

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: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet S Parts I-III Date/Time Prepared: 5/30/2012 7:07 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input checked="" 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: 5/30/2012	Time: 7:07 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 04 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HANCOCK REGIONAL HOSPITAL for the cost reporting period beginning 01/01/2011 and ending 12/31/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title XVIII		HIT	Title XIX	
	Title V	Part A			
	1.00	2.00	3.00	4.00	5.00
PART III - SETTLEMENT SUMMARY					
1.00 Hospital	0	957	-42,647	0	517,782
2.00 Subprovider - IPF	0	540	0	0	0
3.00 Subprovider - IRF	0	-2,213	0	0	0
4.00 SUBPROVIDER I	0	0	0	0	0
5.00 Swing bed - SNF	0	0	0	0	0
6.00 Swing bed - NF	0	0	0	0	0
7.00 SKILLED NURSING FACILITY	0	0	0	0	0
8.00 NURSING FACILITY	0	0	0	0	0
9.00 HOME HEALTH AGENCY I	0	0	0	0	0
10.00 RURAL HEALTH CLINIC I	0	0	2,993	0	0
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0
12.00 CMHC I	0	0	0	0	0
200.00 Total	0	-716	-39,654	0	517,782

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150037		Period: From 01/01/2011 To 12/31/2011		Worksheet S-2 Part I Date/Time Prepared: 5/30/2012 6:15 pm					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: .10 NORTH STATE STREET			PO Box:						1.00	
2.00	City: GREENFIELD			State: IN		Zip Code: 46140-		County: HANCOCK		2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		HANCOCK REGIONAL HOSPITAL	150037	26900	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF		HANCOCK REGIONAL GERO PSYCH UNIT	15S037	26900	4	12/01/1996	N	P	N	4.00
5.00	Subprovider - IRF		HANCOCK REGIONAL HOSPITAL REHAB	15T037	26900	5	01/01/2005	N	P	N	5.00
6.00	Subprovider - (Other)							N	N	N	6.00
7.00	Swing Beds - SNF							N			7.00
8.00	Swing Beds - NF							N		N	8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA		HANCOCK REGIONAL HHA	157092	26900		10/14/1983	N	P	N	12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice		HANCOCK REGIONAL HOSPICE	151547	26900		02/02/1996				14.00
15.00	Hospital-Based Health Clinic - RHC		KNIIGHTSTOWN RURAL HEALTH	153987	26900		09/22/1998	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FOHC										16.00
17.00	Hospital-Based (CMHC) 1										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2011	12/31/2011		20.00	
21.00	Type of Control (see instructions)						9			21.00	
Inpatient PPS Information											
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00	
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.						3	N		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	434	484	0	0	617	0			24.00	
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.	0	7	0	0	0	0			25.00	
							Urban/Rural S	Date of Geogr			
							1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.						1				26.00
27.00	For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification (in column 2).						1				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0				35.00

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		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00				62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000		64.00
		Program Name 1.00	Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00

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		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
65.00	If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. Use subscripted lines 65.01 through 65.50 for each additional primary care program. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4.			0.00	0.00	0.000000		65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
				1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000		66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000		67.00
						1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y				70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			N	N	0		71.00

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			1.00	2.00	3.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.		Y		75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)		N	N 0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.			N	80.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(i)? Enter "Y" for yes and "N" for no.			N	86.00
			V	XIX	
			1.00	2.00	
Title V or XIX Inpatient Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	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	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
			Physical	Occupational	Speech
			1.00	2.00	3.00
			Respiratory		4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	109.00
			1.00		2.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.		N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			2	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.		750,000	3,000,000	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00

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		1.00	2.00				
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	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:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
145.00	If costs for renal services are claimed on Worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.			N		145.00	
						1.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00	
				Part A		Part B	
				1.00		2.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		155.00	
156.00	Subprovider - IPF	N		N		156.00	
157.00	Subprovider - IRF	N		N		157.00	
158.00	SUBPROVIDER	N		N		158.00	
159.00	SNF	N		N		159.00	
160.00	HOME HEALTH AGENCY	N		N		160.00	
161.00	CMHC	N		N		161.00	
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
		Zip Code		CBSA		FTE/Campus	
		3.00		4.00		5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.			N		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part II Date/Time Prepared: 5/30/2012 6:15 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)				3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	04/24/2012	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
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		Legal Oper.	
		1.00		2.00	
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	02/29/2012		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: 150037

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

Worksheet S-2
Part II
Date/Time Prepared:
5/30/2012 6:15 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 150037

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

Worksheet S-2
Part II
Date/Time Prepared:
5/30/2012 6:15 pm

		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	02/29/2012	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.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150037

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2012 6:15 pm

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	67	24,455	0.00		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)		67	24,455	0.00		7.00
8.00 INTENSIVE CARE UNIT	31.00	23	8,395	0.00		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		90	32,850	0.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	40.00	10	3,650			16.00
17.00 SUBPROVIDER - IRF	41.00	5	1,825			17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	7	2,555			24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		112				27.00
28.00 Observation Bed Days						28.00
28.01 SUBPROVIDER - IPF	40.00					28.01
28.02 SUBPROVIDER - IRF	41.00					28.02
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150037

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2012 6:15 pm

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	4,612	228	5,493		1.00
2.00 HMO		0	1,083			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	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	4,612	228	5,493		7.00
8.00 INTENSIVE CARE UNIT	0	498	205	4,927		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	5,110	433	10,420		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF	0	2,235	0	2,346		16.00
17.00 SUBPROVIDER - IRF	0	1,195	7	1,521		17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	5,161	97	18,164		22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE		0	0	385		24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0	279	340	1,762		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		308	2,009		28.00
28.01 SUBPROVIDER - IPF				0		28.01
28.02 SUBPROVIDER - IRF				0		28.02
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)			19	36		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150037

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2012 6:15 pm

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	1,430	1.00
2.00 HMO					0	2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	668.51	0.00	0	1,430	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0.00	0.00	0	232	16.00
17.00 SUBPROVIDER - IRF	0.00	0.00	0.00	0	97	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00	0.00	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00	0.00	0.00			24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00	2.82	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	671.33	0.00			27.00
28.00 Observation Bed Days						28.00
28.01 SUBPROVIDER - IPF						28.01
28.02 SUBPROVIDER - IRF						28.02
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150037

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2012 6:15 pm

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	117	3,040		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)	117	3,040		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF	0	241		16.00
17.00 SUBPROVIDER - IRF	1	127		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
28.01 SUBPROVIDER - IPF				28.01
28.02 SUBPROVIDER - IRF				28.02
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150037

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

Worksheet S-3
Part II
Date/Time Prepared:
5/30/2012 6:15 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
	1.00	2.00	3.00	4.00	5.00	
PART II - WAGE DATA						
SALARIES						
1.00	Total salaries (see instructions)	200.00	37,075,483	0	37,075,483	1,273,815.00 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00 2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00 3.00
4.00	Physician-Part A		0	0	0	0.00 4.00
4.01	Physicians - Part A - direct teaching		0	0	0	0.00 4.01
5.00	Physician-Part B		0	0	0	0.00 5.00
6.00	Non-physician-Part B		165,440	0	165,440	5,509.00 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00 7.00
7.01	Contracted interns and residents (in approved programs)		0	0	0	0.00 7.01
8.00	Home office personnel		0	0	0	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00 9.00
10.00	Excluded area salaries (see instructions)		5,289,619	85,668	5,375,287	184,579.00 10.00
OTHER WAGES & RELATED COSTS						
11.00	Contract labor (see instructions)		794,170	0	794,170	11,607.00 11.00
12.00	Management and administrative services		0	0	0	0.00 12.00
13.00	Contract labor: physician-Part A		0	0	0	0.00 13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00 14.00
15.00	Home office: physician Part A		0	0	0	0.00 15.00
16.00	Teaching physician salaries (see instructions)		0	0	0	0.00 16.00
WAGE-RELATED COSTS						
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24		9,101,722	0	9,101,722	
18.00	Wage-related costs (other)Wkst S-3, Part IV Line 25		0	0	0	18.00
19.00	Excluded areas		1,551,494	0	1,551,494	19.00
20.00	Non-physician anesthetist Part A		0	0	0	20.00
21.00	Non-physician anesthetist Part B		48,101	0	48,101	21.00
22.00	Physician Part A		0	0	0	22.00
23.00	Physician Part B		0	0	0	23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0	24.00
25.00	Interns & residents (in an approved program)		0	0	0	25.00
OVERHEAD COSTS - DIRECT SALARIES						
26.00	Employee Benefits	4.00	312,456	0	312,456	10,005.00 26.00
27.00	Administrative & General	5.00	7,381,182	-85,668	7,295,514	232,103.00 27.00
28.00	Administrative & General under contract (see inst.)		615,663	0	615,663	4,542.00 28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00 29.00
30.00	Operation of Plant	7.00	784,658	0	784,658	30,882.00 30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00 31.00
32.00	Housekeeping	9.00	802,515	0	802,515	61,674.00 32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00 33.00
34.00	Dietary	10.00	1,034,008	-650,465	383,543	25,478.00 34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00 35.00
36.00	Cafeteria	11.00	0	650,465	650,465	43,210.00 36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00 37.00
38.00	Nursing Administration	13.00	645,751	0	645,751	16,650.00 38.00
39.00	Central Services and Supply	14.00	61,430	0	61,430	4,122.00 39.00
40.00	Pharmacy	15.00	1,347,532	-81,536	1,265,996	35,547.00 40.00
41.00	Medical Records & Medical Records Library	16.00	599,871	0	599,871	29,528.00 41.00
42.00	Social Service	17.00	0	0	0	0.00 42.00
43.00	Other General Service	18.00	0	0	0	0.00 43.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet S-3 Part II Date/Time Prepared: 5/30/2012 6:15 pm
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		Average Hourly Wage (col. 4 ÷ col. 5)	
		6.00	
PART II - WAGE DATA			
SALARIES			
1.00	Total salaries (see instructions)	29.11	1.00
2.00	Non-physician anesthetist Part A	0.00	2.00
3.00	Non-physician anesthetist Part B	0.00	3.00
4.00	Physician-Part A	0.00	4.00
4.01	Physicians - Part A - direct teaching	0.00	4.01
5.00	Physician-Part B	0.00	5.00
6.00	Non-physician-Part B	30.03	6.00
7.00	Interns & residents (in an approved program)	0.00	7.00
7.01	Contracted interns and residents (in approved programs)	0.00	7.01
8.00	Home office personnel	0.00	8.00
9.00	SNF	0.00	9.00
10.00	Excluded area salaries (see instructions)	29.12	10.00
OTHER WAGES & RELATED COSTS			
11.00	Contract labor (see instructions)	68.42	11.00
12.00	Management and administrative services	0.00	12.00
13.00	Contract labor: physician-Part A	0.00	13.00
14.00	Home office salaries & wage-related costs	0.00	14.00
15.00	Home office: physician Part A	0.00	15.00
16.00	Teaching physician salaries (see instructions)	0.00	16.00
WAGE-RELATED COSTS			
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24		17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV Line 25		18.00
19.00	Excluded areas		19.00
20.00	Non-physician anesthetist Part A		20.00
21.00	Non-physician anesthetist Part B		21.00
22.00	Physician Part A		22.00
23.00	Physician Part B		23.00
24.00	Wage-related costs (RHC/FOHC)		24.00
25.00	Interns & residents (in an approved program)		25.00
OVERHEAD COSTS - DIRECT SALARIES			
26.00	Employee Benefits	31.23	26.00
27.00	Administrative & General	31.43	27.00
28.00	Administrative & General under contract (see inst.)	135.55	28.00
29.00	Maintenance & Repairs	0.00	29.00
30.00	Operation of Plant	25.41	30.00
31.00	Laundry & Linen Service	0.00	31.00
32.00	Housekeeping	13.01	32.00
33.00	Housekeeping under contract (see instructions)	0.00	33.00
34.00	Dietary	15.05	34.00
35.00	Dietary under contract (see instructions)	0.00	35.00
36.00	Cafeteria	15.05	36.00
37.00	Maintenance of Personnel	0.00	37.00
38.00	Nursing Administration	38.78	38.00
39.00	Central Services and Supply	14.90	39.00
40.00	Pharmacy	35.61	40.00
41.00	Medical Records & Medical Records Library	20.32	41.00
42.00	Social Service	0.00	42.00
43.00	Other General Service	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150037

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

Worksheet S-3
Part III
Date/Time Prepared:
5/30/2012 6:15 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
	1.00	2.00	3.00	4.00	5.00	
PART III - HOSPITAL WAGE INDEX SUMMARY						
1.00	Net salaries (see instructions)	37,525,706	0	37,525,706	1,272,848.00	1.00
2.00	Excluded area salaries (see instructions)	5,289,619	85,668	5,375,287	184,579.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	32,236,087	-85,668	32,150,419	1,088,269.00	3.00
4.00	Subtotal other wages & related costs (see inst.)	794,170	0	794,170	11,607.00	4.00
5.00	Subtotal wage-related costs (see inst.)	9,101,722	0	9,101,722	0.00	5.00
6.00	Total (sum of lines 3 thru 5)	42,131,979	-85,668	42,046,311	1,099,876.00	6.00
7.00	Total overhead cost (see instructions)	13,585,066	-167,204	13,417,862	493,741.00	7.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet S-3 Part III Date/Time Prepared: 5/30/2012 6:15 pm
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		Average Hourly Wage (col. 4 ÷ col. 5)	
		6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY			
1.00	Net salaries (see instructions)	29.48	1.00
2.00	Excluded area salaries (see instructions)	29.12	2.00
3.00	Subtotal salaries (line 1 minus line 2)	29.54	3.00
4.00	Subtotal other wages & related costs (see inst.)	68.42	4.00
5.00	Subtotal wage-related costs (see inst.)	28.31	5.00
6.00	Total (sum of lines 3 thru 5)	38.23	6.00
7.00	Total overhead cost (see instructions)	27.18	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet S-3 Part IV Date/Time Prepared: 5/30/2012 6:15 pm
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		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	1,288,512	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	5,236	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)	4,733,398	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	241,332	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	134,793	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)	54,640	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	277,564	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	0	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	92,096	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	9,520	22.00
23.00	Tuition Reimbursement	46,826	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,883,917	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150037

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

Worksheet S-3
Part V
Date/Time Prepared:
5/30/2012 6:15 pm

Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00		0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet S-4
		Component CCN: 157092		Date/Time Prepared: 5/30/2012 6:15 pm
			Home Health Agency I	PPS

					1.00	
0.00	County	HANCOCK				0.00

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

HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	326.00	0.00	0.00	2.00

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

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	3.69	0.00	3.69 3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00 4.00
5.00	Other Administrative Personnel			3.85	0.00	3.85 5.00
6.00	Direct Nursing Service			6.90	0.00	6.90 6.00
7.00	Nursing Supervisor			0.00	0.00	0.00 7.00
8.00	Physical Therapy Service			4.53	0.00	4.53 8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00 9.00
10.00	Occupational Therapy Service			2.02	0.00	2.02 10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00 11.00
12.00	Speech Pathology Service			0.10	0.00	0.10 12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00 13.00
14.00	Medical Social Service			0.38	0.00	0.38 14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00 15.00
16.00	Home Health Aide			8.09	0.00	8.09 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.			3		19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		99915			20.00
20.01			26900			20.01
20.02			11300			20.02

		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	1,443	47	85	21	1,596 21.00
22.00	Skilled Nursing Visit Charges	261,725	8,519	15,588	3,806	289,638 22.00
23.00	Physical Therapy Visits	1,645	0	74	32	1,751 23.00
24.00	Physical Therapy Visit Charges	317,896	0	14,301	6,184	338,381 24.00
25.00	Occupational Therapy Visits	835	0	16	14	865 25.00
26.00	Occupational Therapy Visit Charges	161,364	0	3,092	2,706	167,162 26.00
27.00	Speech Pathology Visits	31	0	0	0	31 27.00
28.00	Speech Pathology Visit Charges	5,991	0	0	0	5,991 28.00
29.00	Medical Social Service Visits	57	0	2	2	61 29.00
30.00	Medical Social Service Visit Charges	12,455	0	437	437	13,329 30.00
31.00	Home Health Aide Visits	833	4	4	16	857 31.00
32.00	Home Health Aide Visit Charges	66,224	318	318	1,272	68,132 32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,844	51	181	85	5,161 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)	825,655	8,837	33,736	14,405	882,633 35.00
36.00	Total Number of Episodes (standard/non outlier)	323		68	7	398 36.00
37.00	Total Number of Outlier Episodes		1		0	1 37.00
38.00	Total Non-Routine Medical Supply Charges	6,715	53	0	0	6,768 38.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 150037 Component CCN: 153987	Period: From 01/01/2011 To 12/31/2011	Worksheet S-8 Date/Time Prepared: 5/30/2012 6:15 pm
			Rural Health Clinic (RHC) I	Cost
				1.00
1.00	Clinic Address and Identification			
	Street	437 N MCCULLUM		1.00
		City	State	Zip Code
		1.00	2.00	3.00
2.00	City, State, Zip Code, County		KNI GHTSTOWN	IN
				2.00
				1.00
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0
				3.00
				1.00
				2.00
Source of Federal Funds				
4.00	Community Health Center (Section 330(d), PHS Act)		68,816	12/31/2011
5.00	Migrant Health Center (Section 329(d), PHS Act)		0	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)		0	
7.00	Appalachian Regional Commission		0	
8.00	Look-Alikes		0	
9.00	OTHER (SPECIFY)		0	
				1.00
				2.00
10.00	Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes and "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			0
			N	10.00
		Sunday		
	from	to	Monday	
	1.00	2.00	from	to
			3.00	4.00
11.00	Facility hours of operations (1)			
	Clinic	08:00	16:00	08:00
				16:00
				11.00
				1.00
				2.00
12.00	Have you received an approval for an exception to the productivity standard?			N
13.00	Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N
				0
				12.00
				13.00
				1.00
				2.00
14.00	Provider name, CCN number			
				14.00
		Y/N	V	XVIII
		1.00	2.00	3.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes and "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. (see instructions)			0
				0
				0
				15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 150037 Component CCN: 153987	Period: From 01/01/2011 To 12/31/2011	Worksheet S-8 Date/Time Prepared: 5/30/2012 6:15 pm
			Rural Health Clinic (RHC) I	Cost
		County		
		4.00		
2.00	City, State, Zip Code, County			2.00
		Tuesday		
		from	to	
		5.00	6.00	
		Wednesday		
		from	to	
		7.00	8.00	
11.00	Facility hours of operations (1) Clinic	08:00	16:00	08:00
				16:00
				11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 150037 Component CCN: 153987	Period: From 01/01/2011 To 12/31/2011	Worksheet S-8 Date/Time Prepared: 5/30/2012 6:15 pm
		Rural Health Clinic (RHC) I	Cost

	Thursday		Friday			
	from	to	from	to		
	9.00	10.00	11.00	12.00		
11.00 Facility hours of operations (1) Clinic	08:00	16:00	08:00	16:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 150037 Component CCN: 153987	Period: From 01/01/2011 To 12/31/2011	Worksheet S-8 Date/Time Prepared: 5/30/2012 6:15 pm
		Rural Health Clinic (RHC) I	Cost

		Saturday			
		from	to		
		13.00	14.00		
11.00	Facility hours of operations (1) Clinic				11.00

HOSPITAL IDENTIFICATION DATA

Provider CCN: 150037
Component CCN: 151547

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

Worksheet S-9
Parts I & II
Date/Time Prepared:
5/30/2012 6:15 pm

	Unduplicated Days					All Other	
	Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility			
	1.00	2.00	3.00	4.00	5.00		
PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	1.00
2.00	Routine Home Care	4,302	74	3,355	5	814	2.00
3.00	Inpatient Respite Care	19	0	0	0	10	3.00
4.00	General Inpatient Care	207	2	0	0	71	4.00
5.00	Total Hospice Days	4,528	76	3,355	5	895	5.00
Part II - CENSUS DATA							
6.00	Number of Patients Receiving Hospice Care	198	2	27	1	20	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00			7.00
8.00	Average Length of Stay (line 5/line 6)	22.87	38.00	124.26	5.00	44.75	8.00
9.00	Unduplicated Census Count	191	0	0	0	0	9.00

HOSPITAL IDENTIFICATION DATA		Provider CCN: 150037 Component CCN: 151547	Period: From 01/01/2011 To 12/31/2011	Worksheet S-9 Parts I & II Date/Time Prepared: 5/30/2012 6:15 pm
		Hospice I		

		Unduplicated Days	
		Total (sum of cols. 1, 2 & 5)	
		6.00	
PART I - ENROLLMENT DAYS			
1.00	Continuous Home Care	0	1.00
2.00	Routine Home Care	5,190	2.00
3.00	Inpatient Respite Care	29	3.00
4.00	General Inpatient Care	280	4.00
5.00	Total Hospice Days	5,499	5.00
Part II - CENSUS DATA			
6.00	Number of Patients Receiving Hospice Care	220	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare		7.00
8.00	Average Length of Stay (line 5/line 6)	25.00	8.00
9.00	Unduplicated Census Count	191	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet S-10 Date/Time Prepared: 5/30/2012 6:15 pm
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)		0.399107	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		2,219,089	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		3,097,447	5.00	
6.00	Medicaid charges		14,042,650	6.00	
7.00	Medicaid cost (line 1 times line 6)		5,604,520	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)		287,984	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)		287,984	19.00	
			Uninsured patients	Insured patients	
			1.00	2.00	
			Total (col. 1 + col. 2)		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	4,568,751	0	4,568,751	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,823,421	0	1,823,421	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,823,421	0	1,823,421	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			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)		10,157,492	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		203,502	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		9,953,990	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		3,972,707	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		5,796,128	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		6,084,112	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150037

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

Worksheet A
Date/Time Prepared:
5/30/2012 6:15 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT		6,753,020	6,753,020	0	6,753,020	1.00
4.00 EMPLOYEE BENEFITS	312,456	8,378,339	8,690,795	0	8,690,795	4.00
5.00 ADMINISTRATIVE & GENERAL	7,381,182	7,461,217	14,842,399	-553,777	14,288,622	5.00
7.00 OPERATION OF PLANT	784,658	3,657,561	4,442,219	3,879	4,446,098	7.00
9.00 HOUSEKEEPING	802,515	677,024	1,479,539	0	1,479,539	9.00
10.00 DIETARY	1,034,008	971,670	2,005,678	-1,261,715	743,963	10.00
11.00 CAFETERIA	0	0	0	1,261,715	1,261,715	11.00
13.00 NURSING ADMINISTRATION	645,751	55,069	700,820	0	700,820	13.00
14.00 CENTRAL SERVICES & SUPPLY	61,430	38,220	99,650	0	99,650	14.00
15.00 PHARMACY	1,347,532	2,500,434	3,847,966	-96,030	3,751,936	15.00
16.00 MEDICAL RECORDS & LIBRARY	599,871	284,893	884,764	12,607	897,371	16.00
23.00 PARAMED ED PRGM	61,648	12,645	74,293	0	74,293	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	3,520,999	730,325	4,251,324	0	4,251,324	30.00
31.00 INTENSIVE CARE UNIT	2,824,376	563,558	3,387,934	0	3,387,934	31.00
40.00 SUBPROVIDER - IPF	914,376	183,019	1,097,395	0	1,097,395	40.00
41.00 SUBPROVIDER - IRF	651,021	149,593	800,614	0	800,614	41.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	2,119,730	1,406,822	3,526,552	0	3,526,552	50.00
51.00 RECOVERY ROOM	305,982	37,702	343,684	27,787	371,471	51.00
53.00 ANESTHESIOLOGY	0	131,666	131,666	0	131,666	53.00
54.00 RADIOLOGY-DIAGNOSTIC	2,462,301	1,894,653	4,356,954	0	4,356,954	54.00
60.00 LABORATORY	1,489,230	2,445,037	3,934,267	67,193	4,001,460	60.00
65.00 RESPIRATORY THERAPY	1,152,359	293,277	1,445,636	8,238	1,453,874	65.00
66.00 PHYSICAL THERAPY	951,505	223,319	1,174,824	0	1,174,824	66.00
67.00 OCCUPATIONAL THERAPY	277,605	40,886	318,491	0	318,491	67.00
68.00 SPEECH PATHOLOGY	148,335	27,188	175,523	0	175,523	68.00
68.01 OCCUPATIONAL HEALTH	0	66	66	0	66	68.01
69.00 ELECTROCARDIOLOGY	443,750	535,798	979,548	13,450	992,998	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,529,092	3,529,092	0	3,529,092	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	1,483,211	1,483,211	0	1,483,211	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	0	0	0	0	0	76.00
76.97 CARDIAC REHABILITATION	48,998	54,682	103,680	0	103,680	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	165,440	98,486	263,926	0	263,926	88.00
90.00 CLINIC	0	0	0	0	0	90.00
90.01 WOUND CLINIC	99,685	1,091,198	1,190,883	0	1,190,883	90.01
90.02 DIABETES CLINIC	0	0	0	0	0	90.02
90.03 ASTHMA CLINIC	0	0	0	0	0	90.03
90.04 ANDI'S CLINIC	41,741	53,928	95,669	0	95,669	90.04
90.05 PRIME TIME	478,108	134,994	613,102	0	613,102	90.05
90.06 SHELBYVILLE WOUND CLINIC	60,141	66,531	126,672	0	126,672	90.06
91.00 EMERGENCY	2,226,176	526,455	2,752,631	0	2,752,631	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	1,686,025	383,656	2,069,681	0	2,069,681	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 HOSPICE	540,000	819,167	1,359,167	0	1,359,167	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	35,638,934	47,694,401	83,333,335	-516,653	82,816,682	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01 PROFESSIONAL BUI LDING	0	520,334	520,334	-37,124	483,210	190.01
190.02 PHYSICIAN BUI LDING	90,630	182,288	272,918	0	272,918	190.02
190.03 PRIVATE DUTY	369,290	209,166	578,456	0	578,456	190.03
190.04 MARKETING	0	0	0	553,777	553,777	190.04
190.05 WATER LAB	0	0	0	0	0	190.05
190.06 FOUNDATION	88,677	32,403	121,080	0	121,080	190.06
190.07 ASC	0	2,505	2,505	0	2,505	190.07
190.08 ANDERSON WOMEN'S CLINIC	196,934	66,689	263,623	0	263,623	190.08
190.09 HANCOCK OB	591,602	939,468	1,531,070	0	1,531,070	190.09
190.10 HANCOCK WELLNESS	99,416	8,941	108,357	0	108,357	190.10
200.00 TOTAL (SUM OF LINES 118-199)	37,075,483	49,656,195	86,731,678	0	86,731,678	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150037

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

Worksheet A
Date/Time Prepared:
5/30/2012 6:15 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	-1,512,982	5,240,038	1.00
4.00	EMPLOYEE BENEFITS	0	8,690,795	4.00
5.00	ADMINISTRATIVE & GENERAL	-1,300,878	12,987,744	5.00
7.00	OPERATION OF PLANT	-130,152	4,315,946	7.00
9.00	HOUSEKEEPING	-27,383	1,452,156	9.00
10.00	DIETARY	-219,216	524,747	10.00
11.00	CAFETERIA	-559,132	702,583	11.00
13.00	NURSING ADMINISTRATION	0	700,820	13.00
14.00	CENTRAL SERVICES & SUPPLY	-59,608	40,042	14.00
15.00	PHARMACY	-501,465	3,250,471	15.00
16.00	MEDICAL RECORDS & LIBRARY	-76,600	820,771	16.00
23.00	PARAMED ED PRGM	-68,120	6,173	23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-2,271	4,249,053	30.00
31.00	INTENSIVE CARE UNIT	0	3,387,934	31.00
40.00	SUBPROVIDER - IPF	-56,575	1,040,820	40.00
41.00	SUBPROVIDER - IRF	-72,000	728,614	41.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	-568,796	2,957,756	50.00
51.00	RECOVERY ROOM	0	371,471	51.00
53.00	ANESTHESIOLOGY	-130,813	853	53.00
54.00	RADIOLOGY-DIAGNOSTIC	-726,702	3,630,252	54.00
60.00	LABORATORY	-215,977	3,785,483	60.00
65.00	RESPIRATORY THERAPY	-310,951	1,142,923	65.00
66.00	PHYSICAL THERAPY	-2,099	1,172,725	66.00
67.00	OCCUPATIONAL THERAPY	0	318,491	67.00
68.00	SPEECH PATHOLOGY	-627	174,896	68.00
68.01	OCCUPATIONAL HEALTH	-66	0	68.01
69.00	ELECTROCARDIOLOGY	-560	992,438	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	-55	3,529,037	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	1,483,211	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00		0	0	76.00
76.97	CARDIAC REHABILITATION	0	103,680	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	-13,090	250,836	88.00
90.00	CLINIC	0	0	90.00
90.01	WOUND CLINIC	-241,679	949,204	90.01
90.02	DIABETES CLINIC	0	0	90.02
90.03	ASTHMA CLINIC	0	0	90.03
90.04	ANDI'S CLINIC	-56,118	39,551	90.04
90.05	PRIME TIME	-18,200	594,902	90.05
90.06	SHELBYVILLE WOUND CLINIC	0	126,672	90.06
91.00	EMERGENCY	-60,911	2,691,720	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	HOME HEALTH AGENCY	0	2,069,681	101.00
SPECIAL PURPOSE COST CENTERS				
116.00	HOSPICE	-3,439	1,355,728	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-6,936,465	75,880,217	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	PROFESSIONAL BUILDING	0	483,210	190.01
190.02	PHYSICIAN BUILDING	0	272,918	190.02
190.03	PRIVATE DUTY	0	578,456	190.03
190.04	MARKETING	0	553,777	190.04
190.05	WATER LAB	0	0	190.05
190.06	FOUNDATION	0	121,080	190.06
190.07	ASC	0	2,505	190.07
190.08	ANDERSON WOMEN'S CLINIC	0	263,623	190.08
190.09	HANCOCK OB	0	1,531,070	190.09
190.10	HANCOCK WELLNESS	0	108,357	190.10
200.00	TOTAL (SUM OF LINES 118-199)	-6,936,465	79,795,213	200.00

RECLASSIFICATIONS

Provider CCN: 150037

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

Worksheet A-6

Date/Time Prepared:
5/30/2012 6:15 pm

		Increases			
Cost Center		Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	650,465	611,250	1.00
	TOTALS		650,465	611,250	
B - PLANT					
1.00	OPERATION OF PLANT	7.00	0	3,879	1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	12,607	2.00
3.00	ELECTROCARDIOLOGY	69.00	0	12,400	3.00
4.00	RESPIRATORY THERAPY	65.00	0	8,238	4.00
	TOTALS		0	37,124	
C - MARKETING					
1.00	MARKETING	190.04	85,668	468,109	1.00
	TOTALS		85,668	468,109	
D - OUTPATIENT PROCEDURE					
1.00	RECOVERY ROOM	51.00	23,593	4,194	1.00
2.00	LABORATORY	60.00	57,051	10,142	2.00
3.00	ELECTROCARDIOLOGY	69.00	892	158	3.00
	TOTALS		81,536	14,494	
500.00	Grand Total: Increases		817,669	1,130,977	500.00

RECLASSIFICATIONS

Provider CCN: 150037

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

Worksheet A-6
Date/Time Prepared:
5/30/2012 6:15 pm

Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - CAFETERIA							
1.00	DIETARY	10.00	650,465	611,250	0		1.00
	TOTALS		650,465	611,250			
B - PLANT							
1.00	PROFESSIONAL BUILDING	190.01	0	37,124	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		0	37,124			
C - MARKETING							
1.00	ADMINISTRATIVE & GENERAL	5.00	85,668	468,109	0		1.00
	TOTALS		85,668	468,109			
D - OUTPATIENT PROCEDURE							
1.00	PHARMACY	15.00	81,536	14,494	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		81,536	14,494			
500.00	Grand Total: Decreases		817,669	1,130,977			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150037

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/30/2012 6:15 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	270,285	0	0	0	1.00
2.00	Land Improvements	5,382,451	644	0	644	2.00
3.00	Buildings and Fixtures	40,670,101	8,271	0	8,271	3.00
4.00	Building Improvements	56,563,820	797,686	0	797,686	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	45,700,307	6,359,409	0	6,359,409	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	148,586,964	7,166,010	0	7,166,010	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	148,586,964	7,166,010	0	7,166,010	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	4,620,820	0	1,572,950	528,421	1.00
3.00	Total (sum of lines 1-2)	4,620,820	0	1,572,950	528,421	3.00
COMPUTATION OF RATIOS						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150037

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/30/2012 6:15 pm

		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	270,285	0					1.00
2.00	Land Improvements	5,383,095	0					2.00
3.00	Buildings and Fixtures	40,678,372	0					3.00
4.00	Building Improvements	51,149,225	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	52,059,716	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	149,540,693	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	149,540,693	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	6,753,020					1.00
3.00	Total (sum of lines 1-2)	0	6,753,020					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	3,117,753	0	1.00	
3.00	Total (sum of lines 1-2)	0	0	0	3,117,753	0	3.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150037

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/30/2012 6:15 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,563,035	528,421	30,829	0	5,240,038	1.00
3.00	Total (sum of lines 1-2)	1,563,035	528,421	30,829	0	5,240,038	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150037

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

Worksheet A-8

Date/Time Prepared:
5/30/2012 6:15 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center	Line #	
			3.00	4.00	
1.00	2.00	3.00	4.00		
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	*** Cost Center Deleted ***	2.00 2.00
3.00 Investment income - other (chapter 2)			0		0.00 3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00 4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00 5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00 7.00
8.00 Television and radio service (chapter 21)			0		0.00 8.00
9.00 Parking lot (chapter 21)			0		0.00 9.00
10.00 Provider-based physician adjustment	A-8-2	-1,221,746	0		10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00 11.00
12.00 Related organization transactions (chapter 10)	A-8-1		0		12.00
13.00 Laundry and linen service			0		0.00 13.00
14.00 Cafeteria-employees and guests			0		0.00 14.00
15.00 Rental of quarters to employee and others			0		0.00 15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00 16.00
17.00 Sale of drugs to other than patients			0		0.00 17.00
18.00 Sale of medical records and abstracts			0		0.00 18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00 19.00
20.00 Vending machines			0		0.00 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00 23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00 24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00 25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	*** Cost Center Deleted ***	2.00 27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00 28.00
29.00 Physicians' assistant			0		0.00 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00 30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00 31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A		0		0.00 32.00
33.00 HRH MMO RENTAL INCOME	B	-553,223	0	NEW CAP REL COSTS-BLDG & FIXT	1.00 33.00
34.00 HRH OTHER REVENUE SALES TAX	B	41,680	0	ADMINISTRATIVE & GENERAL	5.00 34.00
35.00 HRH OTHER REVENUE MISCELLANEOUS REVE	B	-2,929	0	ADMINISTRATIVE & GENERAL	5.00 35.00
36.00 HRH OTHER REVENUE CHARGE CARD-OTHER	B	3,982	0	ADMINISTRATIVE & GENERAL	5.00 36.00
37.00 HRH GREENFIELD PAR EDUCATION SERVICE	B	-13,876	0	ADMINISTRATIVE & GENERAL	5.00 37.00
38.00 HRH HOME MED EQUIP HME--OTC SALES	B	-64,507	0	ADMINISTRATIVE & GENERAL	5.00 38.00
39.00 HRH CLIN EXCELLENCE MISCELLANEOUS RE	B	-546	0	ADMINISTRATIVE & GENERAL	5.00 39.00
40.00 HRH CLIN EXCELLENCE AHA COURSE REVEN	B	-9,636	0	ADMINISTRATIVE & GENERAL	5.00 40.00
41.00 HRH CLIN EXCELLENCE EDUCATION SERVIC	B	-315	0	ADMINISTRATIVE & GENERAL	5.00 41.00
42.00 HRH MED STAFF SERV QA APPLICATION FE	B	-7,500	0	ADMINISTRATIVE & GENERAL	5.00 42.00
43.00 HRH MEDICAL DUES MEDICAL STAFF DUES	B	-19,050	0	ADMINISTRATIVE & GENERAL	5.00 43.00
44.00 HRH PAT FIN. SERV. BUSINESS SERV-COP	B	-1,994	0	ADMINISTRATIVE & GENERAL	5.00 44.00
45.00 HRH PAT FIN. SERV. EXPENSE REIMBURSE	B	-49,398	0	ADMINISTRATIVE & GENERAL	5.00 45.00
45.01 HRH INFO SERVICES MISCELLANEOUS REVE	B	-100,835	0	ADMINISTRATIVE & GENERAL	5.00 45.01
45.02 HRH ACCOUNTING MISCELLANEOUS REVENUE	B	-10,411	0	ADMINISTRATIVE & GENERAL	5.00 45.02
45.03 HRH ACCOUNTING MANAGEMENT FEES	B	-24,925	0	ADMINISTRATIVE & GENERAL	5.00 45.03
45.04 HRH EXEC ADMIN MISCELLANEOUS REVENUE	B	-843	0	ADMINISTRATIVE & GENERAL	5.00 45.04
45.05 HRH VOLUNTEERS MISCELLANEOUS REVENUE	B	-19	0	ADMINISTRATIVE & GENERAL	5.00 45.05
45.06 HRH VOLUNTEERS OTHER REV CLEARING AC	B	19	0	ADMINISTRATIVE & GENERAL	5.00 45.06
45.07 HRH PURCHASING MISCELLANEOUS REVENUE	B	-94	0	ADMINISTRATIVE & GENERAL	5.00 45.07

ADJUSTMENTS TO EXPENSES

Provider CCN: 150037

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

Worksheet A-8

Date/Time Prepared:
5/30/2012 6:15 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	
			Cost Center	Line #
			1.00	2.00
45.08 HRH PURCHASING REBATES/REFUNDS	B	-1,337	ADMINISTRATIVE & GENERAL	5.00 45.08
45.09 HRH COMMUNICATIONS MISCELLANEOUS REV	B	-81	ADMINISTRATIVE & GENERAL	5.00 45.09
45.10 HRH COMMUNICATIONS PHONE LEASE REVEN	B	-127,333	ADMINISTRATIVE & GENERAL	5.00 45.10
45.11 HRH TRAIN & DEVELOP MISCELLANEOUS RE	B	-78	ADMINISTRATIVE & GENERAL	5.00 45.11
45.12 HRH TRAIN & DEVELOP EDUCATION SERVICE	B	-457	ADMINISTRATIVE & GENERAL	5.00 45.12
45.13 HRH COMM EDUCATION EDUCATION SERVICE	B	-12,575	ADMINISTRATIVE & GENERAL	5.00 45.13
45.14 HRH COMM EDUCATION CAR SEAT COMMUNIT	B	-124	ADMINISTRATIVE & GENERAL	5.00 45.14
45.15 HRH COMM EDUCATION CAR SEAT STATE FU	B	-2,100	ADMINISTRATIVE & GENERAL	5.00 45.15
45.16 HRH TOBACCO AWARENE MISCELLANEOUS RE	B	-59	ADMINISTRATIVE & GENERAL	5.00 45.16
45.17 HRH TOBACCO AWARENE EDUCATION SERVIC	B	-130	ADMINISTRATIVE & GENERAL	5.00 45.17
45.18 HRH WILLIAMS PROPER RENTAL INCOME	B	-11,550	ADMINISTRATIVE & GENERAL	5.00 45.18
45.19 HRH GAIN/LOSS INVENTORY	B	124,962	ADMINISTRATIVE & GENERAL	5.00 45.19
45.20 HRH GAIN/LOSS GROSS VARIANCE INVENTO	B	2,463	ADMINISTRATIVE & GENERAL	5.00 45.20
45.21 HRH PLANT OFFSITE SERVICES	B	-65,671	OPERATION OF PLANT	7.00 45.21
45.22 HRH PLANT REBATES/REFUNDS	B	-15	OPERATION OF PLANT	7.00 45.22
45.23 HRH PLANT PLANT SERVICES REVENUE	B	-260	OPERATION OF PLANT	7.00 45.23
45.24 HRH OFFSITE SERV OFFSITE SERVICES	B	-27,383	HOUSEKEEPING	9.00 45.24
45.25 HRH NUTRITIONAL SER REBATES/REFUNDS	B	-12,135	DIETARY	10.00 45.25
45.26 HRH OTHER REVENUE REBATES/REFUNDS	B	-50,421	CENTRAL SERVICES & SUPPLY	14.00 45.26
45.27 HRH OTHER REVENUE DISCOUNTS EARNED O	B	-9,187	CENTRAL SERVICES & SUPPLY	14.00 45.27
45.28 HRH PHARMACY MISCELLANEOUS REVENUE	B	-2,253	PHARMACY	15.00 45.28
45.29 HRH PHARMACY REBATES/REFUNDS	B	-3,654	PHARMACY	15.00 45.29
45.30 HRH ASSOCIATE PHARM RETAIL PHARMACY-	B	-495,558	PHARMACY	15.00 45.30
45.31 HRH HEALTH INFO SER MEDICAL RECORDS-	B	-4,362	MEDICAL RECORDS & LIBRARY	16.00 45.31
45.32 HRH HEALTH INFO SER MISCELLANEOUS RE	B	-72,238	MEDICAL RECORDS & LIBRARY	16.00 45.32
45.33 HRH MED/SURG-3 WEST REBATES/REFUNDS	B	-315	ADULTS & PEDIATRICS	30.00 45.33
45.34 HRH JOINT & SPINE REBATES/REFUNDS	B	-315	ADULTS & PEDIATRICS	30.00 45.34
45.35 HRH ANDIS UNIT GRANTS	B	-598	ADULTS & PEDIATRICS	30.00 45.35
45.36 HRH ANDIS UNIT REBATES/REFUNDS	B	-728	ADULTS & PEDIATRICS	30.00 45.36
45.37 HRH CCU REBATES/REFUNDS	B	-315	ADULTS & PEDIATRICS	30.00 45.37
45.38 HRH SURGERY REBATES/REFUNDS	B	-315	OPERATING ROOM	50.00 45.38
45.39 HRH BARIATRIC SERV RENTAL INCOME	B	-2,952	OPERATING ROOM	50.00 45.39
45.40 HRH HAN GEN SURG PHYS OTHER REVENUE	B	-1,611,488	OPERATING ROOM	50.00 45.40
45.41 HRH HAN GEN SURG CONTRACTUAL PHYS OT	B	1,087,790	OPERATING ROOM	50.00 45.41
45.42 HRH RADIOLOGY-REV COMMUNITY BENEFITS	B	20	RADIOLOGY-DIAGNOSTIC	54.00 45.42
45.43 HRH DIAG IMAGING MISCELLANEOUS REVEN	B	-238	RADIOLOGY-DIAGNOSTIC	54.00 45.43
45.44 HRH DIAG IMAGING REBATES/REFUNDS	B	-1,140	RADIOLOGY-DIAGNOSTIC	54.00 45.44
45.45 HRH DIAG IMAGING HEARTBEATS REVENUE	B	-5,375	RADIOLOGY-DIAGNOSTIC	54.00 45.45
45.46 HRH PIC - AHN EXPENSE REIMBURSEMENT	B	-547,232	RADIOLOGY-DIAGNOSTIC	54.00 45.46
45.47 HRH MMO-US HEARTBEATS REVENUE	B	-385	RADIOLOGY-DIAGNOSTIC	54.00 45.47
45.48 HRH MMO-DEXA HEARTBEATS REVENUE	B	-280	RADIOLOGY-DIAGNOSTIC	54.00 45.48
45.49 HRH MMO EXPENSE REIMBURSEMENT	B	-172,072	RADIOLOGY-DIAGNOSTIC	54.00 45.49
45.50 HRH LAB WATER TESTING	B	-50,640	LABORATORY	60.00 45.50
45.51 HRH LAB HEARTBEATS REVENUE	B	-40,337	LABORATORY	60.00 45.51
45.52 HRH SLEEP STUDY CLINIC MANAGMENT	B	-97,200	RESPIRATORY THERAPY	65.00 45.52
45.53 HRH SLEEP STUDY SLEEP STUDY FEES	B	-189,751	RESPIRATORY THERAPY	65.00 45.53
45.54 HRH MMO - PT MISCELLANEOUS REVENUE	B	-1,149	PHYSICAL THERAPY	66.00 45.54
45.55 HRH SPEECH THERAPY MISCELLANEOUS REV	B	-5	SPEECH PATHOLOGY	68.00 45.55
45.56 HRH CARDIO SERV CARDIO SERVICES	B	-560	ELECTROCARDIOLOGY	69.00 45.56
45.57 HRH WOUND/SKIN CLIN LEASED EMPLOYEE	B	-66,388	WOUND CLINIC	90.01 45.57
45.58 HRH ANDIS WOMEN'S C KROGER DONATIONS	B	-3,402	ANDIS CLINIC	90.04 45.58
45.59 HRH ANDIS WOMEN'S C IBCAT	B	-5,950	ANDIS CLINIC	90.04 45.59
45.60 HRH ANDIS WOMEN'S C CLINIC MANAGMENT	B	-44,141	ANDIS CLINIC	90.04 45.60
45.61 HRH ER REBATES/REFUNDS	B	-911	EMERGENCY	91.00 45.61
45.62 HRH HOSPICE CHARITABLE TRUST	B	-3,439	HOSPICE	116.00 45.62
45.63 CAFETERIA - EMPLOYEES	B	-492,617	CAFETERIA	11.00 45.63
45.64 DIETARY REVENUE	B	-6,053	DIETARY	10.00 45.64
45.65 MOW	A	-201,028	DIETARY	10.00 45.65
45.66 CAFETERIA GUEST MEALS	A	-66,515	CAFETERIA	11.00 45.66
45.67 PHYSICIAN RECRUITMENT FEES	A	-59,440	ADMINISTRATIVE & GENERAL	5.00 45.67
45.68 DONATIONS & SPONSORSHIPS	A	-43,256	ADMINISTRATIVE & GENERAL	5.00 45.68
45.69 ADVERTISING FEE	A	-240,370	ADMINISTRATIVE & GENERAL	5.00 45.69
45.70 ADVERTISING FEE	A	-600	PHYSICAL THERAPY	66.00 45.70
45.71 ADVERTISING FEE	A	-622	SPEECH PATHOLOGY	68.00 45.71
45.72 ADVERTISING FEE	A	-247	WOUND CLINIC	90.01 45.72
45.73 LI FELINE OTHER EXPENSE	A	-24,923	ADMINISTRATIVE & GENERAL	5.00 45.73
45.74 IHA LOBBYING EXPENSE	A	-2,146	ADMINISTRATIVE & GENERAL	5.00 45.74
45.75 AHA LOBBYING EXPENSE	A	-5,353	ADMINISTRATIVE & GENERAL	5.00 45.75

Provider CCN: 150037
 Period: From 01/01/2011 To 12/31/2011
 Worksheet A-8
 Date/Time Prepared: 5/30/2012 6:15 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	
			Cost Center			
			1.00	2.00		
45.76 PHY OFFICE BLDG	A	-952,804	NEW CAP REL COSTS-BLDG & FI XT	1.00	45.76	
45.77 PHY OFFICE BLDG	A	-64,206	OPERATION OF PLANT	7.00	45.77	
45.78 INTEREST REVENUE	B	-2,591	NEW CAP REL COSTS-BLDG & FI XT	1.00	45.78	
45.79 RENTAL PROPERTIES EXPENSE	A	-98,471	ADMINISTRATIVE & GENERAL	5.00	45.79	
45.80 RENTAL PROPERTIES EXPENSE	A	-7,324	NEW CAP REL COSTS-BLDG & FI XT	1.00	45.80	
45.81 TELEPHONE SERVICES	A	-35,105	ADMINISTRATIVE & GENERAL	5.00	45.81	
45.82 1987 USEFUL LIFE ADJ	A	2,960	NEW CAP REL COSTS-BLDG & FI XT	1.00	45.82	
45.83 OCCUPATIONAL HEALTH	A	-66	OCCUPATIONAL HEALTH	68.01	45.83	
45.84 RENTAL PROPERTIES EXPENSE	A	-55	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	45.84	
45.85 XRAY SCHOOL TUITION REVENUE	B	-68,120	PARAMED ED PRGM	23.00	45.85	
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,936,465			50.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 150037

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

Worksheet A-8
Date/Time Prepared:
5/30/2012 6:15 pm

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	HRH MMO RENTAL INCOME	9	33.00
34.00	HRH OTHER REVENUE SALES TAX	0	34.00
35.00	HRH OTHER REVENUE MISCELLANEOUS REVE	0	35.00
36.00	HRH OTHER REVENUE CHARGE CARD-OTHER	0	36.00
37.00	HRH GREENFIELD PAR EDUCATION SERVICE	0	37.00
38.00	HRH HOME MED EQUIP HME--OTC SALES	0	38.00
39.00	HRH CLIN EXCELLENCE MISCELLANEOUS RE	0	39.00
40.00	HRH CLIN EXCELLENCE AHA COURSE REVEN	0	40.00
41.00	HRH CLIN EXCELLENCE EDUCATION SERVICE	0	41.00
42.00	HRH MED STAFF SERV QA APPLICATION FE	0	42.00
43.00	HRH MEDICAL DUES MEDICAL STAFF DUES	0	43.00
44.00	HRH PAT FIN. SERV. BUSINESS SERV-COP	0	44.00
45.00	HRH PAT FIN. SERV. EXPENSE REIMBURSE	0	45.00
45.01	HRH INFO SERVICES MISCELLANEOUS REVE	0	45.01
45.02	HRH ACCOUNTING MISCELLANEOUS REVENUE	0	45.02
45.03	HRH ACCOUNTING MANAGEMENT FEES	0	45.03
45.04	HRH EXEC ADMIN MISCELLANEOUS REVENUE	0	45.04
45.05	HRH VOLUNTEERS MISCELLANEOUS REVENUE	0	45.05
45.06	HRH VOLUNTEERS OTHER REV CLEARING AC	0	45.06
45.07	HRH PURCHASING MISCELLANEOUS REVENUE	0	45.07
45.08	HRH PURCHASING REBATES/REFUNDS	0	45.08
45.09	HRH COMMUNICATIONS MISCELLANEOUS REV	0	45.09
45.10	HRH COMMUNICATIONS PHONE LEASE REVEN	0	45.10
45.11	HRH TRAIN & DEVELOP MISCELLANEOUS RE	0	45.11
45.12	HRH TRAIN & DEVELOP EDUCATION SERVICE	0	45.12
45.13	HRH COMM EDUCATION EDUCATION SERVICE	0	45.13
45.14	HRH COMM EDUCATION CAR SEAT COMMUNIT	0	45.14
45.15	HRH COMM EDUCATION CAR SEAT STATE FU	0	45.15

ADJUSTMENTS TO EXPENSES

Provider CCN: 150037

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

Worksheet A-8
Date/Time Prepared:
5/30/2012 6:15 pm

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
45.16	HRH TOBACCO AWARENE MISCELLANEOUS RE	0	45.16
45.17	HRH TOBACCO AWARENE EDUCATION SERVIC	0	45.17
45.18	HRH WILLIAMS PROPER RENTAL INCOME	0	45.18
45.19	HRH GAIN/LOSS INVENTORY	0	45.19
45.20	HRH GAIN/LOSS GROSS VARIANCE INVENTO	0	45.20
45.21	HRH PLANT OFFSITE SERVICES	0	45.21
45.22	HRH PLANT REBATES/REFUNDS	0	45.22
45.23	HRH PLANT PLANT SERVICES REVENUE	0	45.23
45.24	HRH OFFSITE SERV OFFSITE SERVICES	0	45.24
45.25	HRH NUTRI TIONAL SER REBATES/REFUNDS	0	45.25
45.26	HRH OTHER REVENUE REBATES/REFUNDS	0	45.26
45.27	HRH OTHER REVENUE DISCOUNTS EARNED O	0	45.27
45.28	HRH PHARMACY MISCELLANEOUS REVENUE	0	45.28
45.29	HRH PHARMACY REBATES/REFUNDS	0	45.29
45.30	HRH ASSOCIATE PHARM RETAIL PHARMACY-	0	45.30
45.31	HRH HEALTH INFO SER MEDICAL RECORDS-	0	45.31
45.32	HRH HEALTH INFO SER MISCELLANEOUS RE	0	45.32
45.33	HRH MED/SURG-3 WEST REBATES/REFUNDS	0	45.33
45.34	HRH JOINT & SPI NE REBATES/REFUNDS	0	45.34
45.35	HRH ANDIS UNIT GRANTS	0	45.35
45.36	HRH ANDIS UNIT REBATES/REFUNDS	0	45.36
45.37	HRH CCU REBATES/REFUNDS	0	45.37
45.38	HRH SURGERY REBATES/REFUNDS	0	45.38
45.39	HRH BARIATRIC SERV RENTAL INCOME	0	45.39
45.40	HRH HAN GEN SURG PHYS OTHER REVENUE	0	45.40
45.41	HRH HAN GEN SURG CONTRACTUAL PHYS OT	0	45.41
45.42	HRH RADIOLOGY-REV COMMUNITY BENEFITS	0	45.42
45.43	HRH DIAG IMAGING MISCELLANEOUS REVEN	0	45.43
45.44	HRH DIAG IMAGING REBATES/REFUNDS	0	45.44
45.45	HRH DIAG IMAGING HEARTBEATS REVENUE	0	45.45
45.46	HRH PIC - AHN EXPENSE REIMBURSEMENT	0	45.46
45.47	HRH MMO-US HEARTBEATS REVENUE	0	45.47
45.48	HRH MMO-DEXA HEARTBEATS REVENUE	0	45.48
45.49	HRH MMO EXPENSE REIMBURSEMENT	0	45.49
45.50	HRH LAB WATER TESTING	0	45.50
45.51	HRH LAB HEARTBEATS REVENUE	0	45.51
45.52	HRH SLEEP STUDY CLINIC MANAGMENT	0	45.52
45.53	HRH SLEEP STUDY SLEEP STUDY FEES	0	45.53
45.54	HRH MMO - PT MISCELLANEOUS REVENUE	0	45.54
45.55	HRH SPEECH THERAPY MISCELLANEOUS REV	0	45.55
45.56	HRH CARDIO SERV CARDIO SERVICES	0	45.56
45.57	HRH WOUND/SKIN CLIN LEASED EMPLOYEE	0	45.57
45.58	HRH ANDIS WOMEN' S C KROGER DONATIONS	0	45.58
45.59	HRH ANDIS WOMEN' S C IBCAT	0	45.59
45.60	HRH ANDIS WOMEN' S C CLINIC MANAGMENT	0	45.60
45.61	HRH E R REBATES/REFUNDS	0	45.61
45.62	HRH HOSPI CE CHARITABLE TRUST	0	45.62
45.63	CAFETERIA - EMPLOYEES	0	45.63
45.64	DIETARY REVENUE	0	45.64
45.65	MOW	0	45.65
45.66	CAFETERIA GUEST MEALS	0	45.66
45.67	PHYSICIAN RECRUITMENT FEES	0	45.67
45.68	DONATIONS & SPONSORSHIPS	0	45.68
45.69	ADVERTISING FEE	0	45.69
45.70	ADVERTISING FEE	0	45.70
45.71	ADVERTISING FEE	0	45.71
45.72	ADVERTISING FEE	0	45.72
45.73	LIFELINE OTHER EXPENSE	0	45.73
45.74	IHA LOBBYING EXPENSE	0	45.74
45.75	AHA LOBBYING EXPENSE	0	45.75
45.76	PHY OFFICE BLDG	9	45.76
45.77	PHY OFFICE BLDG	0	45.77
45.78	INTEREST REVENUE	11	45.78
45.79	RENTAL PROPERTIES EXPENSE	0	45.79
45.80	RENTAL PROPERTIES EXPENSE	11	45.80
45.81	TELEPHONE SERVICES	0	45.81
45.82	1987 USEFUL LIFE ADJ	9	45.82
45.83	OCCUPATIONAL HEALTH	0	45.83
45.84	RENTAL PROPERTIES EXPENSE	0	45.84
45.85	XRAY SCHOOL TUITI ON REVENUE	0	45.85
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: 150037

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

Worksheet A-8-2

Date/Time Prepared:
5/30/2012 6:15 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	502,218	502,218	1.00
2.00	40.00	SUBPROVIDER - IPF	56,575	56,575	2.00
3.00	41.00	SUBPROVIDER - IRF	72,000	72,000	3.00
4.00	50.00	OPERATING ROOM	41,831	41,831	4.00
5.00	53.00	ANESTHESIOLOGY	130,813	130,813	5.00
6.00	60.00	LABORATORY	125,000	125,000	6.00
7.00	65.00	RESPIRATORY THERAPY	24,000	24,000	7.00
8.00	66.00	PHYSICAL THERAPY	350	350	8.00
9.00	88.00	RURAL HEALTH CLINIC	13,090	13,090	9.00
10.00	90.01	WOUND CLINIC	175,044	175,044	10.00
11.00	90.04	ANDI'S CLINIC	2,625	2,625	11.00
12.00	90.05	PRIME TIME	18,200	18,200	12.00
13.00	91.00	EMERGENCY	60,000	60,000	13.00
200.00			1,221,746	1,221,746	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150037

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

Worksheet A-8-2

Date/Time Prepared:
5/30/2012 6:15 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
11.00	0	0	0	0	0	11.00
12.00	0	0	0	0	0	12.00
13.00	0	0	0	0	0	13.00
200.00	0	0	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150037

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

Worksheet A-8-2

Date/Time Prepared:
5/30/2012 6:15 pm

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150037

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

Worksheet A-8-2
Date/Time Prepared:
5/30/2012 6:15 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	502,218	1.00
2.00	0	56,575	2.00
3.00	0	72,000	3.00
4.00	0	41,831	4.00
5.00	0	130,813	5.00
6.00	0	125,000	6.00
7.00	0	24,000	7.00
8.00	0	350	8.00
9.00	0	13,090	9.00
10.00	0	175,044	10.00
11.00	0	2,625	11.00
12.00	0	18,200	12.00
13.00	0	60,000	13.00
200.00	0	1,221,746	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150037

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2012 6:15 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT				
	0	1.00	4.00	4A	5.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT	5,240,038	5,240,038				1.00
4.00 EMPLOYEE BENEFITS	8,690,795	17,010	8,707,805			4.00
5.00 ADMINISTRATIVE & GENERAL	12,987,744	394,859	1,728,042	15,110,645	15,110,645	5.00
7.00 OPERATION OF PLANT	4,315,946	1,352,078	185,856	5,853,880	1,367,499	7.00
9.00 HOUSEKEEPING	1,452,156	33,475	190,086	1,675,717	391,456	9.00
10.00 DIETARY	524,747	56,748	90,847	672,342	157,062	10.00
11.00 CAFETERIA	702,583	96,226	154,071	952,880	222,598	11.00
13.00 NURSING ADMINISTRATION	700,820	0	152,955	853,775	199,446	13.00
14.00 CENTRAL SERVICES & SUPPLY	40,042	0	14,550	54,592	12,753	14.00
15.00 PHARMACY	3,250,471	76,773	299,868	3,627,112	847,311	15.00
16.00 MEDICAL RECORDS & LIBRARY	820,771	45,729	142,087	1,008,587	235,611	16.00
23.00 PARAMED ED PRGM	6,173	17,465	14,602	38,240	8,933	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	4,249,053	403,800	833,994	5,486,847	1,281,755	30.00
31.00 INTENSIVE CARE UNIT	3,387,934	309,925	668,990	4,366,849	1,020,118	31.00
40.00 SUBPROVIDER - I PF	1,040,820	82,855	216,582	1,340,257	313,091	40.00
41.00 SUBPROVIDER - I RF	728,614	57,047	154,203	939,864	219,557	41.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	2,957,756	306,339	502,086	3,766,181	879,799	50.00
51.00 RECOVERY ROOM	371,471	27,549	78,064	477,084	111,449	51.00
53.00 ANESTHESIOLOGY	853	0	0	853	199	53.00
54.00 RADIOLOGY-DIAGNOSTIC	3,630,252	191,933	583,228	4,405,413	1,029,127	54.00
60.00 LABORATORY	3,785,483	82,569	366,257	4,234,309	989,156	60.00
65.00 RESPIRATORY THERAPY	1,142,923	30,044	272,951	1,445,918	337,774	65.00
66.00 PHYSICAL THERAPY	1,172,725	56,488	225,376	1,454,589	339,799	66.00
67.00 OCCUPATIONAL THERAPY	318,491	0	65,754	384,245	89,762	67.00
68.00 SPEECH PATHOLOGY	174,896	6,523	35,135	216,554	50,588	68.00
68.01 OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00 ELECTROCARDIOLOGY	992,438	90,340	105,319	1,188,097	277,545	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,529,037	0	0	3,529,037	824,401	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	1,483,211	0	0	1,483,211	346,486	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	0	0	0	0	0	76.00
76.97 CARDIAC REHABILITATION	103,680	0	11,606	115,286	26,931	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	250,836	0	39,187	290,023	67,751	88.00
90.00 CLINIC	0	0	0	0	0	90.00
90.01 WOUND CLINIC	949,204	37,620	23,612	1,010,436	236,043	90.01
90.02 DIABETES CLINIC	0	0	0	0	0	90.02
90.03 ASTHMA CLINIC	0	0	0	0	0	90.03
90.04 ANDI S CLINIC	39,551	0	9,887	49,438	11,549	90.04
90.05 PRIME TIME	594,902	0	113,246	708,148	165,427	90.05
90.06 SHELBYVILLE WOUND CLINIC	126,672	0	14,245	140,917	32,919	90.06
91.00 EMERGENCY	2,691,720	280,427	527,299	3,499,446	817,488	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	2,069,681	0	399,357	2,469,038	576,780	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 HOSPICE	1,355,728	120,072	127,906	1,603,706	374,634	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	75,880,217	4,173,894	8,347,248	74,453,516	13,862,797	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01 PROFESSIONAL BUILDING	483,210	736,232	0	1,219,442	284,868	190.01
190.02 PHYSICIAN BUILDING	272,918	0	21,467	294,385	68,770	190.02
190.03 PRIVATE DUTY	578,456	0	87,471	665,927	155,564	190.03
190.04 MARKETING	553,777	5,731	20,292	579,800	135,444	190.04
190.05 WATER LAB	0	0	0	0	0	190.05
190.06 FOUNDATION	121,080	0	21,004	142,084	33,192	190.06
190.07 ASC	2,505	301,960	0	304,465	71,125	190.07
190.08 ANDERSON WOMEN'S CLINIC	263,623	22,221	46,646	332,490	77,671	190.08
190.09 HANCOCK OB	1,531,070	0	140,129	1,671,199	390,400	190.09
190.10 HANCOCK WELLNESS	108,357	0	23,548	131,905	30,814	190.10
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)	79,795,213	5,240,038	8,707,805	79,795,213	15,110,645	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150037

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2012 6:15 pm

Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
	7.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT	7,221,379					7.00
9.00 HOUSEKEEPING	69,541	2,136,714				9.00
10.00 DIETARY	117,891	33,906	981,201			10.00
11.00 CAFETERIA	199,905	55,872		1,431,255		11.00
13.00 NURSING ADMINISTRATION	0	0	0	27,462	1,080,683	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	84,752	0	6,799	6,020	14.00
15.00 PHARMACY	159,492	61,821	0	54,764	48,492	15.00
16.00 MEDICAL RECORDS & LIBRARY	94,999	74,362	0	48,703	0	16.00
23.00 PARAMED PRGM	36,283	85,658	0	3,216	2,848	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	838,871	568,309	378,766	183,513	162,497	30.00
31.00 INTENSIVE CARE UNIT	643,852	117,165	337,525	160,411	142,039	31.00
40.00 SUBPROVIDER - IPF	172,126	93,768	160,713	53,189	47,097	40.00
41.00 SUBPROVIDER - IRF	118,512	32,460	104,197	36,067	31,936	41.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	636,402	227,490	0	81,288	71,978	50.00
51.00 RECOVERY ROOM	57,231	83,767	0	14,270	12,636	51.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	398,730	83,275	0	136,954	121,269	54.00
60.00 LABORATORY	171,532	79,466	0	107,516	95,202	60.00
65.00 RESPIRATORY THERAPY	62,415	60,863	0	60,974	53,991	65.00
66.00 PHYSICAL THERAPY	117,351	70,734	0	50,141	44,398	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	15,595	0	67.00
68.00 SPEECH PATHOLOGY	13,552	0	0	6,203	0	68.00
68.01 OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00 ELECTROCARDIOLOGY	187,676	137,919	0	26,362	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	0	0	0	0	0	76.00
76.97 CARDIAC REHABILITATION	0	0	0	4,259	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	9,086	0	88.00
90.00 CLINIC	0	0	0	0	0	90.00
90.01 WOUND CLINIC	78,153	0	0	3,488	0	90.01
90.02 DIABETES CLINIC	0	0	0	0	0	90.02
90.03 ASTHMA CLINIC	0	0	0	0	0	90.03
90.04 ANDI'S CLINIC	0	0	0	2,736	0	90.04
90.05 PRIME TIME	0	0	0	24,284	0	90.05
90.06 SHELBYVILLE WOUND CLINIC	0	0	0	3,873	0	90.06
91.00 EMERGENCY	582,572	121,855	0	101,133	89,550	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	0	63,272	0	101,402	89,788	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 HOSPICE	249,442	0	0	28,803	25,504	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	5,006,528	2,136,714	981,201	1,352,491	1,045,245	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01 PROFESSIONAL BUILDING	1,529,479	0	0	0	0	190.01
190.02 PHYSICIAN BUILDING	0	0	0	7,970	0	190.02
190.03 PRIVATE DUTY	0	0	0	40,022	35,438	190.03
190.04 MARKETING	11,905	0	0	4,725	0	190.04
190.05 WATER LAB	0	0	0	0	0	190.05
190.06 FOUNDATION	0	0	0	5,497	0	190.06
190.07 ASC	627,304	0	0	0	0	190.07
190.08 ANDERSON WOMEN'S CLINIC	46,163	0	0	12,659	0	190.08
190.09 HANCOCK OB	0	0	0	7,891	0	190.09
190.10 HANCOCK WELLNESS	0	0	0	0	0	190.10
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)	7,221,379	2,136,714	981,201	1,431,255	1,080,683	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150037

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

Worksheet B Part I Date/Time Prepared: 5/30/2012 6:15 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED PRGM	Subtotal	
		14.00	15.00	16.00	23.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION						13.00
14.00	CENTRAL SERVICES & SUPPLY	164,916					14.00
15.00	PHARMACY	950	4,799,942				15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	1,462,262			16.00
23.00	PARAMED PRGM	0	0	0	175,178		23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	4,083	0	337,644	0	9,242,285	30.00
31.00	INTENSIVE CARE UNIT	3,960	0	42,159	0	6,834,078	31.00
40.00	SUBPROVIDER - I PF	407	0	34,763	0	2,215,411	40.00
41.00	SUBPROVIDER - I RF	392	0	206,728	0	1,689,713	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	4,414	0	443,782	0	6,111,334	50.00
51.00	RECOVERY ROOM	237	0	0	0	756,674	51.00
53.00	ANESTHESIOLOGY	0	0	0	0	1,052	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,323	0	50,665	175,178	6,401,934	54.00
60.00	LABORATORY	31,531	0	112,425	0	5,821,137	60.00
65.00	RESPIRATORY THERAPY	809	0	0	0	2,022,744	65.00
66.00	PHYSICAL THERAPY	54	0	0	0	2,077,066	66.00
67.00	OCCUPATIONAL THERAPY	26	0	0	0	489,628	67.00
68.00	SPEECH PATHOLOGY	106	0	0	0	287,003	68.00
68.01	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	ELECTROCARDIOLOGY	754	0	57,692	0	1,876,045	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	107,589	0	0	0	4,461,027	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,829,697	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	4,799,942	2,589	0	4,802,531	73.00
76.00		0	0	0	0	0	76.00
76.97	CARDIAC REHABILITATION	24	0	0	0	146,500	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	75	0	0	0	366,935	88.00
90.00	CLINIC	0	0	0	0	0	90.00
90.01	WOUND CLINIC	247	0	0	0	1,328,367	90.01
90.02	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	ANDI'S CLINIC	150	0	0	0	63,873	90.04
90.05	PRIME TIME	215	0	0	0	898,074	90.05
90.06	SHELBYVILLE WOUND CLINIC	101	0	0	0	177,810	90.06
91.00	EMERGENCY	3,440	0	173,445	0	5,388,929	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	271	0	370	0	3,300,921	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	HOSPICE	3,399	0	0	0	2,285,488	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	164,557	4,799,942	1,462,262	175,178	70,876,256	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	PROFESSIONAL BUILDING	1	0	0	0	3,033,790	190.01
190.02	PHYSICIAN BUILDING	67	0	0	0	371,192	190.02
190.03	PRIVATE DUTY	203	0	0	0	897,154	190.03
190.04	MARKETING	0	0	0	0	731,874	190.04
190.05	WATER LAB	0	0	0	0	0	190.05
190.06	FOUNDATION	0	0	0	0	180,773	190.06
190.07	ASC	34	0	0	0	1,002,928	190.07
190.08	ANDERSON WOMEN'S CLINIC	54	0	0	0	469,037	190.08
190.09	HANCOCK OB	0	0	0	0	2,069,490	190.09
190.10	HANCOCK WELLNESS	0	0	0	0	162,719	190.10
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	164,916	4,799,942	1,462,262	175,178	79,795,213	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150037

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2012 6:15 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT			1.00
4.00	EMPLOYEE BENEFITS			4.00
5.00	ADMINISTRATIVE & GENERAL			5.00
7.00	OPERATION OF PLANT			7.00
9.00	HOUSEKEEPING			9.00
10.00	DIETARY			10.00
11.00	CAFETERIA			11.00
13.00	NURSING ADMINISTRATION			13.00
14.00	CENTRAL SERVICES & SUPPLY			14.00
15.00	PHARMACY			15.00
16.00	MEDICAL RECORDS & LIBRARY			16.00
23.00	PARAMED PRGM			23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	9,242,285	30.00
31.00	INTENSIVE CARE UNIT	0	6,834,078	31.00
40.00	SUBPROVIDER - IPF	0	2,215,411	40.00
41.00	SUBPROVIDER - IRF	0	1,689,713	41.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	6,111,334	50.00
51.00	RECOVERY ROOM	0	756,674	51.00
53.00	ANESTHESIOLOGY	0	1,052	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	6,401,934	54.00
60.00	LABORATORY	0	5,821,137	60.00
65.00	RESPIRATORY THERAPY	0	2,022,744	65.00
66.00	PHYSICAL THERAPY	0	2,077,066	66.00
67.00	OCCUPATIONAL THERAPY	0	489,628	67.00
68.00	SPEECH PATHOLOGY	0	287,003	68.00
68.01	OCCUPATIONAL HEALTH	0	0	68.01
69.00	ELECTROCARDIOLOGY	0	1,876,045	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,461,027	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	1,829,697	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	4,802,531	73.00
76.00		0	0	76.00
76.97	CARDIAC REHABILITATION	0	146,500	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	366,935	88.00
90.00	CLINIC	0	0	90.00
90.01	WOUND CLINIC	0	1,328,367	90.01
90.02	DIABETES CLINIC	0	0	90.02
90.03	ASTHMA CLINIC	0	0	90.03
90.04	ANDIS CLINIC	0	63,873	90.04
90.05	PRIME TIME	0	898,074	90.05
90.06	SHELBYVILLE WOUND CLINIC	0	177,810	90.06
91.00	EMERGENCY	0	5,388,929	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	HOME HEALTH AGENCY	0	3,300,921	101.00
SPECIAL PURPOSE COST CENTERS				
116.00	HOSPICE	0	2,285,488	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	70,876,256	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	PROFESSIONAL BUILDING	0	3,033,790	190.01
190.02	PHYSICIAN BUILDING	0	371,192	190.02
190.03	PRIVATE DUTY	0	897,154	190.03
190.04	MARKETING	0	731,874	190.04
190.05	WATER LAB	0	0	190.05
190.06	FOUNDATION	0	180,773	190.06
190.07	ASC	0	1,002,928	190.07
190.08	ANDERSON WOMEN'S CLINIC	0	469,037	190.08
190.09	HANCOCK OB	0	2,069,490	190.09
190.10	HANCOCK WELLNESS	0	162,719	190.10
200.00	Cross Foot Adjustments	0	0	200.00
201.00	Negative Cost Centers	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	79,795,213	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150037

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

Worksheet B
Part II
Date/Time Prepared:
5/30/2012 6:15 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	EMPLOYEE BENEFITS	0	17,010	17,010	17,010		4.00
5.00	ADMINISTRATIVE & GENERAL	0	394,859	394,859	3,364	398,223	5.00
7.00	OPERATION OF PLANT	0	1,352,078	1,352,078	363	36,063	7.00
9.00	HOUSEKEEPING	0	33,475	33,475	372	10,316	9.00
10.00	DIETARY	0	56,748	56,748	178	4,139	10.00
11.00	CAFETERIA	0	96,226	96,226	301	5,866	11.00
13.00	NURSING ADMINISTRATION	0	0	0	299	5,256	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	28	336	14.00
15.00	PHARMACY	0	76,773	76,773	586	22,329	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	45,729	45,729	278	6,209	16.00
23.00	PARAMED PRGM	0	17,465	17,465	29	235	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	403,800	403,800	1,630	33,777	30.00
31.00	INTENSIVE CARE UNIT	0	309,925	309,925	1,308	26,882	31.00
40.00	SUBPROVIDER - IPF	0	82,855	82,855	423	8,251	40.00
41.00	SUBPROVIDER - IRF	0	57,047	57,047	301	5,786	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	306,339	306,339	981	23,185	50.00
51.00	RECOVERY ROOM	0	27,549	27,549	153	2,937	51.00
53.00	ANESTHESIOLOGY	0	0	0	0	5	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	191,933	191,933	1,140	27,120	54.00
60.00	LABORATORY	0	82,569	82,569	716	26,066	60.00
65.00	RESPIRATORY THERAPY	0	30,044	30,044	534	8,901	65.00
66.00	PHYSICAL THERAPY	0	56,488	56,488	441	8,954	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	129	2,365	67.00
68.00	SPEECH PATHOLOGY	0	6,523	6,523	69	1,333	68.00
68.01	OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00	ELECTROCARDIOLOGY	0	90,340	90,340	206	7,314	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	21,725	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	9,131	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00		0	0	0	0	0	76.00
76.97	CARDIAC REHABILITATION	0	0	0	23	710	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	77	1,785	88.00
90.00	CLINIC	0	0	0	0	0	90.00
90.01	WOUND CLINIC	0	37,620	37,620	46	6,220	90.01
90.02	DIABETES CLINIC	0	0	0	0	0	90.02
90.03	ASTHMA CLINIC	0	0	0	0	0	90.03
90.04	ANDIS CLINIC	0	0	0	19	304	90.04
90.05	PRIME TIME	0	0	0	221	4,359	90.05
90.06	SHELBYVILLE WOUND CLINIC	0	0	0	28	867	90.06
91.00	EMERGENCY	0	280,427	280,427	1,031	21,543	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	0	0	0	781	15,199	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	HOSPICE	0	120,072	120,072	250	9,872	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	4,173,894	4,173,894	16,305	365,340	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	PROFESSIONAL BUILDING	0	736,232	736,232	0	7,507	190.01
190.02	PHYSICIAN BUILDING	0	0	0	42	1,812	190.02
190.03	PRIVATE DUTY	0	0	0	171	4,099	190.03
190.04	MARKETING	0	5,731	5,731	40	3,569	190.04
190.05	WATER LAB	0	0	0	0	0	190.05
190.06	FOUNDATION	0	0	0	41	875	190.06
190.07	ASC	0	301,960	301,960	0	1,874	190.07
190.08	ANDERSON WOMEN'S CLINIC	0	22,221	22,221	91	2,047	190.08
190.09	HANCOCK OB	0	0	0	274	10,288	190.09
190.10	HANCOCK WELLNESS	0	0	0	46	812	190.10
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	TOTAL (sum lines 118-201)	0	5,240,038	5,240,038	17,010	398,223	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150037

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

Worksheet B
Part II
Date/Time Prepared:
5/30/2012 6:15 pm

Cost Center Description	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
	7.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT	1,388,504					7.00
9.00 HOUSEKEEPING	13,371	57,534				9.00
10.00 DIETARY	22,668	913	84,646			10.00
11.00 CAFETERIA	38,437	1,504	0	142,334		11.00
13.00 NURSING ADMINISTRATION	0	0	0	2,731	8,286	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	2,282	0	676	46	14.00
15.00 PHARMACY	30,667	1,665	0	5,446	372	15.00
16.00 MEDICAL RECORDS & LIBRARY	18,266	2,002	0	4,843	0	16.00
23.00 PARAMED ED PRGM	6,976	2,306	0	320	22	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	161,295	15,302	32,675	18,249	1,245	30.00
31.00 INTENSIVE CARE UNIT	123,798	3,155	29,118	15,952	1,089	31.00
40.00 SUBPROVIDER - IPF	33,096	2,525	13,864	5,289	361	40.00
41.00 SUBPROVIDER - IRF	22,787	874	8,989	3,587	245	41.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	122,365	6,125	0	8,084	552	50.00
51.00 RECOVERY ROOM	11,004	2,256	0	1,419	97	51.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	76,666	2,242	0	13,620	930	54.00
60.00 LABORATORY	32,982	2,140	0	10,692	730	60.00
65.00 RESPIRATORY THERAPY	12,001	1,639	0	6,064	414	65.00
66.00 PHYSICAL THERAPY	22,564	1,905	0	4,986	340	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	1,551	0	67.00
68.00 SPEECH PATHOLOGY	2,606	0	0	617	0	68.00
68.01 OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00 ELECTROCARDIOLOGY	36,086	3,714	0	2,622	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	0	0	0	0	0	76.00
76.97 CARDIAC REHABILITATION	0	0	0	424	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	904	0	88.00
90.00 CLINIC	0	0	0	0	0	90.00
90.01 WOUND CLINIC	15,027	0	0	347	0	90.01
90.02 DIABETES CLINIC	0	0	0	0	0	90.02
90.03 ASTHMA CLINIC	0	0	0	0	0	90.03
90.04 ANDI'S CLINIC	0	0	0	272	0	90.04
90.05 PRIME TIME	0	0	0	2,415	0	90.05
90.06 SHELBYVILLE WOUND CLINIC	0	0	0	385	0	90.06
91.00 EMERGENCY	112,015	3,281	0	10,057	687	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	0	1,704	0	10,084	688	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 HOSPICE	47,962	0	0	2,864	196	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	962,639	57,534	84,646	134,500	8,014	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01 PROFESSIONAL BUILDING	294,084	0	0	0	0	190.01
190.02 PHYSICIAN BUILDING	0	0	0	793	0	190.02
190.03 PRIVATE DUTY	0	0	0	3,980	272	190.03
190.04 MARKETING	2,289	0	0	470	0	190.04
190.05 WATER LAB	0	0	0	0	0	190.05
190.06 FOUNDATION	0	0	0	547	0	190.06
190.07 ASC	120,616	0	0	0	0	190.07
190.08 ANDERSON WOMEN'S CLINIC	8,876	0	0	1,259	0	190.08
190.09 HANCOCK OB	0	0	0	785	0	190.09
190.10 HANCOCK WELLNESS	0	0	0	0	0	190.10
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)	1,388,504	57,534	84,646	142,334	8,286	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150037

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

Worksheet B
Part II
Date/Time Prepared:
5/30/2012 6:15 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED PRGM	Subtotal	
		14.00	15.00	16.00	23.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION						13.00
14.00	CENTRAL SERVICES & SUPPLY	3,368					14.00
15.00	PHARMACY	19	137,857				15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	77,327			16.00
23.00	PARAMED PRGM	0	0	0	27,353		23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	83	0	17,855		685,911	30.00
31.00	INTENSIVE CARE UNIT	81	0	2,229		513,537	31.00
40.00	SUBPROVIDER - I PF	8	0	1,838		148,510	40.00
41.00	SUBPROVIDER - I RF	8	0	10,932		110,556	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	90	0	23,469		491,190	50.00
51.00	RECOVERY ROOM	5	0	0		45,420	51.00
53.00	ANESTHESIOLOGY	0	0	0		5	53.00
54.00	RADIOLOGY-DIAGNOSTIC	27	0	2,679		316,357	54.00
60.00	LABORATORY	644	0	5,945		162,484	60.00
65.00	RESPIRATORY THERAPY	17	0	0		59,614	65.00
66.00	PHYSICAL THERAPY	1	0	0		95,679	66.00
67.00	OCCUPATIONAL THERAPY	1	0	0		4,046	67.00
68.00	SPEECH PATHOLOGY	2	0	0		11,150	68.00
68.01	OCCUPATIONAL HEALTH	0	0	0		0	68.01
69.00	ELECTROCARDIOLOGY	15	0	3,051		143,348	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,199	0	0		23,924	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0		9,131	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	137,857	137		137,994	73.00
76.00		0	0	0		0	76.00
76.97	CARDIAC REHABILITATION	0	0	0		1,157	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	2	0	0		2,768	88.00
90.00	CLINIC	0	0	0		0	90.00
90.01	WOUND CLINIC	5	0	0		59,265	90.01
90.02	DIABETES CLINIC	0	0	0		0	90.02
90.03	ASTHMA CLINIC	0	0	0		0	90.03
90.04	ANDI'S CLINIC	3	0	0		598	90.04
90.05	PRIME TIME	4	0	0		6,999	90.05
90.06	SHELBYVILLE WOUND CLINIC	2	0	0		1,282	90.06
91.00	EMERGENCY	70	0	9,172		438,283	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	6	0	20		28,482	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	HOSPICE	69	0	0		181,285	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	3,361	137,857	77,327	0	3,678,975	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		0	190.00
190.01	PROFESSIONAL BUILDING	0	0	0		1,037,823	190.01
190.02	PHYSICIAN BUILDING	1	0	0		2,648	190.02
190.03	PRIVATE DUTY	4	0	0		8,526	190.03
190.04	MARKETING	0	0	0		12,099	190.04
190.05	WATER LAB	0	0	0		0	190.05
190.06	FOUNDATION	0	0	0		1,463	190.06
190.07	ASC	1	0	0		424,451	190.07
190.08	ANDERSON WOMEN'S CLINIC	1	0	0		34,495	190.08
190.09	HANCOCK OB	0	0	0		11,347	190.09
190.10	HANCOCK WELLNESS	0	0	0		858	190.10
200.00	Cross Foot Adjustments				27,353	27,353	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	3,368	137,857	77,327	27,353	5,240,038	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150037

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

Worksheet B
Part II
Date/Time Prepared:
5/30/2012 6:15 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT			1.00
4.00	EMPLOYEE BENEFITS			4.00
5.00	ADMINISTRATIVE & GENERAL			5.00
7.00	OPERATION OF PLANT			7.00
9.00	HOUSEKEEPING			9.00
10.00	DIETARY			10.00
11.00	CAFETERIA			11.00
13.00	NURSING ADMINISTRATION			13.00
14.00	CENTRAL SERVICES & SUPPLY			14.00
15.00	PHARMACY			15.00
16.00	MEDICAL RECORDS & LIBRARY			16.00
23.00	PARAMED PRGM			23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	685,911	30.00
31.00	INTENSIVE CARE UNIT	0	513,537	31.00
40.00	SUBPROVIDER - IPF	0	148,510	40.00
41.00	SUBPROVIDER - IRF	0	110,556	41.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	491,190	50.00
51.00	RECOVERY ROOM	0	45,420	51.00
53.00	ANESTHESIOLOGY	0	5	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	316,357	54.00
60.00	LABORATORY	0	162,484	60.00
65.00	RESPIRATORY THERAPY	0	59,614	65.00
66.00	PHYSICAL THERAPY	0	95,679	66.00
67.00	OCCUPATIONAL THERAPY	0	4,046	67.00
68.00	SPEECH PATHOLOGY	0	11,150	68.00
68.01	OCCUPATIONAL HEALTH	0	0	68.01
69.00	ELECTROCARDIOLOGY	0	143,348	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	23,924	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	9,131	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	137,994	73.00
76.00		0	0	76.00
76.97	CARDIAC REHABILITATION	0	1,157	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	2,768	88.00
90.00	CLINIC	0	0	90.00
90.01	WOUND CLINIC	0	59,265	90.01
90.02	DIABETES CLINIC	0	0	90.02
90.03	ASTHMA CLINIC	0	0	90.03
90.04	ANDIS CLINIC	0	598	90.04
90.05	PRIME TIME	0	6,999	90.05
90.06	SHELBYVILLE WOUND CLINIC	0	1,282	90.06
91.00	EMERGENCY	0	438,283	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	HOME HEALTH AGENCY	0	28,482	101.00
SPECIAL PURPOSE COST CENTERS				
116.00	HOSPICE	0	181,285	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	3,678,975	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	PROFESSIONAL BUILDING	0	1,037,823	190.01
190.02	PHYSICIAN BUILDING	0	2,648	190.02
190.03	PRIVATE DUTY	0	8,526	190.03
190.04	MARKETING	0	12,099	190.04
190.05	WATER LAB	0	0	190.05
190.06	FOUNDATION	0	1,463	190.06
190.07	ASC	0	424,451	190.07
190.08	ANDERSON WOMEN'S CLINIC	0	34,495	190.08
190.09	HANCOCK OB	0	11,347	190.09
190.10	HANCOCK WELLNESS	0	858	190.10
200.00	Cross Foot Adjustments	0	27,353	200.00
201.00	Negative Cost Centers	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	5,240,038	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150037

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

Worksheet B-1
Date/Time Prepared:
5/30/2012 6:15 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)						
	1.00	4.00					
GENERAL SERVICE COST CENTERS							
1.00 NEW CAP REL COSTS-BLDG & FIXT	403,242						1.00
4.00 EMPLOYEE BENEFITS	1,309	36,763,027					4.00
5.00 ADMINISTRATIVE & GENERAL	30,386	7,295,514	-15,110,645		64,684,568		5.00
7.00 OPERATION OF PLANT	104,048	784,658		0	5,853,880	267,499	7.00
9.00 HOUSEKEEPING	2,576	802,515		0	1,675,717	2,576	9.00
10.00 DIETARY	4,367	383,543		0	672,342	4,367	10.00
11.00 CAFETERIA	7,405	650,465		0	952,880	7,405	11.00
13.00 NURSING ADMINISTRATION	0	645,751		0	853,775	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	61,430		0	54,592	0	14.00
15.00 PHARMACY	5,908	1,265,996		0	3,627,112	5,908	15.00
16.00 MEDICAL RECORDS & LIBRARY	3,519	599,871		0	1,008,587	3,519	16.00
23.00 PARAMED ED PRGM	1,344	61,648		0	38,240	1,344	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	31,074	3,520,999		0	5,486,847	31,074	30.00
31.00 INTENSIVE CARE UNIT	23,850	2,824,376		0	4,366,849	23,850	31.00
40.00 SUBPROVIDER - IPF	6,376	914,376		0	1,340,257	6,376	40.00
41.00 SUBPROVIDER - IRF	4,390	651,021		0	939,864	4,390	41.00
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	23,574	2,119,730		0	3,766,181	23,574	50.00
51.00 RECOVERY ROOM	2,120	329,575		0	477,084	2,120	51.00
53.00 ANESTHESIOLOGY	0	0		0	853	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	14,770	2,462,301		0	4,405,413	14,770	54.00
60.00 LABORATORY	6,354	1,546,281		0	4,234,309	6,354	60.00
65.00 RESPIRATORY THERAPY	2,312	1,152,359		0	1,445,918	2,312	65.00
66.00 PHYSICAL THERAPY	4,347	951,505		0	1,454,589	4,347	66.00
67.00 OCCUPATIONAL THERAPY	0	277,605		0	384,245	0	67.00
68.00 SPEECH PATHOLOGY	502	148,335		0	216,554	502	68.00
68.01 OCCUPATIONAL HEALTH	0	0		0	0	0	68.01
69.00 ELECTROCARDIOLOGY	6,952	444,642		0	1,188,097	6,952	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	3,529,037	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0		0	1,483,211	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73.00
76.00	0	0		0	0	0	76.00
76.97 CARDIAC REHABILITATION	0	48,998		0	115,286	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	0	165,440		0	290,023	0	88.00
90.00 CLINIC	0	0		0	0	0	90.00
90.01 WOUND CLINIC	2,895	99,685		0	1,010,436	2,895	90.01
90.02 DIABETES CLINIC	0	0		0	0	0	90.02
90.03 ASTHMA CLINIC	0	0		0	0	0	90.03
90.04 ANDI'S CLINIC	0	41,741		0	49,438	0	90.04
90.05 PRIME TIME	0	478,108		0	708,148	0	90.05
90.06 SHELBYVILLE WOUND CLINIC	0	60,141		0	140,917	0	90.06
91.00 EMERGENCY	21,580	2,226,176		0	3,499,446	21,580	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)							92.00
OTHER REIMBURSABLE COST CENTERS							
101.00 HOME HEALTH AGENCY	0	1,686,025		0	2,469,038	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00 HOSPICE	9,240	540,000		0	1,603,706	9,240	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	321,198	35,240,810		-15,110,645	59,342,871	185,455	118.00
NONREIMBURSABLE COST CENTERS							
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	0	190.00
190.01 PROFESSIONAL BUILDING	56,656	0		0	1,219,442	56,656	190.01
190.02 PHYSICIAN BUILDING	0	90,630		0	294,385	0	190.02
190.03 PRIVATE DUTY	0	369,290		0	665,927	0	190.03
190.04 MARKETING	441	85,668		0	579,800	441	190.04
190.05 WATER LAB	0	0		0	0	0	190.05
190.06 FOUNDATION	0	88,677		0	142,084	0	190.06
190.07 ASC	23,237	0		0	304,465	23,237	190.07
190.08 ANDERSON WOMEN'S CLINIC	1,710	196,934		0	332,490	1,710	190.08
190.09 HANCOCK OB	0	591,602		0	1,671,199	0	190.09
190.10 HANCOCK WELLNESS	0	99,416		0	131,905	0	190.10
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)	5,240,038	8,707,805			15,110,645	7,221,379	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	12.994772	0.236863			0.233605	26.995910	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)		17,010			398,223	1,388,504	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)		0.000463			0.006156	5.190689	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150037

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

Worksheet B-1
Date/Time Prepared:
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Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
	9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT						7.00
9.00 HOUSEKEEPING	412,334					9.00
10.00 DIETARY	6,543	14,323				10.00
11.00 CAFETERIA	10,782	0	867,758			11.00
13.00 NURSING ADMINISTRATION	0	0	16,650	739,956		13.00
14.00 CENTRAL SERVICES & SUPPLY	16,355	0	4,122	4,122	5,409,527	14.00
15.00 PHARMACY	11,930	0	33,203	33,203	31,178	15.00
16.00 MEDICAL RECORDS & LIBRARY	14,350	0	29,528	0	0	16.00
23.00 PARAMED PRGM	16,530	0	1,950	1,950	6	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	109,670	5,529	111,263	111,263	133,922	30.00
31.00 INTENSIVE CARE UNIT	22,610	4,927	97,256	97,256	129,903	31.00
40.00 SUBPROVIDER - IPF	18,095	2,346	32,248	32,248	13,357	40.00
41.00 SUBPROVIDER - IRF	6,264	1,521	21,867	21,867	12,871	41.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	43,900	0	49,284	49,284	144,776	50.00
51.00 RECOVERY ROOM	16,165	0	8,652	8,652	7,790	51.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	16,070	0	83,034	83,034	43,387	54.00
60.00 LABORATORY	15,335	0	65,186	65,186	1,034,262	60.00
65.00 RESPIRATORY THERAPY	11,745	0	36,968	36,968	26,531	65.00
66.00 PHYSICAL THERAPY	13,650	0	30,400	30,400	1,762	66.00
67.00 OCCUPATIONAL THERAPY	0	0	9,455	0	853	67.00
68.00 SPEECH PATHOLOGY	0	0	3,761	0	3,489	68.00
68.01 OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00 ELECTROCARDIOLOGY	26,615	0	15,983	0	24,734	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,529,092	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	0	0	0	0	0	76.00
76.97 CARDIAC REHABILITATION	0	0	2,582	0	799	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	5,509	0	2,457	88.00
90.00 CLINIC	0	0	0	0	0	90.00
90.01 WOUND CLINIC	0	0	2,115	0	8,086	90.01
90.02 DIABETES CLINIC	0	0	0	0	0	90.02
90.03 ASTHMA CLINIC	0	0	0	0	0	90.03
90.04 ANDI'S CLINIC	0	0	1,659	0	4,930	90.04
90.05 PRIME TIME	0	0	14,723	0	7,040	90.05
90.06 SHELBYVILLE WOUND CLINIC	0	0	2,348	0	3,302	90.06
91.00 EMERGENCY	23,515	0	61,316	61,316	112,835	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	12,210	0	61,479	61,479	8,893	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 HOSPICE	0	0	17,463	17,463	111,486	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	412,334	14,323	820,004	715,691	5,397,741	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01 PROFESSIONAL BUILDING	0	0	0	0	45	190.01
190.02 PHYSICIAN BUILDING	0	0	4,832	0	2,183	190.02
190.03 PRIVATE DUTY	0	0	24,265	24,265	6,674	190.03
190.04 MARKETING	0	0	2,865	0	0	190.04
190.05 WATER LAB	0	0	0	0	0	190.05
190.06 FOUNDATION	0	0	3,333	0	0	190.06
190.07 ASC	0	0	0	0	1,115	190.07
190.08 ANDERSON WOMEN'S CLINIC	0	0	7,675	0	1,769	190.08
190.09 HANCOCK OB	0	0	4,784	0	0	190.09
190.10 HANCOCK WELLNESS	0	0	0	0	0	190.10
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	2,136,714	981,201	1,431,255	1,080,683	164,916	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	5.181998	68.505271	1.649371	1.460469	0.030486	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	57,534	84,646	142,334	8,286	3,368	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.139533	5.909795	0.164025	0.011198	0.000623	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150037

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

Worksheet B-1
Date/Time Prepared:
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Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	PARAMED ED PRGM (ASSIGNED TIME)	
	15.00	16.00	23.00	
GENERAL SERVICE COST CENTERS				
1.00 NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00 EMPLOYEE BENEFITS				4.00
5.00 ADMINISTRATIVE & GENERAL				5.00
7.00 OPERATION OF PLANT				7.00
9.00 HOUSEKEEPING				9.00
10.00 DIETARY				10.00
11.00 CAFETERIA				11.00
13.00 NURSING ADMINISTRATION				13.00
14.00 CENTRAL SERVICES & SUPPLY				14.00
15.00 PHARMACY	100			15.00
16.00 MEDICAL RECORDS & LIBRARY	0	3,954		16.00
23.00 PARAMED ED PRGM	0	0	100	23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS	0	913	0	30.00
31.00 INTENSIVE CARE UNIT	0	114	0	31.00
40.00 SUBPROVIDER - IPF	0	94	0	40.00
41.00 SUBPROVIDER - IRF	0	559	0	41.00
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	1,200	0	50.00
51.00 RECOVERY ROOM	0	0	0	51.00
53.00 ANESTHESIOLOGY	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	137	100	54.00
60.00 LABORATORY	0	304	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
68.01 OCCUPATIONAL HEALTH	0	0	0	68.01
69.00 ELECTROCARDIOLOGY	0	156	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	100	7	0	73.00
76.00	0	0	0	76.00
76.97 CARDIAC REHABILITATION	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
90.00 CLINIC	0	0	0	90.00
90.01 WOUND CLINIC	0	0	0	90.01
90.02 DIABETES CLINIC	0	0	0	90.02
90.03 ASTHMA CLINIC	0	0	0	90.03
90.04 ANDIS CLINIC	0	0	0	90.04
90.05 PRIME TIME	0	0	0	90.05
90.06 SHELBYVILLE WOUND CLINIC	0	0	0	90.06
91.00 EMERGENCY	0	469	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS				
101.00 HOME HEALTH AGENCY	0	1	0	101.00
SPECIAL PURPOSE COST CENTERS				
116.00 HOSPICE	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	100	3,954	100	118.00
NONREIMBURSABLE COST CENTERS				
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
190.01 PROFESSIONAL BUILDING	0	0	0	190.01
190.02 PHYSICIAN BUILDING	0	0	0	190.02
190.03 PRIVATE DUTY	0	0	0	190.03
190.04 MARKETING	0	0	0	190.04
190.05 WATER LAB	0	0	0	190.05
190.06 FOUNDATION	0	0	0	190.06
190.07 ASC	0	0	0	190.07
190.08 ANDERSON WOMEN'S CLINIC	0	0	0	190.08
190.09 HANCOCK OB	0	0	0	190.09
190.10 HANCOCK WELLNESS	0	0	0	190.10
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)	4,799,942	1,462,262	175,178	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	47,999.420000	369.818412	1,751.780000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	137,857	77,327	27,353	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	1,378.570000	19.556651	273.530000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150037		Period: From 01/01/2011 To 12/31/2011		Worksheet C Part I Date/Time Prepared: 5/30/2012 6:15 pm	
		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS		9,242,285	0	9,242,285	30.00	
31.00	INTENSIVE CARE UNIT		6,834,078	0	6,834,078	31.00	
40.00	SUBPROVIDER - IPF		2,215,411	0	2,215,411	40.00	
41.00	SUBPROVIDER - IRF		1,689,713	0	1,689,713	41.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM		6,111,334	0	6,111,334	50.00	
51.00	RECOVERY ROOM		756,674	0	756,674	51.00	
53.00	ANESTHESIOLOGY		1,052	0	1,052	53.00	
54.00	RADIOLOGY-DIAGNOSTIC		6,401,934	0	6,401,934	54.00	
60.00	LABORATORY		5,821,137	0	5,821,137	60.00	
65.00	RESPIRATORY THERAPY	0	2,022,744	0	2,022,744	65.00	
66.00	PHYSICAL THERAPY	0	2,077,066	0	2,077,066	66.00	
67.00	OCCUPATIONAL THERAPY	0	489,628	0	489,628	67.00	
68.00	SPEECH PATHOLOGY	0	287,003	0	287,003	68.00	
68.01	OCCUPATIONAL HEALTH	0	0	0	0	68.01	
69.00	ELECTROCARDIOLOGY		1,876,045	0	1,876,045	69.00	
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		4,461,027	0	4,461,027	71.00	
72.00	IMPL. DEV. CHARGED TO PATIENT		1,829,697	0	1,829,697	72.00	
73.00	DRUGS CHARGED TO PATIENTS		4,802,531	0	4,802,531	73.00	
76.00			0	0	0	76.00	
76.97	CARDIAC REHABILITATION		146,500	0	146,500	76.97	
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC		366,935	0	366,935	88.00	
90.00	CLINIC		0	0	0	90.00	
90.01	WOUND CLINIC		1,328,367	0	1,328,367	90.01	
90.02	DIABETES CLINIC		0	0	0	90.02	
90.03	ASTHMA CLINIC		0	0	0	90.03	
90.04	ANDI'S CLINIC		63,873	0	63,873	90.04	
90.05	PRIME TIME		898,074	0	898,074	90.05	
90.06	SHELBYVILLE WOUND CLINIC		177,810	0	177,810	90.06	
91.00	EMERGENCY		5,388,929	0	5,388,929	91.00	
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		2,475,048	0	2,475,048	92.00	
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY		3,300,921	0	3,300,921	101.00	
SPECIAL PURPOSE COST CENTERS							
116.00	HOSPICE		2,285,488	0	2,285,488	116.00	
200.00	Subtotal (see instructions)	0	73,351,304	0	73,351,304	200.00	
201.00	Less Observation Beds		2,475,048		2,475,048	201.00	
202.00	Total (see instructions)	0	70,876,256	0	70,876,256	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150037

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

Worksheet C
Part I
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		Title XVIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	5,762,746		5,762,746			30.00
31.00	INTENSIVE CARE UNIT	6,073,066		6,073,066			31.00
40.00	SUBPROVIDER - IPF	2,556,919		2,556,919			40.00
41.00	SUBPROVIDER - IRF	1,647,348		1,647,348			41.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	7,129,003	7,714,370	14,843,373	0.411721	0.000000	50.00
51.00	RECOVERY ROOM	956,508	894,035	1,850,543	0.408893	0.000000	51.00
53.00	ANESTHESIOLOGY	16,120	1,435	17,555	0.059926	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	5,011,964	35,587,262	40,599,226	0.157686	0.000000	54.00
60.00	LABORATORY	6,351,521	22,021,885	28,373,406	0.205162	0.000000	60.00
65.00	RESPIRATORY THERAPY	3,118,146	3,604,267	6,722,413	0.300896	0.000000	65.00
66.00	PHYSICAL THERAPY	1,382,269	2,677,968	4,060,237	0.511563	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	950,632	530,160	1,480,792	0.330653	0.000000	67.00
68.00	SPEECH PATHOLOGY	203,249	252,315	455,564	0.629995	0.000000	68.00
68.01	OCCUPATIONAL HEALTH	0	0	0	0.000000	0.000000	68.01
69.00	ELECTROCARDIOLOGY	3,125,460	6,786,361	9,911,821	0.189273	0.000000	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,932,138	2,812,933	5,745,071	0.776496	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	4,244,945	745,195	4,990,140	0.366662	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	11,561,209	6,038,655	17,599,864	0.272873	0.000000	73.00
76.00		0	0	0	0.000000	0.000000	76.00
76.97	CARDIAC REHABILITATION	0	245,184	245,184	0.597510	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	232,116	232,116			88.00
90.00	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	WOUND CLINIC	36,005	5,499,561	5,535,566	0.239969	0.000000	90.01
90.02	DIABETES CLINIC	0	0	0	0.000000	0.000000	90.02
90.03	ASTHMA CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	ANDIS CLINIC	0	418,741	418,741	0.152536	0.000000	90.04
90.05	PRIME TIME	0	1,400,282	1,400,282	0.641352	0.000000	90.05
90.06	SHELBYVILLE WOUND CLINIC	1,430	983,481	984,911	0.180534	0.000000	90.06
91.00	EMERGENCY	2,351,051	13,712,354	16,063,405	0.335479	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,786,252	1,786,252	1.385610	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	0	2,533,227	2,533,227			101.00
SPECIAL PURPOSE COST CENTERS							
116.00	HOSPICE	242,828	1,655,960	1,898,788			116.00
200.00	Subtotal (see instructions)	65,654,557	118,133,999	183,788,556			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	65,654,557	118,133,999	183,788,556			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150037

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
31.00	INTENSIVE CARE UNIT				31.00
40.00	SUBPROVIDER - IPF				40.00
41.00	SUBPROVIDER - IRF				41.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.411721			50.00
51.00	RECOVERY ROOM	0.408893			51.00
53.00	ANESTHESIOLOGY	0.059926			53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.157686			54.00
60.00	LABORATORY	0.205162			60.00
65.00	RESPIRATORY THERAPY	0.300896			65.00
66.00	PHYSICAL THERAPY	0.511563			66.00
67.00	OCCUPATIONAL THERAPY	0.330653			67.00
68.00	SPEECH PATHOLOGY	0.629995			68.00
68.01	OCCUPATIONAL HEALTH	0.000000			68.01
69.00	ELECTROCARDIOLOGY	0.189273			69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.776496			71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.366662			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.272873			73.00
76.00		0.000000			76.00
76.97	CARDIAC REHABILITATION	0.597510			76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC				88.00
90.00	CLINIC	0.000000			90.00
90.01	WOUND CLINIC	0.239969			90.01
90.02	DIABETES CLINIC	0.000000			90.02
90.03	ASTHMA CLINIC	0.000000			90.03
90.04	ANDIS CLINIC	0.152536			90.04
90.05	PRIME TIME	0.641352			90.05
90.06	SHELBYVILLE WOUND CLINIC	0.180534			90.06
91.00	EMERGENCY	0.335479			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.385610			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
116.00	HOSPICE				116.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150037		Period: From 01/01/2011 To 12/31/2011		Worksheet C Part I Date/Time Prepared: 5/30/2012 6:15 pm	
		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS		9,242,285	0	0	30.00	
31.00	INTENSIVE CARE UNIT		6,834,078	0	0	31.00	
40.00	SUBPROVIDER - IPF		2,215,411	0	0	40.00	
41.00	SUBPROVIDER - IRF		1,689,713	0	0	41.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM		6,111,334	0	0	50.00	
51.00	RECOVERY ROOM		756,674	0	0	51.00	
53.00	ANESTHESIOLOGY		1,052	0	0	53.00	
54.00	RADIOLOGY-DIAGNOSTIC		6,401,934	0	0	54.00	
60.00	LABORATORY		5,821,137	0	0	60.00	
65.00	RESPIRATORY THERAPY	0	2,022,744	0	0	65.00	
66.00	PHYSICAL THERAPY	0	2,077,066	0	0	66.00	
67.00	OCCUPATIONAL THERAPY	0	489,628	0	0	67.00	
68.00	SPEECH PATHOLOGY	0	287,003	0	0	68.00	
68.01	OCCUPATIONAL HEALTH	0	0	0	0	68.01	
69.00	ELECTROCARDIOLOGY		1,876,045	0	0	69.00	
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		4,461,027	0	0	71.00	
72.00	IMPL. DEV. CHARGED TO PATIENT		1,829,697	0	0	72.00	
73.00	DRUGS CHARGED TO PATIENTS		4,802,531	0	0	73.00	
76.00			0	0	0	76.00	
76.97	CARDIAC REHABILITATION		146,500	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC		366,935	0	0	88.00	
90.00	CLINIC		0	0	0	90.00	
90.01	WOUND CLINIC		1,328,367	0	0	90.01	
90.02	DIABETES CLINIC		0	0	0	90.02	
90.03	ASTHMA CLINIC		0	0	0	90.03	
90.04	ANDIS CLINIC		63,873	0	0	90.04	
90.05	PRIME TIME		898,074	0	0	90.05	
90.06	SHELBYVILLE WOUND CLINIC		177,810	0	0	90.06	
91.00	EMERGENCY		5,388,929	0	0	91.00	
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		2,475,048	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY		3,300,921		0	101.00	
SPECIAL PURPOSE COST CENTERS							
116.00	HOSPICE		2,285,488		0	116.00	
200.00	Subtotal (see instructions)	0	73,351,304	0	0	200.00	
201.00	Less Observation Beds		2,475,048		0	201.00	
202.00	Total (see instructions)	0	70,876,256	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/30/2012 6:15 pm
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Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
Title XIX Hospital Cost						
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	5,762,746		5,762,746		30.00
31.00	INTENSIVE CARE UNIT	6,073,066		6,073,066		31.00
40.00	SUBPROVIDER - IPF	2,556,919		2,556,919		40.00
41.00	SUBPROVIDER - IRF	1,647,348		1,647,348		41.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	7,129,003	7,714,370	14,843,373	0.411721	50.00
51.00	RECOVERY ROOM	956,508	894,035	1,850,543	0.408893	51.00
53.00	ANESTHESIOLOGY	16,120	1,435	17,555	0.059926	53.00
54.00	RADIOLOGY-DIAGNOSTIC	5,011,964	35,587,262	40,599,226	0.157686	54.00
60.00	LABORATORY	6,351,521	22,021,885	28,373,406	0.205162	60.00
65.00	RESPIRATORY THERAPY	3,118,146	3,604,267	6,722,413	0.300896	65.00
66.00	PHYSICAL THERAPY	1,382,269	2,677,968	4,060,237	0.511563	66.00
67.00	OCCUPATIONAL THERAPY	950,632	530,160	1,480,792	0.330653	67.00
68.00	SPEECH PATHOLOGY	203,249	252,315	455,564	0.629995	68.00
68.01	OCCUPATIONAL HEALTH	0	0	0	0.000000	68.01
69.00	ELECTROCARDIOLOGY	3,125,460	6,786,361	9,911,821	0.189273	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,932,138	2,812,933	5,745,071	0.776496	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	4,244,945	745,195	4,990,140	0.366662	72.00
73.00	DRUGS CHARGED TO PATIENTS	11,561,209	6,038,655	17,599,864	0.272873	73.00
76.00		0	0	0	0.000000	76.00
76.97	CARDIAC REHABILITATION	0	245,184	245,184	0.597510	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	232,116	232,116	1.580826	88.00
90.00	CLINIC	0	0	0	0.000000	90.00
90.01	WOUND CLINIC	36,005	5,499,561	5,535,566	0.239969	90.01
90.02	DIABETES CLINIC	0	0	0	0.000000	90.02
90.03	ASTHMA CLINIC	0	0	0	0.000000	90.03
90.04	ANDIS CLINIC	0	418,741	418,741	0.152536	90.04
90.05	PRIME TIME	0	1,400,282	1,400,282	0.641352	90.05
90.06	SHELBYVILLE WOUND CLINIC	1,430	983,481	984,911	0.180534	90.06
91.00	EMERGENCY	2,351,051	13,712,354	16,063,405	0.335479	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,786,252	1,786,252	1.385610	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	2,533,227	2,533,227		101.00
SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	242,828	1,655,960	1,898,788		116.00
200.00	Subtotal (see instructions)	65,654,557	118,133,999	183,788,556		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	65,654,557	118,133,999	183,788,556		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/30/2012 6:15 pm
		Title XIX	Hospital	Cost

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
40.00 SUBPROVIDER - IPF			40.00
41.00 SUBPROVIDER - IRF			41.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	0.000000		50.00
51.00 RECOVERY ROOM	0.000000		51.00
53.00 ANESTHESIOLOGY	0.000000		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
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
68.01 OCCUPATIONAL HEALTH	0.000000		68.01
69.00 ELECTROCARDIOLOGY	0.000000		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	0.000000		76.00
76.97 CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS			
88.00 RURAL HEALTH CLINIC	0.000000		88.00
90.00 CLINIC	0.000000		90.00
90.01 WOUND CLINIC	0.000000		90.01
90.02 DIABETES CLINIC	0.000000		90.02
90.03 ASTHMA CLINIC	0.000000		90.03
90.04 ANDIS CLINIC	0.000000		90.04
90.05 PRIME TIME	0.000000		90.05
90.06 SHELBYVILLE WOUND CLINIC	0.000000		90.06
91.00 EMERGENCY	0.000000		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS			
101.00 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS			
116.00 HOSPICE			116.00
200.00 Subtotal (see instructions)			200.00
201.00 Less Observation Beds			201.00
202.00 Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part I Date/Time Prepared: 5/30/2012 6:15 pm
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Cost Center Description	Title XVIII			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	685,911	0	685,911	7,502	91.43	30.00
31.00 INTENSIVE CARE UNIT	513,537		513,537	4,927	104.23	31.00
40.00 SUBPROVIDER - IPF	148,510	0	148,510	2,346	63.30	40.00
41.00 SUBPROVIDER - IRF	110,556	0	110,556	1,521	72.69	41.00
200.00 Total (lines 30-199)	1,458,514		1,458,514	16,296		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part I Date/Time Prepared: 5/30/2012 6:15 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
	6.00	7.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS	4,612	421,675		30.00
31.00 INTENSIVE CARE UNIT	498	51,907		31.00
40.00 SUBPROVIDER - IPF	2,235	141,476		40.00
41.00 SUBPROVIDER - IRF	1,195	86,865		41.00
200.00 Total (lines 30-199)	8,540	701,923		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part II Date/Time Prepared: 5/30/2012 6:15 pm
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Cost Center Description		Title XVIII			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	491,190	14,843,373	0.033092	2,248,355	74,403	50.00
51.00	RECOVERY ROOM	45,420	1,850,543	0.024544	291,555	7,156	51.00
53.00	ANESTHESIOLOGY	5	17,555	0.000285	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	316,357	40,599,226	0.007792	2,657,375	20,706	54.00
60.00	LABORATORY	162,484	28,373,406	0.005727	3,599,214	20,613	60.00
65.00	RESPIRATORY THERAPY	59,614	6,722,413	0.008868	1,501,154	13,312	65.00
66.00	PHYSICAL THERAPY	95,679	4,060,237	0.023565	464,550	10,947	66.00
67.00	OCCUPATIONAL THERAPY	4,046	1,480,792	0.002732	235,677	644	67.00
68.00	SPEECH PATHOLOGY	11,150	455,564	0.024475	68,684	1,681	68.00
68.01	OCCUPATIONAL HEALTH	0	0	0.000000	0	0	68.01
69.00	ELECTROCARDIOLOGY	143,348	9,911,821	0.014462	1,832,988	26,509	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,924	5,745,071	0.004164	340,328	1,417	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	9,131	4,990,140	0.001830	1,686,238	3,086	72.00
73.00	DRUGS CHARGED TO PATIENTS	137,994	17,599,864	0.007841	8,231,294	64,542	73.00
76.00		0	0	0.000000	0	0	76.00
76.97	CARDIAC REHABILITATION	1,157	245,184	0.004719	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	2,768	232,116	0.011925	0	0	88.00
90.00	CLINIC	0	0	0.000000	0	0	90.00
90.01	WOUND CLINIC	59,265	5,535,566	0.010706	4,597	49	90.01
90.02	DIABETES CLINIC	0	0	0.000000	0	0	90.02
90.03	ASTHMA CLINIC	0	0	0.000000	0	0	90.03
90.04	ANDIS CLINIC	598	418,741	0.001428	0	0	90.04
90.05	PRIME TIME	6,999	1,400,282	0.004998	0	0	90.05
90.06	SHELBYVILLE WOUND CLINIC	1,282	984,911	0.001302	191	0	90.06
91.00	EMERGENCY	438,283	16,063,405	0.027285	1,164,833	31,782	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	183,683	1,786,252	0.102832	0	0	92.00
200.00	Total (Lines 50-199)	2,194,377	163,316,462		24,327,033	276,847	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150037		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part III Date/Time Prepared: 5/30/2012 6:15 pm	
Cost Center Description		Title XVIII		Hospital		PPS	
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
200.00	Total (Lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150037		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part III Date/Time Prepared: 5/30/2012 6:15 pm	
Cost Center Description		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PPS	
		6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	7,502	0.00	4,612	0	30.00	
31.00	INTENSIVE CARE UNIT	4,927	0.00	498	0	31.00	
40.00	SUBPROVIDER - IPF	2,346	0.00	2,235	0	40.00	
41.00	SUBPROVIDER - IRF	1,521	0.00	1,195	0	41.00	
200.00	Total (lines 30-199)	16,296		8,540	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/30/2012 6:15 pm
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Cost Center Description	Title XVIII				Hospital	PPS	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	0	51.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	175,178	175,178	54.00	54.00
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
68.01 OCCUPATIONAL HEALTH	0	0	0	0	0	0	68.01
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 PATIENT	0	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00	0	0	0	0	0	0	76.00
76.97 CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
90.00 CLINIC	0	0	0	0	0	0	90.00
90.01 WOUND CLINIC	0	0	0	0	0	0	90.01
90.02 DIABETES CLINIC	0	0	0	0	0	0	90.02
90.03 ASTHMA CLINIC	0	0	0	0	0	0	90.03
90.04 ANDIS CLINIC	0	0	0	0	0	0	90.04
90.05 PRIME TIME	0	0	0	0	0	0	90.05
90.06 SHELBYVILLE WOUND CLINIC	0	0	0	0	0	0	90.06
91.00 EMERGENCY	0	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00 Total (Lines 50-199)	0	0	0	0	175,178	200.00	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/30/2012 6:15 pm
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Cost Center Description		Title XVIII				Hospital	
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	PPS
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	14,843,373	0.000000	0.000000	2,248,355	50.00
51.00	RECOVERY ROOM	0	1,850,543	0.000000	0.000000	291,555	51.00
53.00	ANESTHESIOLOGY	0	17,555	0.000000	0.000000	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	175,178	40,599,226	0.004315	0.004315	2,657,375	54.00
60.00	LABORATORY	0	28,373,406	0.000000	0.000000	3,599,214	60.00
65.00	RESPIRATORY THERAPY	0	6,722,413	0.000000	0.000000	1,501,154	65.00
66.00	PHYSICAL THERAPY	0	4,060,237	0.000000	0.000000	464,550	66.00
67.00	OCCUPATIONAL THERAPY	0	1,480,792	0.000000	0.000000	235,677	67.00
68.00	SPEECH PATHOLOGY	0	455,564	0.000000	0.000000	68,684	68.00
68.01	OCCUPATIONAL HEALTH	0	0	0.000000	0.000000	0	68.01
69.00	ELECTROCARDIOLOGY	0	9,911,821	0.000000	0.000000	1,832,988	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,745,071	0.000000	0.000000	340,328	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	4,990,140	0.000000	0.000000	1,686,238	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	17,599,864	0.000000	0.000000	8,231,294	73.00
76.00		0	0	0.000000	0.000000	0	76.00
76.97	CARDIAC REHABILITATION	0	245,184	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	232,116	0.000000	0.000000	0	88.00
90.00	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	WOUND CLINIC	0	5,535,566	0.000000	0.000000	4,597	90.01
90.02	DIABETES CLINIC	0	0	0.000000	0.000000	0	90.02
90.03	ASTHMA CLINIC	0	0	0.000000	0.000000	0	90.03
90.04	ANDIS CLINIC	0	418,741	0.000000	0.000000	0	90.04
90.05	PRIME TIME	0	1,400,282	0.000000	0.000000	0	90.05
90.06	SHELBYVILLE WOUND CLINIC	0	984,911	0.000000	0.000000	191	90.06
91.00	EMERGENCY	0	16,063,405	0.000000	0.000000	1,164,833	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,786,252	0.000000	0.000000	0	92.00
200.00	Total (Lines 50-199)	175,178	163,316,462			24,327,033	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150037

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

Worksheet D
Part IV
Date/Time Prepared:
5/30/2012 6:15 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	1,775,830	0	50.00
51.00	RECOVERY ROOM	0	234,444	0	51.00
53.00	ANESTHESIOLOGY	0	2,538	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	11,467	9,486,434	40,934	54.00
60.00	LABORATORY	0	698,393	0	60.00
65.00	RESPIRATORY THERAPY	0	921,331	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	72	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	68.00
68.01	OCCUPATIONAL HEALTH	0	0	0	68.01
69.00	ELECTROCARDIOLOGY	0	3,562,379	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	66,678	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	296,016	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	4,420,194	0	73.00
76.00		0	0	0	76.00
76.97	CARDIAC REHABILITATION	0	103,733	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0	88.00
90.00	CLINIC	0	0	0	90.00
90.01	WOUND CLINIC	0	426,988	0	90.01
90.02	DIABETES CLINIC	0	0	0	90.02
90.03	ASTHMA CLINIC	0	0	0	90.03
90.04	ANDIS CLINIC	0	453	0	90.04
90.05	PRIME TIME	0	8,074	0	90.05
90.06	SHELBYVILLE WOUND CLINIC	0	106,407	0	90.06
91.00	EMERGENCY	0	2,587,906	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,850,457	0	92.00
200.00	Total (Lines 50-199)	11,467	26,548,327	40,934	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/30/2012 6:15 pm
	Title XVIII	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		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.411721	1,775,830	0	0	50.00
51.00	RECOVERY ROOM	0.408893	234,444	0	0	51.00
53.00	ANESTHESIOLOGY	0.059926	2,538	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.157686	9,486,434	0	0	54.00
60.00	LABORATORY	0.205162	698,393	0	0	60.00
65.00	RESPIRATORY THERAPY	0.300896	921,331	0	0	65.00
66.00	PHYSICAL THERAPY	0.511563	0	-262	0	66.00
67.00	OCCUPATIONAL THERAPY	0.330653	72	0	0	67.00
68.00	SPEECH PATHOLOGY	0.629995	0	0	0	68.00
68.01	OCCUPATIONAL HEALTH	0.000000	0	0	0	68.01
69.00	ELECTROCARDIOLOGY	0.189273	3,562,379	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.776496	66,678	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.366662	296,016	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.272873	4,420,194	0	13,774	73.00
76.00		0.000000	0	0	0	76.00
76.97	CARDIAC REHABILITATION	0.597510	103,733	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000				88.00
90.00	CLINIC	0.000000	0	0	0	90.00
90.01	WOUND CLINIC	0.239969	426,988	0	0	90.01
90.02	DIABETES CLINIC	0.000000	0	0	0	90.02
90.03	ASTHMA CLINIC	0.000000	0	0	0	90.03
90.04	ANDIS CLINIC	0.152536	453	0	0	90.04
90.05	PRIME TIME	0.641352	8,074	0	0	90.05
90.06	SHELBYVILLE WOUND CLINIC	0.180534	106,407	0	0	90.06
91.00	EMERGENCY	0.335479	2,587,906	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.385610	1,850,457	0	0	92.00
200.00	Subtotal (see instructions)		26,548,327	-262	13,774	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		26,548,327	-262	13,774	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/30/2012 6:15 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	731,147	0	0		50.00
51.00 RECOVERY ROOM	95,863	0	0		51.00
53.00 ANESTHESIOLOGY	152	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	1,495,878	0	0		54.00
60.00 LABORATORY	143,284	0	0		60.00
65.00 RESPIRATORY THERAPY	277,225	0	0		65.00
66.00 PHYSICAL THERAPY	0	-134	0		66.00
67.00 OCCUPATIONAL THERAPY	24	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0	0		68.00
68.01 OCCUPATIONAL HEALTH	0	0	0		68.01
69.00 ELECTROCARDIOLOGY	674,262	0	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	51,775	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	108,538	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	1,206,152	0	3,759		73.00
76.00	0	0	0		76.00
76.97 CARDIAC REHABILITATION	61,982	0	0		76.97
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0		88.00
90.00 CLINIC	0	0	0		90.00
90.01 WOUND CLINIC	102,464	0	0		90.01
90.02 DIABETES CLINIC	0	0	0		90.02
90.03 ASTHMA CLINIC	0	0	0		90.03
90.04 ANDIS CLINIC	69	0	0		90.04
90.05 PRIME TIME	5,178	0	0		90.05
90.06 SHELBYVILLE WOUND CLINIC	19,210	0	0		90.06
91.00 EMERGENCY	868,188	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	2,564,012	0	0		92.00
200.00 Subtotal (see instructions)	8,405,403	-134	3,759		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	8,405,403	-134	3,759		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150037 Component CCN: 15S037		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part II Date/Time Prepared: 5/30/2012 6:15 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	491,190	14,843,373	0.033092	92,171	3,050	50.00
51.00	RECOVERY ROOM	45,420	1,850,543	0.024544	841	21	51.00
53.00	ANESTHESIOLOGY	5	17,555	0.000285	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	316,357	40,599,226	0.007792	125,164	975	54.00
60.00	LABORATORY	162,484	28,373,406	0.005727	301,067	1,724	60.00
65.00	RESPIRATORY THERAPY	59,614	6,722,413	0.008868	41,761	370	65.00
66.00	PHYSICAL THERAPY	95,679	4,060,237	0.023565	95,273	2,245	66.00
67.00	OCCUPATIONAL THERAPY	4,046	1,480,792	0.002732	76,975	210	67.00
68.00	SPEECH PATHOLOGY	11,150	455,564	0.024475	4,200	103	68.00
68.01	OCCUPATIONAL HEALTH	0	0	0.000000	0	0	68.01
69.00	ELECTROCARDIOLOGY	143,348	9,911,821	0.014462	14,337	207	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,924	5,745,071	0.004164	13,304	55	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	9,131	4,990,140	0.001830	2,497	5	72.00
73.00	DRUGS CHARGED TO PATIENTS	137,994	17,599,864	0.007841	577,383	4,527	73.00
76.00		0	0	0.000000	0	0	76.00
76.97	CARDIAC REHABILITATION	1,157	245,184	0.004719	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	2,768	232,116	0.011925	0	0	88.00
90.00	CLINIC	0	0	0.000000	0	0	90.00
90.01	WOUND CLINIC	59,265	5,535,566	0.010706	0	0	90.01
90.02	DIABETES CLINIC	0	0	0.000000	0	0	90.02
90.03	ASTHMA CLINIC	0	0	0.000000	0	0	90.03
90.04	ANDIS CLINIC	598	418,741	0.001428	0	0	90.04
90.05	PRIME TIME	6,999	1,400,282	0.004998	0	0	90.05
90.06	SHELBYVILLE WOUND CLINIC	1,282	984,911	0.001302	0	0	90.06
91.00	EMERGENCY	438,283	16,063,405	0.027285	38,895	1,061	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	183,683	1,786,252	0.102832	0	0	92.00
200.00	Total (lines 50-199)	2,194,377	163,316,462		1,383,868	14,553	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150037 Component CCN: 15S037	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/30/2012 6:15 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	175,178	175,178	54.00
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
68.01 OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	0	0	0	0	0	76.00
76.97 CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00 CLINIC	0	0	0	0	0	90.00
90.01 WOUND CLINIC	0	0	0	0	0	90.01
90.02 DIABETES CLINIC	0	0	0	0	0	90.02
90.03 ASTHMA CLINIC	0	0	0	0	0	90.03
90.04 ANDIS CLINIC	0	0	0	0	0	90.04
90.05 PRIME TIME	0	0	0	0	0	90.05
90.06 SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	175,178	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150037 Component CCN: 15S037	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/30/2012 6:15 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	14,843,373	0.000000	0.000000	92,171	50.00
51.00 RECOVERY ROOM	0	1,850,543	0.000000	0.000000	841	51.00
53.00 ANESTHESIOLOGY	0	17,555	0.000000	0.000000	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	175,178	40,599,226	0.004315	0.004315	125,164	54.00
60.00 LABORATORY	0	28,373,406	0.000000	0.000000	301,067	60.00
65.00 RESPIRATORY THERAPY	0	6,722,413	0.000000	0.000000	41,761	65.00
66.00 PHYSICAL THERAPY	0	4,060,237	0.000000	0.000000	95,273	66.00
67.00 OCCUPATIONAL THERAPY	0	1,480,792	0.000000	0.000000	76,975	67.00
68.00 SPEECH PATHOLOGY	0	455,564	0.000000	0.000000	4,200	68.00
68.01 OCCUPATIONAL HEALTH	0	0	0.000000	0.000000	0	68.01
69.00 ELECTROCARDIOLOGY	0	9,911,821	0.000000	0.000000	14,337	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,745,071	0.000000	0.000000	13,304	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	4,990,140	0.000000	0.000000	2,497	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	17,599,864	0.000000	0.000000	577,383	73.00
76.00	0	0	0.000000	0.000000	0	76.00
76.97 CARDIAC REHABILITATION	0	245,184	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	232,116	0.000000	0.000000	0	88.00
90.00 CLINIC	0	0	0.000000	0.000000	0	90.00
90.01 WOUND CLINIC	0	5,535,566	0.000000	0.000000	0	90.01
90.02 DIABETES CLINIC	0	0	0.000000	0.000000	0	90.02
90.03 ASTHMA CLINIC	0	0	0.000000	0.000000	0	90.03
90.04 ANDI'S CLINIC	0	418,741	0.000000	0.000000	0	90.04
90.05 PRIME TIME	0	1,400,282	0.000000	0.000000	0	90.05
90.06 SHELBYVILLE WOUND CLINIC	0	984,911	0.000000	0.000000	0	90.06
91.00 EMERGENCY	0	16,063,405	0.000000	0.000000	38,895	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,786,252	0.000000	0.000000	0	92.00
200.00 Total (lines 50-199)	175,178	163,316,462			1,383,868	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150037 Component CCN: 15S037	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/30/2012 6:15 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	51.00
53.00 ANESTHESIOLOGY	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	540	0	0	54.00
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
68.01 OCCUPATIONAL HEALTH	0	0	0	68.01
69.00 ELECTROCARDIOLOGY	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00	0	0	0	76.00
76.97 CARDIAC REHABILITATION	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
90.00 CLINIC	0	0	0	90.00
90.01 WOUND CLINIC	0	0	0	90.01
90.02 DIABETES CLINIC	0	0	0	90.02
90.03 ASTHMA CLINIC	0	0	0	90.03
90.04 ANDI'S CLINIC	0	0	0	90.04
90.05 PRIME TIME	0	0	0	90.05
90.06 SHELBYVILLE WOUND CLINIC	0	0	0	90.06
91.00 EMERGENCY	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00 Total (lines 50-199)	540	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150037 Component CCN: 15T037		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part II Date/Time Prepared: 5/30/2012 6:15 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	491,190	14,843,373	0.033092	134,216	4,441	50.00
51.00	RECOVERY ROOM	45,420	1,850,543	0.024544	2,863	70	51.00
53.00	ANESTHESIOLOGY	5	17,555	0.000285	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	316,357	40,599,226	0.007792	74,816	583	54.00
60.00	LABORATORY	162,484	28,373,406	0.005727	135,425	776	60.00
65.00	RESPIRATORY THERAPY	59,614	6,722,413	0.008868	63,395	562	65.00
66.00	PHYSICAL THERAPY	95,679	4,060,237	0.023565	444,258	10,469	66.00
67.00	OCCUPATIONAL THERAPY	4,046	1,480,792	0.002732	417,987	1,142	67.00
68.00	SPEECH PATHOLOGY	11,150	455,564	0.024475	80,759	1,977	68.00
68.01	OCCUPATIONAL HEALTH	0	0	0.000000	0	0	68.01
69.00	ELECTROCARDIOLOGY	143,348	9,911,821	0.014462	20,308	294	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,924	5,745,071	0.004164	15,861	66	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	9,131	4,990,140	0.001830	1,155	2	72.00
73.00	DRUGS CHARGED TO PATIENTS	137,994	17,599,864	0.007841	407,650	3,196	73.00
76.00		0	0	0.000000	0	0	76.00
76.97	CARDIAC REHABILITATION	1,157	245,184	0.004719	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	2,768	232,116	0.011925	0	0	88.00
90.00	CLINIC	0	0	0.000000	0	0	90.00
90.01	WOUND CLINIC	59,265	5,535,566	0.010706	0	0	90.01
90.02	DIABETES CLINIC	0	0	0.000000	0	0	90.02
90.03	ASTHMA CLINIC	0	0	0.000000	0	0	90.03
90.04	ANDIS CLINIC	598	418,741	0.001428	0	0	90.04
90.05	PRIME TIME	6,999	1,400,282	0.004998	0	0	90.05
90.06	SHELBYVILLE WOUND CLINIC	1,282	984,911	0.001302	0	0	90.06
91.00	EMERGENCY	438,283	16,063,405	0.027285	11,335	309	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	183,683	1,786,252	0.102832	0	0	92.00
200.00	Total (lines 50-199)	2,194,377	163,316,462		1,810,028	23,887	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150037 Component CCN: 15T037	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/30/2012 6:15 pm
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	175,178	175,178	54.00
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
68.01 OCCUPATIONAL HEALTH	0	0	0	0	0	68.01
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	0	0	0	0	0	76.00
76.97 CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00 CLINIC	0	0	0	0	0	90.00
90.01 WOUND CLINIC	0	0	0	0	0	90.01
90.02 DIABETES CLINIC	0	0	0	0	0	90.02
90.03 ASTHMA CLINIC	0	0	0	0	0	90.03
90.04 ANDIS CLINIC	0	0	0	0	0	90.04
90.05 PRIME TIME	0	0	0	0	0	90.05
90.06 SHELBYVILLE WOUND CLINIC	0	0	0	0	0	90.06
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	175,178	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150037 Component CCN: 15T037	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/30/2012 6:15 pm
Title XVIII		Subprovider - IRF	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	14,843,373	0.000000	0.000000	134,216	50.00
51.00 RECOVERY ROOM	0	1,850,543	0.000000	0.000000	2,863	51.00
53.00 ANESTHESIOLOGY	0	17,555	0.000000	0.000000	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	175,178	40,599,226	0.004315	0.004315	74,816	54.00
60.00 LABORATORY	0	28,373,406	0.000000	0.000000	135,425	60.00
65.00 RESPIRATORY THERAPY	0	6,722,413	0.000000	0.000000	63,395	65.00
66.00 PHYSICAL THERAPY	0	4,060,237	0.000000	0.000000	444,258	66.00
67.00 OCCUPATIONAL THERAPY	0	1,480,792	0.000000	0.000000	417,987	67.00
68.00 SPEECH PATHOLOGY	0	455,564	0.000000	0.000000	80,759	68.00
68.01 OCCUPATIONAL HEALTH	0	0	0.000000	0.000000	0	68.01
69.00 ELECTROCARDIOLOGY	0	9,911,821	0.000000	0.000000	20,308	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,745,071	0.000000	0.000000	15,861	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	4,990,140	0.000000	0.000000	1,155	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	17,599,864	0.000000	0.000000	407,650	73.00
76.00	0	0	0.000000	0.000000	0	76.00
76.97 CARDIAC REHABILITATION	0	245,184	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	232,116	0.000000	0.000000	0	88.00
90.00 CLINIC	0	0	0.000000	0.000000	0	90.00
90.01 WOUND CLINIC	0	5,535,566	0.000000	0.000000	0	90.01
90.02 DIABETES CLINIC	0	0	0.000000	0.000000	0	90.02
90.03 ASTHMA CLINIC	0	0	0.000000	0.000000	0	90.03
90.04 ANDI'S CLINIC	0	418,741	0.000000	0.000000	0	90.04
90.05 PRIME TIME	0	1,400,282	0.000000	0.000000	0	90.05
90.06 SHELBYVILLE WOUND CLINIC	0	984,911	0.000000	0.000000	0	90.06
91.00 EMERGENCY	0	16,063,405	0.000000	0.000000	11,335	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,786,252	0.000000	0.000000	0	92.00
200.00 Total (lines 50-199)	175,178	163,316,462			1,810,028	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150037 Component CCN: 15T037	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/30/2012 6:15 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	51.00
53.00 ANESTHESIOLOGY	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	323	0	0	54.00
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
68.01 OCCUPATIONAL HEALTH	0	0	0	68.01
69.00 ELECTROCARDIOLOGY	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00	0	0	0	76.00
76.97 CARDIAC REHABILITATION	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
90.00 CLINIC	0	0	0	90.00
90.01 WOUND CLINIC	0	0	0	90.01
90.02 DIABETES CLINIC	0	0	0	90.02
90.03 ASTHMA CLINIC	0	0	0	90.03
90.04 ANDI'S CLINIC	0	0	0	90.04
90.05 PRIME TIME	0	0	0	90.05
90.06 SHELBYVILLE WOUND CLINIC	0	0	0	90.06
91.00 EMERGENCY	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00 Total (lines 50-199)	323	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/30/2012 6:15 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,502	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,502	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)		7,502	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)		4,612	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		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		9,242,285	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)		9,242,285	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		5,762,746	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		5,762,746	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.603799	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)		768.16	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)		9,242,285	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,231.98	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,681,892	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)		5,681,892	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/30/2012 6:15 pm				
Cost Center Description			Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
Title XVIII			Hospital		PPS				
Cost Center Description			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			6,834,078	4,927	1,387.07	498	690,761	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)							6,880,388	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)							13,253,041	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)							473,582	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)							288,314	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)							761,896	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)							12,491,145	53.00
TARGET AMOUNT AND LIMIT COMPUTATION									
54.00	Program discharges							0	54.00
55.00	Target amount per discharge							0.00	55.00
56.00	Target amount (line 54 x line 55)							0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							0	57.00
58.00	Bonus payment (see instructions)							0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket							0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket							0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							0	61.00
62.00	Relief payment (see instructions)							0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)							0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST									
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)							0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)							0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)							0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY									
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)								70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)								71.00
72.00	Program routine service cost (line 9 x line 71)								72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)								73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)								74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)								75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)								76.00
77.00	Program capital-related costs (line 9 x line 76)								77.00
78.00	Inpatient routine service cost (line 74 minus line 77)								78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)								79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)								80.00
81.00	Inpatient routine service cost per diem limitation								81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)								82.00
83.00	Reasonable inpatient routine service costs (see instructions)								83.00
84.00	Program inpatient ancillary services (see instructions)								84.00
85.00	Utilization review - physician compensation (see instructions)								85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)								86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
87.00	Total observation bed days (see instructions)							2,009	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)							1,231.98	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)							2,475,048	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150037		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 5/30/2012 6:15 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	685,911	9,242,285	0.074214	2,475,048	183,683	90.00
91.00	Nursing School cost	0	9,242,285	0.000000	2,475,048	0	91.00
92.00	Allied health cost	0	9,242,285	0.000000	2,475,048	0	92.00
93.00	All other Medical Education	0	9,242,285	0.000000	2,475,048	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Component CCN: 15S037		Date/Time Prepared: 5/30/2012 6:15 pm
		Title XVIII	Subprovider - IPF	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)		2,346	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,346	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)		2,346	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,235	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		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,215,411	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,215,411	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,556,919	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,556,919	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.866438	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,089.91	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)		2,215,411	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)		944.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,110,600	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,110,600	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150037		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1	
		Component CCN: 15S037				Date/Time Prepared: 5/30/2012 6:15 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					393,761	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,504,361	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)					141,476	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					15,093	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					156,569	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,347,792	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					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: 150037		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1	
		Component CCN: 15S037				Date/Time Prepared: 5/30/2012 6:15 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	148,510	2,215,411	0.067035	0	0	90.00
91.00	Nursing School cost	0	2,215,411	0.000000	0	0	91.00
92.00	Allied health cost	0	2,215,411	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,215,411	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Component CCN: 15T037		Date/Time Prepared: 5/30/2012 6:15 pm
		Title XVIII	Subprovider - IRF	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)		1,521	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,521	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)		1,521	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)		1,195	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		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		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,689,713	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)		1,689,713	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,647,348	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		1,647,348	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.025717	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,083.07	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)		1,689,713	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,110.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,327,549	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)		1,327,549	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150037		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1	
		Component CCN: 15T037				Date/Time Prepared: 5/30/2012 6:15 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)							42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					663,063		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,990,612		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)					86,865		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					24,210		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					111,075		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					1,879,537		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					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: 150037 Component CCN: 15T037		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 5/30/2012 6:15 pm	
		Title XVIII		Subprovider - IRF		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	110,556	1,689,713	0.065429	0	0	90.00
91.00	Nursing School cost	0	1,689,713	0.000000	0	0	91.00
92.00	Allied health cost	0	1,689,713	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,689,713	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/30/2012 6:15 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,502	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,502	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)		7,502	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)		228	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		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		9,242,285	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)		9,242,285	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		5,762,746	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		5,762,746	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.603799	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)		768.16	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)		9,242,285	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,231.98	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		280,891	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)		280,891	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/30/2012 6:15 pm			
Cost Center Description			Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
NURSERY (title V & XIX only)			1.00	2.00	3.00	4.00	5.00	
42.00	Intensive Care Type Inpatient Hospital Units						42.00	
43.00	INTENSIVE CARE UNIT	6,834,078	4,927	1,387.07	205	284,349	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)						552,758	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						1,117,998	49.00
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)						2,009	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,231.98	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						2,475,048	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150037		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 5/30/2012 6:15 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/30/2012 6:15 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		2,098,470		30.00
31.00	INTENSIVE CARE UNIT		3,243,908		31.00
40.00	SUBPROVIDER - IPF		0		40.00
41.00	SUBPROVIDER - IRF		0		41.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.411721	2,248,355	925,695	50.00
51.00	RECOVERY ROOM	0.408893	291,555	119,215	51.00
53.00	ANESTHESIOLOGY	0.059926	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.157686	2,657,375	419,031	54.00
60.00	LABORATORY	0.205162	3,599,214	738,422	60.00
65.00	RESPIRATORY THERAPY	0.300896	1,501,154	451,691	65.00
66.00	PHYSICAL THERAPY	0.511563	464,550	237,647	66.00
67.00	OCCUPATIONAL THERAPY	0.330653	235,677	77,927	67.00
68.00	SPEECH PATHOLOGY	0.629995	68,684	43,271	68.00
68.01	OCCUPATIONAL HEALTH	0.000000	0	0	68.01
69.00	ELECTROCARDIOLOGY	0.189273	1,832,988	346,935	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.776496	340,328	264,263	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.366662	1,686,238	618,279	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.272873	8,231,294	2,246,098	73.00
76.00		0.000000	0	0	76.00
76.97	CARDIAC REHABILITATION	0.597510	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	CLINIC	0.000000	0	0	90.00
90.01	WOUND CLINIC	0.239969	4,597	1,103	90.01
90.02	DIABETES CLINIC	0.000000	0	0	90.02
90.03	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	ANDIS CLINIC	0.152536	0	0	90.04
90.05	PRIME TIME	0.641352	0	0	90.05
90.06	SHELBYVILLE WOUND CLINIC	0.180534	191	34	90.06
91.00	EMERGENCY	0.335479	1,164,833	390,777	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.385610	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		24,327,033	6,880,388	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		24,327,033		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3	
		Component CCN: 15S037		Date/Time Prepared: 5/30/2012 6:15 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		28,261		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
40.00	SUBPROVIDER - IPF		2,456,265		40.00
41.00	SUBPROVIDER - IRF		0		41.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.411721	92,171	37,949	50.00
51.00	RECOVERY ROOM	0.408893	841	344	51.00
53.00	ANESTHESIOLOGY	0.059926	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.157686	125,164	19,737	54.00
60.00	LABORATORY	0.205162	301,067	61,768	60.00
65.00	RESPIRATORY THERAPY	0.300896	41,761	12,566	65.00
66.00	PHYSICAL THERAPY	0.511563	95,273	48,738	66.00
67.00	OCCUPATIONAL THERAPY	0.330653	76,975	25,452	67.00
68.00	SPEECH PATHOLOGY	0.629995	4,200	2,646	68.00
68.01	OCCUPATIONAL HEALTH	0.000000	0	0	68.01
69.00	ELECTROCARDIOLOGY	0.189273	14,337	2,714	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.776496	13,304	10,331	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.366662	2,497	916	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.272873	577,383	157,552	73.00
76.00		0.000000	0	0	76.00
76.97	CARDIAC REHABILITATION	0.597510	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	CLINIC	0.000000	0	0	90.00
90.01	WOUND CLINIC	0.239969	0	0	90.01
90.02	DIABETES CLINIC	0.000000	0	0	90.02
90.03	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	ANDIS CLINIC	0.152536	0	0	90.04
90.05	PRIME TIME	0.641352	0	0	90.05
90.06	SHELBYVILLE WOUND CLINIC	0.180534	0	0	90.06
91.00	EMERGENCY	0.335479	38,895	13,048	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.385610	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,383,868	393,761	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)		1,383,868		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150037 Component CCN: 15T037	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/30/2012 6:15 pm
		Title XVIII	Subprovider - IRF	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		8,302	30.00
31.00	INTENSIVE CARE UNIT		0	31.00
40.00	SUBPROVIDER - IPF		0	40.00
41.00	SUBPROVIDER - IRF		1,307,928	41.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.411721	134,216	50.00
51.00	RECOVERY ROOM	0.408893	2,863	51.00
53.00	ANESTHESIOLOGY	0.059926	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.157686	74,816	54.00
60.00	LABORATORY	0.205162	135,425	60.00
65.00	RESPIRATORY THERAPY	0.300896	63,395	65.00
66.00	PHYSICAL THERAPY	0.511563	444,258	66.00
67.00	OCCUPATIONAL THERAPY	0.330653	417,987	67.00
68.00	SPEECH PATHOLOGY	0.629995	80,759	68.00
68.01	OCCUPATIONAL HEALTH	0.000000	0	68.01
69.00	ELECTROCARDIOLOGY	0.189273	20,308	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.776496	15,861	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.366662	1,155	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.272873	407,650	73.00
76.00		0.000000	0	76.00
76.97	CARDIAC REHABILITATION	0.597510	0	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0.000000	0	88.00
90.00	CLINIC	0.000000	0	90.00
90.01	WOUND CLINIC	0.239969	0	90.01
90.02	DIABETES CLINIC	0.000000	0	90.02
90.03	ASTHMA CLINIC	0.000000	0	90.03
90.04	ANDIS CLINIC	0.152536	0	90.04
90.05	PRIME TIME	0.641352	0	90.05
90.06	SHELBYVILLE WOUND CLINIC	0.180534	0	90.06
91.00	EMERGENCY	0.335479	11,335	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.385610	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,810,028	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net Charges (line 200 minus line 201)		1,810,028	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/30/2012 6:15 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		697,540		30.00
31.00	INTENSIVE CARE UNIT		152,896		31.00
40.00	SUBPROVIDER - IPF		0		40.00
41.00	SUBPROVIDER - IRF		0		41.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.411721	379,481	156,240	50.00
51.00	RECOVERY ROOM	0.408893	43,934	17,964	51.00
53.00	ANESTHESIOLOGY	0.059926	1,738	104	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.157686	147,218	23,214	54.00
60.00	LABORATORY	0.205162	217,588	44,641	60.00
65.00	RESPIRATORY THERAPY	0.300896	71,222	21,430	65.00
66.00	PHYSICAL THERAPY	0.511563	7,295	3,732	66.00
67.00	OCCUPATIONAL THERAPY	0.330653	3,442	1,138	67.00
68.00	SPEECH PATHOLOGY	0.629995	2,103	1,325	68.00
68.01	OCCUPATIONAL HEALTH	0.000000	0	0	68.01
69.00	ELECTROCARDIOLOGY	0.189273	73,721	13,953	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.776496	153,064	118,854	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.366662	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.272873	470,193	128,303	73.00
76.00		0.000000	0	0	76.00
76.97	CARDIAC REHABILITATION	0.597510	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	1.580826	0	0	88.00
90.00	CLINIC	0.000000	0	0	90.00
90.01	WOUND CLINIC	0.239969	722	173	90.01
90.02	DIABETES CLINIC	0.000000	0	0	90.02
90.03	ASTHMA CLINIC	0.000000	0	0	90.03
90.04	ANDIS CLINIC	0.152536	0	0	90.04
90.05	PRIME TIME	0.641352	0	0	90.05
90.06	SHELBYVILLE WOUND CLINIC	0.180534	0	0	90.06
91.00	EMERGENCY	0.335479	64,646	21,687	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.385610	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,636,367	552,758	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)		1,636,367		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part A Date/Time Prepared: 5/30/2012 6:15 pm
		Title XVII I	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		9,958,727	1.00
2.00	Outlier payments for discharges. (see instructions)		179,456	2.00
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		84.50	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.72	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		14.68	31.00
32.00	Sum of lines 30 and 31		17.40	32.00
33.00	Allowable disproportionate share percentage (see instructions)		4.06	33.00
34.00	Disproportionate share adjustment (see instructions)		404,324	34.00
Additional payment for high percentage of ESRD beneficiary discharges				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0	46.00
47.00	Subtotal (see instructions)		10,542,507	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		10,542,507	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		813,124	50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0	56.00
57.00	Routine service other pass through costs		0	57.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part A Date/Time Prepared: 5/30/2012 6:15 pm
		Title XVIII	Hospital	PPS
		1.00		
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)			11,467 58.00
59.00	Total (sum of amounts on lines 49 through 58)			11,367,098 59.00
60.00	Primary payer payments			2,620 60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			11,364,478 61.00
62.00	Deductibles billed to program beneficiaries			1,179,128 62.00
63.00	Coinsurance billed to program beneficiaries			7,358 63.00
64.00	Allowable bad debts (see instructions)			130,628 64.00
65.00	Adjusted reimbursable bad debts (see instructions)			91,440 65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			130,628 66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			10,269,432 67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)			0 68.00
69.00	Outlier payments reconciliation			0 69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 70.00
70.95	Recovery of Accelerated Depreciation			0 70.95
70.96	Low Volume Payment-1			0 70.96
70.97	Low Volume Payment-2			0 70.97
70.98	Low Volume Payment-3			0 70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			10,269,432 71.00
72.00	Interim payments			10,268,475 72.00
73.00	Tentative settlement (for contractor use only)			0 73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)			957 74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			150,583 75.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Operating outlier amount from Worksheet E, Part A line 2			0 90.00
91.00	Capital outlier from Worksheet L, Part I, line 2			0 91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0 92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0 93.00
94.00	The rate used to calculate the Time Value of Money			0.00 94.00
95.00	Time Value of Money for operating expenses(see instructions)			0 95.00
96.00	Time Value of Money for capital related expenses (see instructions)			0 96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/30/2012 6:15 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		3,625	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		8,364,469	2.00
3.00	PPS payments		5,235,753	3.00
4.00	Outlier payment (see instructions)		80,246	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		40,934	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		3,625	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		13,512	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)		13,512	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)		13,512	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		9,887	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)		3,625	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)		5,356,933	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)		1,358,649	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)		4,001,909	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)		4,001,909	30.00
31.00	Primary payer payments		754	31.00
32.00	Subtotal (line 30 minus line 31)		4,001,155	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)		160,088	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		112,062	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		160,088	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		4,113,217	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-13	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		4,113,230	40.00
41.00	Interim payments		4,155,877	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)		-42,647	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: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/30/2012 6:15 pm
		Component CCN: 15S037	Title XVIII	Subprovider - IPF
		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		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
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)		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)		0	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		0	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
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		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)		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)		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: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/30/2012 6:15 pm
		Component CCN: 15T037	Title XVIII	Subprovider - IRF
		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		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
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)		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)		0	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		0	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
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		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)		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)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150037

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

Worksheet E-1
Part I
Date/Time Prepared:
5/30/2012 6:15 pm

		Title XVIII		Hospital		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		10,109,456		3,959,163	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	12/31/2011	111,233	12/31/2011	198,201	3.01	
3.02		09/09/2011	45,519		0	3.02	
3.03		11/22/2011	2,267		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0	09/09/2011	1,487	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)		159,019		196,714	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)		10,268,475		4,155,877	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		957		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		42,647	6.02	
7.00	Total Medicare program liability (see instructions)		10,269,432		4,113,230	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: 150037

Period: From 01/01/2011

Worksheet E-1

Component CCN: 15S037

To 12/31/2011

Part I
Date/Time Prepared:
5/30/2012 6:15 pm

Title XVIII

Subprovider -
IPF

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					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		1,761,424		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)		1,761,424		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		540		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,761,964		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: 150037
Component CCN: 15T037

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

Worksheet E-1
Part I
Date/Time Prepared:
5/30/2012 6:15 pm
PPS

Title XVIII

Subprovider -
IRF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider				0	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		1,514,726		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	09/09/2011	792		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)		792		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)		1,515,518		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		2,213		0	6.02
7.00	Total Medicare program liability (see instructions)		1,513,305		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		Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part II Date/Time Prepared: 5/30/2012 6:15 pm
		Component CCN: 15S037	Title XVII I	Subprovider - IPF
		PPS		
		1.00		
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		1,948,213	1.00
2.00	Net IPF PPS Outlier Payments		7,002	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		6.427397	9.00
10.00	Medical Education Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$.		0.000000	10.00
11.00	Medical Education Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		1,955,215	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition		0	14.00
15.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	15.00
16.00	Subtotal (see instructions)		1,955,215	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		1,955,215	18.00
19.00	Deductibles		178,792	19.00
20.00	Subtotal (line 18 minus line 19)		1,776,423	20.00
21.00	Coinurance		14,999	21.00
22.00	Subtotal (line 20 minus line 21)		1,761,424	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	25.00
26.00	Subtotal (sum of lines 22 and 24)		1,761,424	26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	27.00
28.00	Other pass through costs (see instructions)		540	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.99	Recovery of Accelerated Depreciation		0	30.99
31.00	Total amount payable to the provider (see instructions)		1,761,964	31.00
32.00	Interim payments		1,761,424	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus the sum lines 32 and 33)		540	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part III Date/Time Prepared: 5/30/2012 6:15 pm
		Component CCN: 15T037	Title XVIII	Subprovider - IRF
		PPS		
		1.00		
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)		1,409,667	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0098	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		9,329	3.00
4.00	Outlier Payments		106,155	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		0.00	5.00
6.00	New Teaching program adjustment. (see instructions)		0.00	6.00
7.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)		0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)		0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)		0.00	9.00
10.00	Average Daily Census (see instructions)		4.167123	10.00
11.00	Medical Education Adjustment Factor $\{((1 + (\text{line } 9/\text{line } 10)) \text{ raised to the power of } .6876 - 1)\}$.		0.000000	11.00
12.00	Medical Education Adjustment (line 1 multiplied by line 11).		0	12.00
13.00	Total PPS Payment (sum of lines 1, 3, 4 and 12)		1,525,151	13.00
14.00	Nursing and Allied Health Managed Care payment (see instruction)		0	14.00
15.00	Organ acquisition		0	15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	16.00
17.00	Subtotal (see instructions)		1,525,151	17.00
18.00	Primary payer payments		0	18.00
19.00	Subtotal (line 17 less line 18).		1,525,151	19.00
20.00	Deductibles		11,320	20.00
21.00	Subtotal (line 19 minus line 20)		1,513,831	21.00
22.00	Coinsurance		849	22.00
23.00	Subtotal (line 21 minus line 22)		1,512,982	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	26.00
27.00	Subtotal (sum of lines 23 and 25)		1,512,982	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	28.00
29.00	Other pass through costs (see instructions)		323	29.00
30.00	Outlier payments reconciliation		0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	31.00
31.99	Recovery of Accelerated Depreciation		0	31.99
32.00	Total amount payable to the provider (see instructions)		1,513,305	32.00
33.00	Interim payments		1,515,518	33.00
34.00	Tentative settlement (for contractor use only)		0	34.00
35.00	Balance due provider/program (line 32 minus the sum lines 33 and 34)		-2,213	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2012 6:15 pm
		Title XIX	Hospital	Cost
				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		1,117,998	1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1,117,998	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)		1,117,998	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		697,540	8.00
9.00	Ancillary service charges		1,636,367	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)		2,333,907	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)		2,333,907	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		1,215,909	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)		1,117,998	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.		1,117,998	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)		1,117,998	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)		1,117,998	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		1,117,998	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)		1,117,998	40.00
41.00	Interim payments		600,216	41.00
42.00	Balance due provider/program (line 40 minus 41)		517,782	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: 150037

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

Worksheet G

Date/Time Prepared:
5/30/2012 6:15 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	9,327,760	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	11,332,335	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	5,051,386	0	0	0	7.00
8.00	Prepaid expenses	0	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)	25,711,481	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	59,695,035	0	0	0	15.00
16.00	Accumulated depreciation	0	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)	59,695,035	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	42,925,043	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	9,172,523	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	52,097,566	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	137,504,082	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,754,282	0	0	0	37.00
38.00	Salaries, wages, and fees payable	6,432,530	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	960,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,447,679	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	15,594,491	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	29,245,000	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)	29,245,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	44,839,491	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	92,664,591	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)	92,664,591	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	137,504,082	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150037

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

Worksheet G-1

Date/Time Prepared:
5/30/2012 6:15 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		93,147,700	
2.00	Net income (loss) (From Wkst. G-3, line 29)		-483,109			2.00
3.00	Total (sum of line 1 and line 2)		92,664,591		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		92,664,591		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)		92,664,591		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150037

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

Worksheet G-1

Date/Time Prepared:
5/30/2012 6:15 pm

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
1.00			0		0	1.00
2.00						2.00
3.00			0		0	3.00
4.00	0			0		4.00
5.00	0			0		5.00
6.00	0			0		6.00
7.00	0			0		7.00
8.00	0			0		8.00
9.00	0			0		9.00
10.00		0			0	10.00
11.00		0			0	11.00
12.00	0			0		12.00
13.00	0			0		13.00
14.00	0			0		14.00
15.00	0			0		15.00
16.00	0			0		16.00
17.00	0			0		17.00
18.00		0			0	18.00
19.00		0			0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150037

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

Worksheet G-2 Parts

Date/Time Prepared:
5/30/2012 6:15 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	7,030,807		7,030,807	1.00
2.00	SUBPROVIDER - IPF	2,556,919		2,556,919	2.00
3.00	SUBPROVIDER - IRF	1,647,348		1,647,348	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	11,235,074		11,235,074	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	6,834,085		6,834,085	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	6,834,085		6,834,085	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	18,069,159		18,069,159	17.00
18.00	Ancillary services	46,983,164	89,892,833	136,875,997	18.00
19.00	Outpatient services	2,391,737	26,104,171	28,495,908	19.00
20.00	RURAL HEALTH CLINIC	0	232,116	232,116	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,533,227	2,533,227	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	1,655,960	1,655,960	26.00
27.00		0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	67,444,060	120,418,307	187,862,367	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		86,731,678		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00		0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		86,731,678		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150037

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

Worksheet G-3

Date/Time Prepared:
5/30/2012 6:15 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	187,862,367	1.00
2.00	Less contractual allowances and discounts on patients' accounts	109,417,150	2.00
3.00	Net patient revenues (line 1 minus line 2)	78,445,217	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	86,731,678	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-8,286,461	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	8,138,693	24.00
24.01	OTHER INCOME	93,932	24.01
25.00	Total other income (sum of lines 6-24)	8,232,625	25.00
26.00	Total (line 5 plus line 25)	-53,836	26.00
27.00	NON-OPERATING EXPENSE	301,765	27.00
27.01	OTHER EXPENSE	127,508	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	429,273	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-483,109	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 150037

Period: From 01/01/2011

Worksheet H

HHA CCN: 157092

To 12/31/2011

Date/Time Prepared: 5/30/2012 6:15 pm

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures		0		0	1.00
2.00	Capital Related - Movable Equipment		0		0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	447,978	0	125,656	0	258,000 5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	433,898	0	0	0	6.00
7.00	Physical Therapy	386,609	0	0	0	7.00
8.00	Occupational Therapy	161,676	0	0	0	8.00
9.00	Speech Pathology	6,819	0	0	0	9.00
10.00	Medical Social Services	17,474	0	0	0	10.00
11.00	Home Health Aide	231,571	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,686,025	0	125,656	0	258,000 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: 150037

Period: From 01/01/2011

Worksheet H

HHA CCN: 157092

To 12/31/2011

Date/Time Prepared: 5/30/2012 6:15 pm

Home Health Agency I

PPS

		Total (sum of col.s. 1 thru 5)	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	831,634	0	831,634	0	831,634	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	433,898	0	433,898	0	433,898	6.00
7.00	Physical Therapy	386,609	0	386,609	0	386,609	7.00
8.00	Occupational Therapy	161,676	0	161,676	0	161,676	8.00
9.00	Speech Pathology	6,819	0	6,819	0	6,819	9.00
10.00	Medical Social Services	17,474	0	17,474	0	17,474	10.00
11.00	Home Health Aide	231,571	0	231,571	0	231,571	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)	2,069,681	0	2,069,681	0	2,069,681	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: 150037	Period: From 01/01/2011	Worksheet H-1 Part I Date/Time Prepared: 5/30/2012 6:15 pm
	HHA CCN: 157092	To 12/31/2011	
		Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	
		Bldgs & Fixtures	Movable Equipment			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	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	831,634	0	0	0	5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	433,898	0	0	0	6.00
7.00	Physical Therapy	386,609	0	0	0	7.00
8.00	Occupational Therapy	161,676	0	0	0	8.00
9.00	Speech Pathology	6,819	0	0	0	9.00
10.00	Medical Social Services	17,474	0	0	0	10.00
11.00	Home Health Aide	231,571	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	2,069,681	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 150037	Period: From 01/01/2011	Worksheet H-1
		HHA CCN: 157092	To 12/31/2011	Part I
			Home Health Agency I	Date/Time Prepared: 5/30/2012 6:15 pm
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	Subtotal (col s. 0-4)	Administrative & General	Total (col s. 4A + 5)	
	4A.00	5.00	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	831,634	831,634	5.00
HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	433,898	291,462	725,360
7.00	Physical Therapy	386,609	259,697	646,306
8.00	Occupational Therapy	161,676	108,603	270,279
9.00	Speech Pathology	6,819	4,581	11,400
10.00	Medical Social Services	17,474	11,738	29,212
11.00	Home Health Aide	231,571	155,553	387,124
12.00	Supplies (see instructions)	0	0	0
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)	1,238,047		2,069,681

COST ALLOCATION - HHA STATISTICAL BASIS		Provider CCN: 150037 HHA CCN: 157092		Period: From 01/01/2011 To 12/31/2011		Worksheet H-1 Part II Date/Time Prepared: 5/30/2012 6:15 pm	
				Home Health Agency I		PPS	
		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)				
		1.00	2.00	3.00	4.00	5A.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation (see instructions)	0	0	0	0	0	4.00
5.00	Administrative and General	0	0	0	0	-831,634	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-831,634	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: 150037	Period: From 01/01/2011	Worksheet H-1 Part II Date/Time Prepared: 5/30/2012 6:15 pm
	HHA CCN: 157092	To 12/31/2011	
		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	1,238,047	5.00
HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	433,898	6.00
7.00	Physical Therapy	386,609	7.00
8.00	Occupational Therapy	161,676	8.00
9.00	Speech Pathology	6,819	9.00
10.00	Medical Social Services	17,474	10.00
11.00	Home Health Aide	231,571	11.00
12.00	Supplies (see instructions)	0	12.00
13.00	Drugs	0	13.00
14.00	DME	0	14.00
HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	15.00
16.00	Respiratory Therapy	0	16.00
17.00	Private Duty Nursing	0	17.00
18.00	Clinic	0	18.00
19.00	Health Promotion Activities	0	19.00
20.00	Day Care Program	0	20.00
21.00	Home Delivered Meals Program	0	21.00
22.00	Homemaker Service	0	22.00
23.00	All Others (specify)	0	23.00
24.00	Total (sum of lines 1-23)	1,238,047	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	831,634	25.00
26.00	Unit Cost Multiplier	0.671731	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 150037	Period: From 01/01/2011	Worksheet H-2
		HHA CCN: 157092	To 12/31/2011	Part I
			Home Health Agency I	Date/Time Prepared: 5/30/2012 6:15 pm
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	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
1.00 Administrative and General	0	0	0	399,357	399,357	93,292	1.00
2.00 Skilled Nursing Care	725,360	0	0	0	725,360	169,448	2.00
3.00 Physical Therapy	646,306	0	0	0	646,306	150,980	3.00
4.00 Occupational Therapy	270,279	0	0	0	270,279	63,139	4.00
5.00 Speech Pathology	11,400	0	0	0	11,400	2,663	5.00
6.00 Medical Social Services	29,212	0	0	0	29,212	6,824	6.00
7.00 Home Health Aide	387,124	0	0	0	387,124	90,434	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	2,069,681	0	0	399,357	2,469,038	576,780	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: 150037	Period: From 01/01/2011	Worksheet H-2
		HHA CCN: 157092	To 12/31/2011	Part I
				Date/Time Prepared: 5/30/2012 6:15 pm
			Home Health Agency I	PPS

	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
	7.00	9.00	10.00	11.00	13.00	
1.00 Administrative and General	0	63,272	0	101,402	89,788	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	0	63,272	0	101,402	89,788	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: 150037

Period: From 01/01/2011

Worksheet H-2

HHA CCN: 157092

To 12/31/2011

Part I
Date/Time Prepared:
5/30/2012 6:15 pm

Home Health Agency I

PPS

		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED PRGM	Subtotal	
		14.00	15.00	16.00	23.00	24.00	
1.00	Administrative and General	271	0	370	0	747,752	1.00
2.00	Skilled Nursing Care	0	0	0	0	894,808	2.00
3.00	Physical Therapy	0	0	0	0	797,286	3.00
4.00	Occupational Therapy	0	0	0	0	333,418	4.00
5.00	Speech Pathology	0	0	0	0	14,063	5.00
6.00	Medical Social Services	0	0	0	0	36,036	6.00
7.00	Home Health Aide	0	0	0	0	477,558	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	271	0	370	0	3,300,921	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: 150037	Period: From 01/01/2011	Worksheet H-2 Part I Date/Time Prepared: 5/30/2012 6:15 pm
		HHA CCN: 157092	To 12/31/2011	
			Home Health Agency I	PPS

	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
	25.00	26.00	27.00	28.00	
1.00	Administrative and General	0	747,752		1.00
2.00	Skilled Nursing Care	0	894,808	262,064	2.00
3.00	Physical Therapy	0	797,286	233,503	3.00
4.00	Occupational Therapy	0	333,418	97,649	4.00
5.00	Speech Pathology	0	14,063	4,119	5.00
6.00	Medical Social Services	0	36,036	10,554	6.00
7.00	Home Health Aide	0	477,558	139,863	7.00
8.00	Supplies (see instructions)	0	0	0	8.00
9.00	Drugs	0	0	0	9.00
10.00	DME	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	13.00
14.00	Clinic	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	15.00
16.00	Day Care Program	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	17.00
18.00	Homemaker Service	0	0	0	18.00
19.00	All Others (specify)	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	3,300,921	747,752	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.			0.292872	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: 150037
HHA CCN: 157092

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

Worksheet H-2
Part II
Date/Time Prepared:
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Home Health Agency I

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	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)	1.00					
	4.00	5A					
1.00	Administrative and General	0	1,686,025	0	399,357	0	1.00
2.00	Skilled Nursing Care	0	0	0	725,360	0	2.00
3.00	Physical Therapy	0	0	0	646,306	0	3.00
4.00	Occupational Therapy	0	0	0	270,279	0	4.00
5.00	Speech Pathology	0	0	0	11,400	0	5.00
6.00	Medical Social Services	0	0	0	29,212	0	6.00
7.00	Home Health Aide	0	0	0	387,124	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	1,686,025		2,469,038	0	20.00
21.00	Total cost to be allocated	0	399,357		576,780	0	21.00
22.00	Unit cost multiplier	0.000000	0.236863		0.233605	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150037
HHA CCN: 157092

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

Worksheet H-2
Part II
Date/Time Prepared:
5/30/2012 6:15 pm

		Home Health Agency I		PPS			
		HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	12,210	0	61,479	61,479	8,893	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	12,210	0	61,479	61,479	8,893	20.00
21.00	Total cost to be allocated	63,272	0	101,402	89,788	271	21.00
22.00	Unit cost multiplier	5.181982	0.000000	1.649376	1.460466	0.030473	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 150037	Period: From 01/01/2011	Worksheet H-2 Part II Date/Time Prepared: 5/30/2012 6:15 pm
	HHA CCN: 157092	To 12/31/2011	
		Home Health Agency I	PPS

	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	PARAMED PRGM (ASSIGNED TIME)		
	15.00	16.00	23.00		
1.00	Administrative and General	0	1	0	1.00
2.00	Skilled Nursing Care	0	0	0	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	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	8.00
9.00	Drugs	0	0	0	9.00
10.00	DME	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	13.00
14.00	Clinic	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	15.00
16.00	Day Care Program	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	17.00
18.00	Homemaker Service	0	0	0	18.00
19.00	All Others (specify)	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	1	0	20.00
21.00	Total cost to be allocated	0	370	0	21.00
22.00	Unit cost multiplier	0.000000	370.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet H-3 Parts I-III Date/Time Prepared: 5/30/2012 6:15 pm			
		HHA CCN: 157092	Title XVIII		Home Health Agency I PPS		
Cost Center Description	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits		
	0	1.00	2.00	3.00	4.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,156,872	1,156,872	5,302	1.00	
2.00	Physical Therapy	3.00	1,030,789	0	1,030,789	3,997	2.00
3.00	Occupational Therapy	4.00	431,067	0	431,067	1,935	3.00
4.00	Speech Pathology	5.00	18,182	0	18,182	77	4.00
5.00	Medical Social Services	6.00	46,590		46,590	124	5.00
6.00	Home Health Aide	7.00	617,421		617,421	6,729	6.00
7.00	Total (sum of lines 1-6)		3,300,921	0	3,300,921	18,164	7.00
Program Visits							
Part B							
Not Subject to Deductibles & Coinsurance							
Subject to Deductibles							
		0	1.00	2.00	3.00	4.00	
Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	129	297		8.00
8.01	Skilled Nursing Care		26900	484	665		8.01
8.02	Skilled Nursing Care		11300	16	5		8.02
9.00	Physical Therapy		99915	266	211		9.00
9.01	Physical Therapy		26900	648	596		9.01
9.02	Physical Therapy		11300	3	27		9.02
10.00	Occupational Therapy		99915	127	112		10.00
10.01	Occupational Therapy		26900	352	251		10.01
10.02	Occupational Therapy		11300	2	21		10.02
11.00	Speech Pathology		99915	2	0		11.00
11.01	Speech Pathology		26900	28	1		11.01
11.02	Speech Pathology		11300	0	0		11.02
12.00	Medical Social Services		99915	2	7		12.00
12.01	Medical Social Services		26900	27	24		12.01
12.02	Medical Social Services		11300	0	1		12.02
13.00	Home Health Aide		99915	19	231		13.00
13.01	Home Health Aide		26900	74	524		13.01
13.02	Home Health Aide		11300	6	3		13.02
14.00	Total (sum of lines 8-13)			2,185	2,976		14.00
Cost Center Description							
	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)		
	0	1.00	2.00	3.00	4.00		
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	15.00	
16.00	Cost of Drugs	9.00	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	0.511563	0	1.00	
2.00	Occupational Therapy		67.00	0.330653	0	2.00	
3.00	Speech Pathology		68.00	0.629995	0	3.00	
3.01	Speech Pathology 1		68.01	0.000000	0	3.01	
4.00	Cost of Medical Supplies		71.00	0.776496	0	4.00	
5.00	Cost of Drugs		73.00	0.272873	0	5.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150037

Period: From 01/01/2011

Worksheet H-3

HHA CCN: 157092

To 12/31/2011

Parts I-II
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Title XVIII

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Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Part A	Program Visits			
			Not Subject to Deductibles & Coi nsurance	Subject to Deductibles & Coi nsurance		
	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	218.20	629	967		1.00
2.00	Physical Therapy	257.89	917	834		2.00
3.00	Occupational Therapy	222.77	481	384		3.00
4.00	Speech Pathology	236.13	30	1		4.00
5.00	Medical Social Services	375.73	29	32		5.00
6.00	Home Health Aide	91.76	99	758		6.00
7.00	Total (sum of lines 1-6)		2,185	2,976		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
8.01	Skilled Nursing Care					8.01
8.02	Skilled Nursing Care					8.02
9.00	Physical Therapy					9.00
9.01	Physical Therapy					9.01
9.02	Physical Therapy					9.02
10.00	Occupational Therapy					10.00
10.01	Occupational Therapy					10.01
10.02	Occupational Therapy					10.02
11.00	Speech Pathology					11.00
11.01	Speech Pathology					11.01
11.02	Speech Pathology					11.02
12.00	Medical Social Services					12.00
12.01	Medical Social Services					12.01
12.02	Medical Social Services					12.02
13.00	Home Health Aide					13.00
13.01	Home Health Aide					13.01
13.02	Home Health Aide					13.02
14.00	Total (sum of lines 8-13)					14.00
	Cost Center Description	Ratio (col. 3 ÷ col. 4)	Part A	Program Covered Charges		
				Part B		
				Not Subject to Deductibles & Coi nsurance	Subject to Deductibles & Coi nsurance	
		5.00	6.00	7.00	8.00	
Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	0.000000	0	6,768	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
3.01	Speech Pathology 1		col. 2, line 4.01			3.01
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: 150037

Period: From 01/01/2011

Worksheet H-3

HHA CCN: 157092

To 12/31/2011

Parts I-III
Date/Time Prepared:
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Title XVIII

Home Health Agency I

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Cost Center Description	Cost of Services			Total Program Cost (sum of col.s. 9-10)	
	Part A	Part B			
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
9.00	10.00	11.00	12.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION					
Cost Per Visit Computation					
1.00	Skilled Nursing Care	137,248	210,999	348,247	1.00
2.00	Physical Therapy	236,485	215,080	451,565	2.00
3.00	Occupational Therapy	107,152	85,544	192,696	3.00
4.00	Speech Pathology	7,084	236	7,320	4.00
5.00	Medical Social Services	10,896	12,023	22,919	5.00
6.00	Home Health Aide	9,084	69,554	78,638	6.00
7.00	Total (sum of lines 1-6)	507,949	593,436	1,101,385	7.00
Cost Center Description					
		10.00	11.00	12.00	
Limitation Cost Computation					
8.00	Skilled Nursing Care				8.00
8.01	Skilled Nursing Care				8.01
8.02	Skilled Nursing Care				8.02
9.00	Physical Therapy				9.00
9.01	Physical Therapy				9.01
9.02	Physical Therapy				9.02
10.00	Occupational Therapy				10.00
10.01	Occupational Therapy				10.01
10.02	Occupational Therapy				10.02
11.00	Speech Pathology				11.00
11.01	Speech Pathology				11.01
11.02	Speech Pathology				11.02
12.00	Medical Social Services				12.00
12.01	Medical Social Services				12.01
12.02	Medical Social Services				12.02
13.00	Home Health Aide				13.00
13.01	Home Health Aide				13.01
13.02	Home Health Aide				13.02
14.00	Total (sum of lines 8-13)				14.00
Cost of Services					
Cost Center Description	Part A	Part B			
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	9.00	10.00	11.00		
Supplies and Drugs Cost Computations					
15.00	Cost of Medical Supplies	0	0	0	15.00
16.00	Cost of Drugs	0	0	0	16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 150037 HHA CCN: 157092	Period: From 01/01/2011 To 12/31/2011	Worksheet H-4 Part I-II Date/Time Prepared: 5/30/2012 6:15 pm
		Title XVII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	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
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		474,488	493,398
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	2,323
13.00	Total PPS Reimbursement - LUPA Episodes		11,518	12,771
14.00	Total PPS Reimbursement - PEP Episodes		2,877	5,277
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	1,233
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		488,883	515,002
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		488,883	515,002
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		488,883	515,002
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		488,883	515,002
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		488,883	515,002
32.00	Interim payments (see instructions)		488,883	515,002
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 32 and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	0

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

Provider CCN: 150037
HHA CCN: 157092

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

Worksheet H-5
Date/Time Prepared:
5/30/2012 6:15 pm
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		488,883		515,002	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
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)		488,883		515,002	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)		488,883		515,002	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150037

Period: From 01/01/2011

Worksheet K

Hospice CCN: 151547

To 12/31/2011

Date/Time Prepared: 5/30/2012 6:15 pm

		Hospice I					
		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	2,008	0	0	0	819,167	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	390,294	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	101,987	0	0	0	0	15.00
16.00	Spiritual Counseling	297	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	45,414	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	540,000	0	0	0	819,167	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150037

Period: From 01/01/2011

Worksheet K

Hospice CCN: 151547

To 12/31/2011

Date/Time Prepared: 5/30/2012 6:15 pm

		Hospice I					
		Total (col. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	821,175	0	821,175	-3,439	817,736	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	390,294	0	390,294	0	390,294	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	101,987	0	101,987	0	101,987	15.00
16.00	Spiritual Counseling	297	0	297	0	297	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	45,414	0	45,414	0	45,414	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1,359,167	0	1,359,167	-3,439	1,355,728	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150037

Period: From 01/01/2011

Worksheet K-1

Hospice CCN: 151547

To 12/31/2011

Date/Time Prepared: 5/30/2012 6:15 pm

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	2,008	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	390,294	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	101,987	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	2,008	0	101,987	0	390,294	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150037

Period: From 01/01/2011

Worksheet K-1

Hospice CCN: 151547

To 12/31/2011

Date/Time Prepared: 5/30/2012 6:15 pm

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	0	2,008	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services		0	0	0	9.00
10.00	Nursing Care		0	0	390,294	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services		0	0	101,987	15.00
16.00	Spiritual Counseling		0	297	297	16.00
17.00	Dietary Counseling		0	0	0	17.00
18.00	Counseling - Other		0	0	0	18.00
19.00	Home Health Aide and Homemaker		45,414	0	45,414	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	45,414	297	540,000	39.00

HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)		Provider CCN: 150037	Period: From 01/01/2011	Worksheet K-2
		Hospice CCN: 151547	To 12/31/2011	Date/Time Prepared: 5/30/2012 6:15 pm

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

HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)

Provider CCN: 150037

Period: From 01/01/2011

Worksheet K-2

Hospice CCN: 151547

To 12/31/2011

Date/Time Prepared: 5/30/2012 6:15 pm

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

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150037

Period: From 01/01/2011

Worksheet K-4

Hospice CCN: 151547

To 12/31/2011

Part I
Date/Time Prepared:
5/30/2012 6:15 pm

		CAPITAL RELATED COST				Hospice I	
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
			1.00	2.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	817,736	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	390,294	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	101,987	0	0	0	0	15.00
16.00	Spiritual Counseling	297	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	45,414	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1,355,728	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150037

Period: From 01/01/2011

Worksheet K-4

Hospice CCN: 151547

To 12/31/2011

Part I
Date/Time Prepared:
5/30/2012 6:15 pm

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)	
		5.00	5A	6.00	7.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.		0			1.00
2.00	Capital Related Costs-Movable Equip.		0			2.00
3.00	Plant Operation and Maintenance		0			3.00
4.00	Transportation - Staff		0			4.00
5.00	Volunteer Service Coordination	0				5.00
6.00	Administrative and General	0	817,736			6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services	0	0	0	0	9.00
10.00	Nursing Care	0	390,294	593,239	983,533	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services	0	101,987	155,018	257,005	15.00
16.00	Spiritual Counseling	0	297	451	748	16.00
17.00	Dietary Counseling	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	45,414	69,028	114,442	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	20.00
21.00	Other	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	33.00
34.00	Other	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	537,992	817,736	1,355,728	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150037

Period: From 01/01/2011

Worksheet K-4

Hospice CCN: 151547

To 12/31/2011

Part II
Date/Time Prepared:
5/30/2012 6:15 pm

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150037

Period: From 01/01/2011

Worksheet K-4

Hospice CCN: 151547

To 12/31/2011

Part II
Date/Time Prepared:
5/30/2012 6:15 pm

Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	
		6A	6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0		1.00
2.00	Capital Related Costs-Movable Equip.	0		2.00
3.00	Plant Operation and Maintenance	0		3.00
4.00	Transportation - Staff	0		4.00
5.00	Volunteer Service Coordination			5.00
6.00	Administrative and General	-817,736	537,992	6.00
INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	0	7.00
8.00	Inpatient - Respite Care	0	0	8.00
VISITING SERVICES				
9.00	Physician Services	0	0	9.00
10.00	Nursing Care	0	390,294	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	0	12.00
13.00	Occupational Therapy	0	0	13.00
14.00	Speech/ Language Pathology	0	0	14.00
15.00	Medical Social Services	0	101,987	15.00
16.00	Spiritual Counseling	0	297	16.00
17.00	Dietary Counseling	0	0	17.00
18.00	Counseling - Other	0	0	18.00
19.00	Home Health Aide and Homemaker	0	45,414	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00	Other	0	0	21.00
OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	0	22.00
23.00	Analgesics	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	24.00
25.00	Other - Specify	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	26.00
27.00	Patient Transportation	0	0	27.00
28.00	Imaging Services	0	0	28.00
29.00	Labs and Diagnostics	0	0	29.00
30.00	Medical Supplies	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	31.00
32.00	Radiation Therapy	0	0	32.00
33.00	Chemotherapy	0	0	33.00
34.00	Other	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0	35.00
36.00	Volunteer Program Costs	0	0	36.00
37.00	Fundraising	0	0	37.00
38.00	Other Program Costs	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		817,736	39.00
40.00	Unit Cost Multiplier		1.519978	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150037

Period: From 01/01/2011

Worksheet K-5

Hospice CCN: 151547

To 12/31/2011

Part I
Date/Time Prepared:
5/30/2012 6:15 pm

Cost Center Description	Hospice I						
	Hospice Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		0	NEW BLDG & FIXT				1.00
1.00 Administrative and General		120,072		127,906	247,978	57,929	1.00
2.00 Inpatient - General Care	0	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	0	4.00
5.00 Nursing Care	983,533	0	0	0	983,533	229,758	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	0	9.00
10.00 Medical Social Services	257,005	0	0	0	257,005	60,038	10.00
11.00 Spiritual Counseling	748	0	0	0	748	175	11.00
12.00 Dietary Counseling	0	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	114,442	0	0	0	114,442	26,734	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	1,355,728	120,072		127,906	1,603,706	374,634	34.00
35.00 Unit Cost Multiplier (see instructions)					0.000000		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150037

Period:

Worksheet K-5

Hospice CCN: 151547

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

Part I
Date/Time Prepared:
5/30/2012 6:15 pm

Cost Center Description		Hospice I					
		OPERATION OF PLANT 7.00	HOUSEKEEPING 9.00	DIETARY 10.00	CAFETERIA 11.00	NURSING ADMINISTRATION 13.00	
1.00	Administrative and General	249,442	0	0	28,803	25,504	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	249,442	0	0	28,803	25,504	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150037

Period: From 01/01/2011

Worksheet K-5

Hospice CCN: 151547

To 12/31/2011

Part I
Date/Time Prepared:
5/30/2012 6:15 pm

Cost Center Description		Hospice I				Subtotal (col s. 4A-23)	
		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	PARAMED ED PRGM		
		14.00	15.00	16.00	23.00	24.00	
1.00	Administrative and General	3,399	0	0	0	613,055	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	1,213,291	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	317,043	10.00
11.00	Spiritual Counseling	0	0	0	0	923	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	141,176	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	3,399	0	0	0	2,285,488	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS		Provider CCN: 150037	Period: From 01/01/2011	Worksheet K-5
		Hospice CCN: 151547	To 12/31/2011	Part I
				Date/Time Prepared: 5/30/2012 6:15 pm

Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (col.s. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (col.s. 26 ± 27)		
	25.00	26.00	27.00	28.00		
1.00 Administrative and General						1.00
2.00 Inpatient - General Care	0	0	0	0		2.00
3.00 Inpatient - Respite Care	0	0	0	0		3.00
4.00 Physician Services	0	0	0	0		4.00
5.00 Nursing Care	0	1,213,291	444,750	1,658,041		5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0		6.00
7.00 Physical Therapy	0	0	0	0		7.00
8.00 Occupational Therapy	0	0	0	0		8.00
9.00 Speech/ Language Pathology	0	0	0	0		9.00
10.00 Medical Social Services	0	317,043	116,217	433,260		10.00
11.00 Spiritual Counseling	0	923	338	1,261		11.00
12.00 Dietary Counseling	0	0	0	0		12.00
13.00 Counseling - Other	0	0	0	0		13.00
14.00 Home Health Aide and Homemaker	0	141,176	51,750	192,926		14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00
16.00 Other	0	0	0	0		16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0		17.00
18.00 Analgesics	0	0	0	0		18.00
19.00 Sedatives / Hypnotics	0	0	0	0		19.00
20.00 Other - Specify	0	0	0	0		20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0		21.00
22.00 Patient Transportation	0	0	0	0		22.00
23.00 Imaging Services	0	0	0	0		23.00
24.00 Labs and Diagnostics	0	0	0	0		24.00
25.00 Medical Supplies	0	0	0	0		25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0		26.00
27.00 Radiation Therapy	0	0	0	0		27.00
28.00 Chemotherapy	0	0	0	0		28.00
29.00 Other	0	0	0	0		29.00
30.00 Bereavement Program Costs	0	0	0	0		30.00
31.00 Volunteer Program Costs	0	0	0	0		31.00
32.00 Fundraising	0	0	0	0		32.00
33.00 Other Program Costs	0	0	0	0		33.00
34.00 Total (sum of lines 1 thru 33) (2)	0	2,285,488		2,285,488		34.00
35.00 Unit Cost Multiplier (see instructions)			0.366565			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150037

Period:

Worksheet K-5

Hospice CCN: 151547

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

Part II
Date/Time Prepared:
5/30/2012 6:15 pm

Cost Center Description		CAPITAL RELATED COSTS		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)				
		1.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	97,970	127,860	0	247,978	239,195	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	983,533	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	257,005	0	10.00
11.00	Spiritual Counseling	0	0	0	748	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	114,442	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	97,970	127,860		1,603,706	239,195	34.00
35.00	Total cost to be allocated	120,072	127,906		374,634	249,442	35.00
36.00	Unit Cost Multiplier (see instructions)	1.225600	1.000360		0.233605	1.042840	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150037

Hospice CCN: 151547

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

Worksheet K-5
Part II
Date/Time Prepared:
5/30/2012 6:15 pm

Cost Center Description		Hospice I					
		HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (MANHOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	0	21,982	20,483	3,219	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	21,982	20,483	3,219	34.00
35.00	Total cost to be allocated	0	0	28,803	25,504	3,399	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	1.310299	1.245130	1.055918	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150037
Hospice CCN: 151547

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

Worksheet K-5
Part II
Date/Time Prepared:
5/30/2012 6:15 pm

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

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 150037

Period: From 01/01/2011

Worksheet K-5

Hospice CCN: 151547

To 12/31/2011

Part III
Date/Time Prepared:
5/30/2012 6:15 pm

Cost Center Description		Hospice I			
		Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)
		0	1.00	2.00	3.00
ANCI LLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.511563	0	0 1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.330653	0	0 2.00
3.00	SPEECH PATHOLOGY	68.00	0.629995	0	0 3.00
3.01	OCCUPATIONAL HEALTH	68.01	0.000000	0	0 3.01
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.272873	0	0 4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00			5.00
6.00	LABORATORY	60.00	0.205162	0	0 6.00
6.01	BLOOD LABORATORY	60.01			6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.776496	0	0 7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00			8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00			9.00
10.00		76.00	0.000000	0	0 10.00
10.97	CARDIAC REHABILITATION	76.97	0.597510	0	0 10.97
11.00	Totals (sum of lines 1-10)				0 11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 150037

Period: From 01/01/2011

Worksheet K-6

Hospice CCN: 151547

To 12/31/2011

Date/Time Prepared: 5/30/2012 6:15 pm

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				2,285,488	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				5,499	2.00
3.00	Average cost per diem (line 1 divided by line 2)				415.62	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	4,528				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	1,881,927				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		76			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		31,587			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	3,355				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	1,394,405				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		5			10.00
11.00	Aggregate NF cost (line 3 times line 10)		2,078			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			895		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			371,980		13.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet L Parts I-III Date/Time Prepared: 5/30/2012 6:15 pm
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		805,888	1.00
2.00	Capital DRG outlier payments		7,236	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		28.55	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		813,124	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 150037 Component CCN: 153987	Period: From 01/01/2011 To 12/31/2011	Worksheet M-1 Date/Time Prepared: 5/30/2012 6:15 pm
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		Title XVIII		Rural Health Clinic (RHC) I	Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	2.00
3.00	Nurse Practitioner	112,312	0	112,312	0	3.00
4.00	Visiting Nurse	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	24,894	0	24,894	0	9.00
10.00	Subtotal (sum of lines 1-9)	137,206	0	137,206	0	10.00
11.00	Physician Services Under Agreement	0	13,090	13,090	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	13,090	13,090	0	14.00
15.00	Medical Supplies	0	2,457	2,457	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	2,457	2,457	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	137,206	15,547	152,753	0	22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	6,411	6,411	0	23.00
24.00	Dental	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	6,411	6,411	0	28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	76,528	76,528	0	29.00
30.00	Administrative Costs	28,234	0	28,234	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	28,234	76,528	104,762	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	165,440	98,486	263,926	0	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 150037 Component CCN: 153987	Period: From 01/01/2011 To 12/31/2011	Worksheet M-1 Date/Time Prepared: 5/30/2012 6:15 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	0
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	112,312
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	0
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	24,894
10.00	Subtotal (sum of lines 1-9)	0	137,206
11.00	Physician Services Under Agreement	0	13,090
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11-13)	0	13,090
15.00	Medical Supplies	0	2,457
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15-20)	0	2,457
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	152,753
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	6,411
24.00	Dental	0	0
25.00	Optometry	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	6,411
FACILITY OVERHEAD			
29.00	Facility Costs	-13,090	63,438
30.00	Administrative Costs	0	28,234
31.00	Total Facility Overhead (sum of lines 29 and 30)	-13,090	91,672
32.00	Total facility costs (sum of lines 22, 28 and 31)	-13,090	250,836

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet M-2		
		Component CCN: 153987		Date/Time Prepared: 5/30/2012 6:15 pm		
		Title XVIII	Rural Health Clinic (RHC) I	Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.00	0	4,200	0	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	1.06	1,738	2,100	2,226	3.00
4.00	Subtotal (sum of lines 1-3)	1.06	1,738		2,226	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	1.06	1,738		2,226	8.00
9.00	Physician Services Under Agreements		24		24	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)				152,753	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)				6,411	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				159,164	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				0.959721	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)				91,672	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				116,099	15.00
16.00	Total overhead (sum of lines 14 and 15)				207,771	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				207,771	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				199,402	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				352,155	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet M-3
		Component CCN: 153987		Date/Time Prepared: 5/30/2012 6:15 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		352,155	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		10,731	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		341,424	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		2,226	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		24	5.00
6.00	Total adjusted visits (line 4 plus line 5)		2,250	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		151.74	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27, Sec. 505 or your contractor)	0.00	78.07	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	78.07	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	279	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	21,782	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)	0	0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	21,782	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		13,985	16.04
16.05	Total program cost (see instructions)		13,985	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,301	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		13,985	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,778	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		16,763	22.00
23.00	Reimbursable bad debts (see instructions)		0	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		16,763	26.00
27.00	Interim payments		13,770	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		2,993	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 150037

Period:

Worksheet M-4

Component CCN: 153987

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

Date/Time Prepared:
5/30/2012 6:15 pm

Title XVIII

Rural Health
Clinic (RHC) I

Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	137,206	137,206	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001180	0.009216	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	162	1,264	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,152	1,969	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,314	3,233	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	152,753	152,753	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	207,771	207,771	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.008602	0.021165	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,787	4,397	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	3,101	7,630	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	16	125	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	193.81	61.04	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	3	36	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	581	2,197	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		10,731	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		2,778	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 150037	Period: From 01/01/2011 To 12/31/2011	Worksheet M-5
	Component CCN: 153987		Date/Time Prepared: 5/30/2012 6:15 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		13,770	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	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	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		13,770	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	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		2,993	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		16,763	7.00
		Contractor Number	Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00