/2010	Worksheet H-1		
		HHA CCN: 157445	To 09/30/2011	Part I		
		Home Health Agency I		Date/Time Prepared: 2/9/2012 10:27 am		
		PPS				
	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	
		Bldgs & Fixtures	Movable Equipment			
	0	1.00	2.00	3.00	4.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	92,441	0	0	0	5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	208,460	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	10.00
11.00	Home Health Aide	75,971	0	0	0	11.00
12.00	Supplies (see instructions)	601	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DMF	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 Outy 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)	377,473	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 151319	Period: From 10/31/2010	Worksheet H-1 Part I Date/Time Prepared: 2/9/2012 10:27 am
		HHA CCN: 157445	To 09/30/2011	
			Home Health Agency I	PPS

	Subtotal (cols. 0-4) 4A.00	Administrative & General 5.00	Total (cols. 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	92,441	92,441	5.00
HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	208,460	67,607	276,067
7.00	Physical Therapy	0	0	0
8.00	Occupational Therapy	0	0	0
9.00	Speech Pathology	0	0	0
10.00	Medical Social Services	0	0	0
11.00	Home Health Aide	75,971	24,639	100,610
12.00	Supplies (see instructions)	601	195	796
13.00	Drugs	0	0	0
14.00	DME	0	0	0
HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0	0
16.00	Respiratory Therapy	0	0	0
17.00	Private Duty Nursing	0	0	0
18.00	Clinic	0	0	0
19.00	Health Promotion Activities	0	0	0
20.00	Day Care Program	0	0	0
21.00	Home Delivered Meals Program	0	0	0
22.00	Homemaker Service	0	0	0
23.00	All Others (specify)	0	0	0
24.00	Total (sum of lines 1-23)	285,032		377,473

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 151319

Period: From 10/31/2010

Worksheet H-1

HHA CCN: 157445

To 09/30/2011

Part II

Date/Time Prepared: 2/9/2012 10:27 am

Home Health Agency I

PPS

	Capital Related Costs			Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00	3.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	433				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	433		0	3.00
4.00	Transportation (see instructions)	0	0	0	0	0	4.00
5.00	Administrative and General	0	0	0	0	-92,441	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	433	0	433	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)	433	0	433	0	-92,441	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: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet H-1 Part II Date/Time Prepared: 2/9/2012 10:27 am
		HHA CCN: 157445	Home Health Agency I	PPS

		Administrative & General (ACCUM. COST)	
		5.00	
GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures		1.00
2.00	Capital Related - Movable Equipment		2.00
3.00	Plant Operation & Maintenance		3.00
4.00	Transportation (see instructions)		4.00
5.00	Administrative and General	285,032	5.00
HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	208,460	6.00
7.00	Physical Therapy	0	7.00
8.00	Occupational Therapy	0	8.00
9.00	Speech Pathology	0	9.00
10.00	Medical Social Services	0	10.00
11.00	Home Health Aide	75,971	11.00
12.00	Supplies (see instructions)	601	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)	285,032	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	92,441	25.00
26.00	Unit Cost Multiplier	0.324318	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151319

Period: From 10/31/2010

Worksheet H-2

HHA CCN: 157445

To 09/30/2011

Part I

Date/Time Prepared: 2/9/2012 10:27 am

Home Health Agency I

PPS

	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
1.00 Administrative and General	0	4,728	7,893	9,024	21,645	1.00
2.00 Skilled Nursing Care	276,067	0	0	0	276,067	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	100,610	0	0	0	100,610	7.00
8.00 Supplies (see instructions)	796	0	0	0	796	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)	377,473	4,728	7,893	9,024	399,118	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: 151319
HHA CCN: 157445

Period:
From 10/31/2010
To 09/30/2011

Worksheet H-2
Part I
Date/Time Prepared:
2/9/2012 10:27 am

Home Health
Agency I

PPS

	ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
1.00	Administrative and General	3,121	10,694	0	3,801	0 1.00
2.00	Skilled Nursing Care	39,799	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	14,505	0	0	0	0 7.00
8.00	Supplies (see instructions)	115	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 Outy 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)	57,540	10,694	0	3,801	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.					0 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: 151319	Period: From 10/31/2010	Worksheet H-2 Part I
		HHA CCN: 157445	To 09/30/2011	Date/Time Prepared: 2/9/2012 10:27 am
			Home Health Agency I	PPS

	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	11.00	13.00	16.00	24.00	25.00	
1.00	Administrative and General	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	115,115	7.00
8.00	Supplies (see instructions)	0	0	0	911	8.00
9.00	Drugs	0	0	0	0	9.00
10.00	DME	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	471,153	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: 151319	Period: From 10/31/2010	Worksheet H-2 Part I
		HHA CCN: 157445	To 09/30/2011	Date/Time Prepared: 2/9/2012 10:27 am
			Home Health Agency I	PPS

	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
	26.00	27.00	28.00	
1.00 Administrative and General	39,261			1.00
2.00 Skilled Nursing Care	315,866	28,713	344,579	2.00
3.00 Physical Therapy	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	4.00
5.00 Speech Pathology	0	0	0	5.00
6.00 Medical Social Services	0	0	0	6.00
7.00 Home Health Aide	115,115	10,465	125,580	7.00
8.00 Supplies (see instructions)	911	83	994	8.00
9.00 Drugs	0	0	0	9.00
10.00 DME	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	13.00
14.00 Clinic	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	15.00
16.00 Day Care Program	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	17.00
18.00 Homemaker Service	0	0	0	18.00
19.00 All others (specify)	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	471,153	39,261	471,153	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.		0.090905		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: 151319	Period: From 10/31/2010	Worksheet H-2 Part II Date/Time Prepared: 2/9/2012 10:27 am
	HHA CCN: 157445	To 09/30/2011	
		Home Health Agency I	PPS

	CAPITAL RELATED COSTS			Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)		
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)				
	1.00	2.00	4.00				
1.00	Administrative and General	433	433	258,253	0	21,645	1.00
2.00	Skilled Nursing Care	0	0	0	0	276,067	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	100,610	7.00
8.00	Supplies (see instructions)	0	0	0	0	796	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)	433	433	258,253		399,118	20.00
21.00	Total cost to be allocated	4,728	7,893	9,024		57,540	21.00
22.00	Unit cost multiplier	10.919169	18.228637	0.034942		0.144168	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 151319	Period: From 10/31/2010	Worksheet H-2 Part II Date/Time Prepared: 2/9/2012 10:27 am
	HHA CCN: 157445	To 09/30/2011	
		Home Health Agency I	PPS

	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	433	0	433	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	9.00
10.00	DME	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	433	0	433	0	20.00
21.00	Total cost to be allocated	10,694	0	3,801	0	21.00
22.00	Unit cost multiplier	24.697460	0.000000	8.778291	0.000000	0.000000 22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet H-2
Part II
Date/Time Prepared:
2/9/2012 10:27 am

HHA CCN: 157445

Home Health
Agency I

PPS

	NURSING ADMINISTRATION (NRSE FTE'S)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
	13.00	16.00	
1.00	Administrative and General	0	1.00
2.00	Skilled Nursing Care	0	2.00
3.00	Physical Therapy	0	3.00
4.00	Occupational Therapy	0	4.00
5.00	Speech Pathology	0	5.00
6.00	Medical Social Services	0	6.00
7.00	Home Health Aide	0	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)	0	20.00
21.00	Total cost to be allocated	0	21.00
22.00	Unit cost multiplier	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 151319 HHA CCN: 157445		Period: From 10/31/2010 To 09/30/2011		Worksheet H-3 Parts I-II Date/Time Prepared: 2/9/2012 10:27 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	344,579		344,579	2,117	1.00
2.00	Physical Therapy	3.00	0	0	0	1,135	2.00
3.00	Occupational Therapy	4.00	0	0	0	234	3.00
4.00	Speech Pathology	5.00	0	0	0	132	4.00
5.00	Medical Social Services	6.00	0		0	4	5.00
6.00	Home Health Aide	7.00	125,580		125,580	693	6.00
7.00	Total (sum of lines 1-6)		470,159	0	470,159	4,315	7.00
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance Subject to Deductibles		
		0	1.00	2.00	3.00 4.00		
Limitation Cost Computation							
8.00	Skilled Nursing Care		15999	0	0		8.00
9.00	Physical Therapy		15999	0	0		9.00
10.00	Occupational Therapy		15999	0	0		10.00
11.00	Speech Pathology		15999	0	0		11.00
12.00	Medical Social Services		15999	0	0		12.00
13.00	Home Health Aide		15999	0	0		13.00
14.00	Total (sum of lines 8-13)			0	0		14.00
Cost Center Description		From wkst. H-2 Part I, col. 28, line	Facility Costs (from wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	
		0	1.00	2.00	3.00	4.00	
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	994	0	994	6,794	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	16.00
Cost Center Description			From wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	
			0	1.00	2.00	3.00	
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy		66.00	0.353840	0	0	1.00
2.00	Occupational Therapy		67.00	0.291035	0	0	2.00
3.00	Speech Pathology		68.00	0.328023	0	0	3.00
4.00	Cost of Medical Supplies		71.00	0.348379	0	0	4.00
5.00	Cost of Drugs		73.00	0.437490	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151319

Period:
From 10/31/2010
To 09/30/2011

Worksheet H-3
Parts I-II
Date/Time Prepared:
2/9/2012 10:27 am

HHA CCN: 157445

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Part A	Program Visits			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	5.00	6.00	7.00	8.00		
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	162.77	813	695		1.00
2.00	Physical Therapy	0.00	424	302		2.00
3.00	Occupational Therapy	0.00	105	77		3.00
4.00	Speech Pathology	0.00	104	16		4.00
5.00	Medical Social Services	0.00	2	3		5.00
6.00	Home Health Aide	181.21	240	218		6.00
7.00	Total (sum of lines 1-6)		1,688	1,311		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
Program Covered Charges						
Cost Center Description	Ratio (col. 3 ÷ col. 4)	Part A	Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	5.00	6.00	7.00	8.00		
Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	0.146306	0	2,934	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: 151319 HHA CCN: 157445		Period: From 10/31/2010 To 09/30/2011		Worksheet H-3 Parts I-II Date/Time Prepared: 2/9/2012 10:27 am	
				Title XVIII		Home Health Agency I	PPS
Cost Center Description	Cost of Services			Total Program Cost (sum of cols. 9-10)			
	Part A	Part B					
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance				
9.00	10.00	11.00	12.00				
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	132,332	113,125		245,457		1.00
2.00	Physical Therapy	0	0		0		2.00
3.00	Occupational Therapy	0	0		0		3.00
4.00	Speech Pathology	0	0		0		4.00
5.00	Medical Social Services	0	0		0		5.00
6.00	Home Health Aide	43,490	39,504		82,994		6.00
7.00	Total (sum of lines 1-6)	175,822	152,629		328,451		7.00
Cost Center Description							
		10.00	11.00	12.00			
Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00
Cost of Services							
Cost Center Description	Part A	Part B					
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance				
	9.00	10.00	11.00				
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	429	0			15.00
16.00	Cost of Drugs	0	0	0			16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 151319 HHA CCN: 157445	Period: From 10/31/2010 To 09/30/2011	Worksheet H-4 Part I-II Date/Time Prepared: 2/9/2012 10:27 am	
		Title XVIII	Home Health Agency I	PPS	
		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES					
Reasonable Cost of Part A & Part B Services					
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
Customary Charges					
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00
			Part A Services	Part B Services	
			1.00	2.00	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
10.00	Total reasonable cost (see instructions)		0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		197,394	160,267	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		9,215	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes		2,288	2,044	13.00
14.00	Total PPS Reimbursement - PEP Episodes		733	0	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0	16.00
17.00	Total Other Payments		0	0	17.00
18.00	DME Payments		0	0	18.00
19.00	Oxygen Payments		0	0	19.00
20.00	Prosthetic and Orthotic Payments		0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		209,630	162,311	22.00
23.00	Excess reasonable cost (from line 8)		0	0	23.00
24.00	Subtotal (line 22 minus line 23)		209,630	162,311	24.00
25.00	Coinsurance billed to program patients (from your records)		0	0	25.00
26.00	Net cost (line 24 minus line 25)		209,630	162,311	26.00
27.00	Reimbursable bad debts (from your records)		0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)		209,630	162,311	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)		209,630	162,311	31.00
32.00	Interim payments (see instructions)		209,630	162,311	32.00
33.00	Tentative settlement (for contractor use only)		0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 32 and 33)		0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	0	35.00

Health Financial Systems

In Lieu of Form CMS-2552-10

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 151319	Period: From 10/31/2010 To 09/30/2011	Worksheet H-5
	HHA CCN: 157445	Home Health Agency I	Date/Time Prepared: 2/9/2012 10:27 am PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1.00	Total interim payments paid to provider	1.00	2.00	3.00	4.00	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		209,630		162,311	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. H-4, Part II, column as appropriate, line 32)		209,630		162,311	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)		209,630		162,311	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00