

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).
 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY
 Provider CCN: 151331
 Period: From 01/01/2011 To 12/31/2011
 Worksheet 5
 Parts I-III
 Date/Time Prepared: 5/22/2012 4:25 pm

PART I - COST REPORT STATUS

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

Contractor use only
 5. Cost Report Status
 (1) As Submitted
 (2) Settled without Audit
 (3) Settled with Audit
 (4) Reopened
 (5) Amended
 6. Date Received:
 7. Contractor No.
 8. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN
 10. NPR Date:
 11. Contractor's Vendor Code: 04
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 5/22/2012 Time: 4:25 pm

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 HARRISON COUNTY 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.

Encryption Information

ECR: Date: 5/22/2012 Time: 4:25 pm
 Sadv4r:MIW6FXJvv.XbjxmITIF8d40
 EWBqh0j7Opqp0Aep09mvy8uIm0:.o.
 zie.0D.pev0KPWvz
 PI: Date: 5/22/2012 Time: 4:25 pm
 UT41wb22djAZxz5kucw9XHF::qj1Z0
 Rfwq.0dn97qFocfStZ:RWCK8u0iECB
 151nS8xG3I0TI05A

(Signed)

[Handwritten Signature]
 Officer or Administrator of Provider(s)

Title

CEO

Date

5/21/12

	Title V 1.00	Title XVIII		Title XIX 5.00	
		Part A 2.00	Part B 3.00		
1.00 Hospital	0	-82,476	114,944	0	0 1.00
2.00 Subprovider - IPF	0	0	0	0	0 2.00
3.00 Subprovider - IRF	0	0	0	0	0 3.00
4.00 SUBPROVIDER I	0	0	0	0	0 4.00
5.00 Swing bed - SNF	0	5,101	0	0	0 5.00
6.00 Swing bed - NF	0	0	0	0	0 6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0 7.00
8.00 NURSING FACILITY	0	0	0	0	0 8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0 9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0 10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0 11.00
12.00 CMHC I	0	0	0	0	0 12.00
200.00 Total	0	-77,375	114,944	0	0 200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA
 Provider CCN: 151331 Period: From 01/01/2011 To 12/31/2011
 Worksheet S-2 Part I Date/Time Prepared: 5/22/2012 4:24 pm

1.00 Hospital and Hospital Health Care Complex Address:
 Street: 245 ATWOOD ST. PO Box:
 2.00 City: CORYDON State: TN Zip Code: 47112- County: HARRISON

Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			3.00
					V	XVIII	XIX	
1.00 Hospital	151331	15999	1	12/15/2005	N	O	O	3.00
4.00 Subprovider - IPF								4.00
5.00 Subprovider - IRF								5.00
6.00 Subprovider - (Other)								6.00
7.00 Swing Beds - SNF	152331	15999		08/14/2011	N	O	O	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	157242	15999		12/23/1992	N	P	N	12.00
13.00 Separately Certified ASC								13.00
14.00 Hospital-Based Hospice								14.00
15.00 Hospital-Based Health Clinic - RHC								15.00
16.00 Hospital-Based Health Clinic - FQHC								16.00
17.00 Hospital-Based (CMHC) 1								17.00
18.00 Renal Dialysis								18.00
19.00 Other								19.00

20.00 Cost Reporting Period (mm/dd/yyyy) From: 01/01/2011 To: 12/31/2011 20.00
 21.00 Type of Control (see instructions) 9 21.00

22.00 Inpatient PPS Information
 Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. N N 22.00
 23.00 Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no. 2 N 23.00

	In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.	0	0	0	0	0	0	25.00

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. Urban/Rural S Date of Geogr 2 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). 2 27.00
 35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period. 0 35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151331

Period: worksheet 5-2
 From 01/01/2011 Part I
 To 12/31/2011 Date/Time Prepared:
 5/22/2012 4:24 pm

	Beginning:	Ending:	
	1.00	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.		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	XVIII	XIX	
	1.00	2.00	3.00	

Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)			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			46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.			47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.			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.			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.			58.00
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.			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)			60.00

	Y/N	IME Average	Direct GME Average	
	1.00	2.00	3.00	

61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)			61.00
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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)			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)			62.01

63.00	Teaching Hospitals that Claim Residents in Non-Provider Settings 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)			63.00
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	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	1.00	2.00	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.			64.00
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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

	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)						
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
			1.00	2.00	3.00		
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.					N	70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	71.00

1.00	2.00	3.00
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Inpatient Rehabilitation Facility PPS		
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N 75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	0 76.00

1.00

Long Term Care Hospital PPS		
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.	N 80.00
TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N 85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	N 86.00

V	XIX
1.00	2.00

Title V or XIX Inpatient Services		
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N Y 90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N N 91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.	N N 92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N N 93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N N 94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00 0.00 95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N N 96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00 0.00 97.00

Rural Providers		
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y 105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N 106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N N 107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N 108.00

Physical	Occupational	Speech	Respiratory
1.00	2.00	3.00	4.00
Y	Y	Y	N
1.00	2.00	3.00	4.00

109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y N 109.00
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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.	N 117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0 118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.	0 0119 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151331	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/22/2012 4:24 pm				
		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	2.00					
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00				
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	Y		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	Y	Y	155.00				
156.00	Subprovider - IPF	N	N	156.00				
157.00	Subprovider - IRF	N	N	157.00				
158.00	SUBPROVIDER	N	N	158.00				
159.00	SNF	N	N	159.00				
160.00	HOME HEALTH AGENCY	N	N	160.00				
161.00	CMHC		N	161.00				
			1.00					
Multicampus								
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N		165.00				
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5.							0.00 166.00
								1.00
Health Information Technology (HIT) Incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	N		167.00				
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			0168.00				
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.00 169.00				

	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) N 3.00

Y/N	Type	Date
1.00	2.00	3.00

Financial Data and Reports

4.00 Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. Y C 05/15/2012 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	Legal Oper.
1.00	2.00

Approved Educational Activities

6.00 Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program? N 6.00

7.00 Are costs claimed for Allied Health Programs? If "Y" see instructions. N 7.00

8.00 Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions. N 8.00

9.00 Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions. N 9.00

10.00 Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions. N 10.00

11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions. N 11.00

Y/N
1.00

Bad Debts

12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. Y 12.00

13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy. N 13.00

14.00 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. N 14.00

Bed Complement

15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions. N 15.00

Description	Part A	
	Y/N	Date
0	1.00	2.00

16.00 PS&R Data
 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 04/05/2012 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

Description	Part A		21.00
	Y/N	Date	
0	1.00	2.00	
21.00 was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

1.00

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

Capital Related Cost

22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00

Interest Expense

28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00

Purchased Services

32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N/A	33.00

Provider-Based Physicians

34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

Y/N	Date
1.00	2.00

Home Office Costs

36.00	Were home office costs claimed on the cost report?	N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N/A	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N/A	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N/A	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N/A	40.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 151331

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

Worksheet 5-2
Part II
Date/Time Prepared:
5/22/2012 4:24 pm

		Part B		
		Y/N	Date	
		3.00	4.00	
16.00	PS&R Data 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	04/05/2012	16.00
17.00	was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

Cost Center Description	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	1.00 30.00	21	7,665	118,824.00	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)		21	7,665	118,824.00	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	12,648.00	8.00
9.00 CORONARY CARE UNIT					9.00
10.00 BURN INTENSIVE CARE UNIT					10.00
11.00 SURGICAL INTENSIVE CARE UNIT					11.00
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00
13.00 NURSERY	43.00				13.00
14.00 Total (see instructions)		25	9,125	131,472.00	14.00
15.00 CAH visits					15.00
16.00 SUBPROVIDER - IPF					16.00
17.00 SUBPROVIDER - IRF					17.00
18.00 SUBPROVIDER					18.00
19.00 SKILLED NURSING FACILITY					19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE					21.00
22.00 HOME HEALTH AGENCY	101.00				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00 HOSPICE					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)		25			27.00
28.00 Observation Bed Days					28.00
29.00 Ambulance Trips					29.00
30.00 Employee discount days (see instruction)					30.00
31.00 Employee discount days - IRF					31.00
32.00 Labor & delivery days (see instructions)					32.00
33.00 LTCH non-covered days					33.00

I/P Days / O/P Visits / Trips

Cost Center Description	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	2,605	805	4,951	1.00
2.00 HMO		192	0		2.00
3.00 HMO IPF		0	0		3.00
4.00 HMO IRF		0	0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	3	0	3	5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		30	30	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,608	835	4,984	7.00
8.00 INTENSIVE CARE UNIT	0	355	64	527	8.00
9.00 CORONARY CARE UNIT					9.00
10.00 BURN INTENSIVE CARE UNIT					10.00
11.00 SURGICAL INTENSIVE CARE UNIT					11.00
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00
13.00 NURSERY	0		454	834	13.00
14.00 Total (see instructions)	0	2,963	1,353	6,345	14.00
15.00 CAH visits	0	0	0	0	15.00
16.00 SUBPROVIDER - IPF					16.00
17.00 SUBPROVIDER - IRF					17.00
18.00 SUBPROVIDER					18.00
19.00 SKILLED NURSING FACILITY					19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE					21.00
22.00 HOME HEALTH AGENCY	0	3,698	456	5,351	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00 HOSPICE					24.00
25.00 CMHC - CMHC					25.00
26.00 RURAL HEALTH CLINIC					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25
27.00 Total (sum of lines 14-26)					27.00
28.00 Observation Bed Days	0		121	604	28.00
29.00 Ambulance Trips		0			29.00
30.00 Employee discount days (see instruction)				0	30.00
31.00 Employee discount days - IRF				0	31.00
32.00 Labor & delivery days (see instructions)			0	0	32.00
33.00 LTCH non-covered days		0			33.00

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	758	1.00
2.00 HMO					45	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	331.22	0.00	0	758	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00	7.99	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	339.21	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

Cost Center Description	Discharges		
	Title XIX	Total All Patients	
	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	278	1,539	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)	278	1,539	14.00
15.00 CAH visits			15.00
16.00 SUBPROVIDER - IPF			16.00
17.00 SUBPROVIDER - IRF			17.00
18.00 SUBPROVIDER			18.00
19.00 SKILLED NURSING FACILITY			19.00
20.00 NURSING FACILITY			20.00
21.00 OTHER LONG TERM CARE			21.00
22.00 HOME HEALTH AGENCY			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)			23.00
24.00 HOSPICE			24.00
25.00 CMHC - CMHC			25.00
26.00 RURAL HEALTH CLINIC			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER			26.25
27.00 Total (sum of lines 14-26)			27.00
28.00 Observation Bed Days			28.00
29.00 Ambulance Trips			29.00
30.00 Employee discount days (see instruction)			30.00
31.00 Employee discount days - IRF			31.00
32.00 Labor & delivery days (see instructions)			32.00
33.00 LTCH non-covered days			33.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 151331

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

Worksheet S-3
Part IV
Date/Time Prepared:
5/22/2012 4:24 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401k Employer Contributions	765,908	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	0	3.00
4.00	Prior Year Pension Service Cost	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401k/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	1,937,363	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	28,212	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)	130,189	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	109,305	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	1,308,413	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	56,322	19.00
20.00	State or Federal unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	35,409	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	4,371,121	24.00
25.00	Part B - Other than Core Related Cost OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOME HEALTH AGENCY STATISTICAL DATA

Provider CCN: 151331 Period: From 01/01/2011 To 12/31/2011
 Component CCN: 157242 Date/Time Prepared: 5/22/2012 4:24 pm

Worksheet S-4

PPS

Home Health Agency I

HARRISON 1.00 0.00

0.00 County

Title v 1.00	Title XVIII 2.00	Title XIX 3.00	Other 4.00	Total 5.00	
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HOME HEALTH AGENCY STATISTICAL DATA
 1.00 Home Health Aide Hours 0 0 0 0 0 1.00
 2.00 Unduplicated Census Count (see instructions) 0.00 111.00 0.00 0.00 0.00 2.00

Number of Employees (Full Time Equivalent)

Enter the number of hours in your normal work week

Staff 1.00	Contract 2.00	Total 3.00
---------------	------------------	---------------

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

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

HOME HEALTH AGENCY CBSA CODES

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

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

PPS ACTIVITY DATA

21.00 Skilled Nursing Visits	1,435	125	79	18	1,657	21.00
22.00 Skilled Nursing Visit Charges	196,323	19,856	12,514	2,250	230,943	22.00
23.00 Physical Therapy Visits	785	8	6	23	822	23.00
24.00 Physical Therapy Visit Charges	119,842	1,056	792	3,036	124,726	24.00
25.00 Occupational Therapy Visits	438	0	0	10	448	25.00
26.00 Occupational Therapy Visit Charges	66,992	0	0	1,335	68,327	26.00
27.00 Speech Pathology Visits	0	0	0	0	0	27.00
28.00 Speech Pathology Visit Charges	0	0	0	0	0	28.00
29.00 Medical Social Service Visits	30	2	0	0	32	29.00
30.00 Medical Social Service Visit Charges	5,250	350	0	0	5,600	30.00
31.00 Home Health Aide Visits	697	30	0	12	739	31.00
32.00 Home Health Aide Visit Charges	41,697	1,650	0	660	44,007	32.00
33.00 Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,385	165	85	63	3,698	33.00
34.00 Other Charges	19,522	7,259	214	0	26,995	34.00
35.00 Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	449,626	30,171	13,520	7,281	500,598	35.00
36.00 Total Number of Episodes (standard/non outlier)	170		35	5	210	36.00
37.00 Total Number of Outlier Episodes		3		0	3	37.00
38.00 Total Non-routine Medical Supply Charges	11,552	1,909	1,749	75	15,285	38.00

		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)	0.332307	1.00
Medicaid (see instructions for each line)			
2.00	Net revenue from Medicaid	3,032,268	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?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	1,180,266	5.00
6.00	Medicaid charges	16,805,079	6.00
7.00	Medicaid cost (line 1 times line 6)	5,584,445	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,371,911	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)			
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
Other state or local government indigent care program (see instructions for each line)			
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
Uncompensated care (see instructions for each line)			
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,371,911	19.00
		Uninsured patients	Insured patients
		1.00	2.00
		Total (col. 1 + col. 2)	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	2,377,867	386,579
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	790,182	128,463
22.00	Partial payment by patients approved for charity care	23,308	28,136
23.00	Cost of charity care (line 21 minus line 22)	766,874	100,327
		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	6,306,359	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	927,774	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	5,378,585	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	1,787,341	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	2,654,542	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,026,453	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151331

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

Worksheet A

Date/Time Prepared:
5/22/2012 4:24 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT		2,303,145	2,303,145	1,265,496	3,568,641	1.00
1.01 MOB		904,965	904,965	0	904,965	1.01
1.02 AMB DEPR		0	0	77,845	77,845	1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP		2,247,724	2,247,724	-120,635	2,127,089	2.00
2.01 AMB EQUIP		0	0	171,477	171,477	2.01
4.00 EMPLOYEE BENEFITS	161,296	4,476,416	4,637,712	0	4,637,712	4.00
5.01 OTHER A&G	1,258,479	1,485,057	2,743,536	0	2,743,536	5.01
5.02 ADMITTING	361,064	39,227	400,291	0	400,291	5.02
5.03 PATIENT ACCOUNTING	334,857	513,403	848,260	0	848,260	5.03
7.00 OPERATION OF PLANT	212,051	1,281,918	1,493,969	0	1,493,969	7.00
7.01 AMB PLANT OPS	0	44,281	44,281	0	44,281	7.01
8.00 LAUNDRY & LINEN SERVICE	20,629	192,936	213,565	0	213,565	8.00
9.00 HOUSEKEEPING	386,470	109,183	495,653	0	495,653	9.00
10.00 DIETARY	345,438	315,715	661,153	-414,785	246,368	10.00
11.00 CAFETERIA	0	0	0	414,785	414,785	11.00
13.00 NURSING ADMINISTRATION	654,551	150,477	805,028	0	805,028	13.00
14.00 CENTRAL SERVICES & SUPPLY	220,749	19,998	240,747	1,037	241,784	14.00
16.00 MEDICAL RECORDS & LIBRARY	500,025	146,031	646,056	0	646,056	16.00
17.00 SOCIAL SERVICE	154,554	8,347	162,901	0	162,901	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,585,054	441,180	3,026,234	-421,352	2,604,882	30.00
31.00 INTENSIVE CARE UNIT	382,614	73,561	456,175	-42,375	413,800	31.00
43.00 NURSERY	0	294	294	263,443	263,737	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	929,154	1,208,065	2,137,219	-858,366	1,278,853	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	470,240	437,154	907,394	-22,805	884,589	53.00
54.00 RADIOLOGY-DIAGNOSTIC	1,025,560	924,743	1,950,303	-159,280	1,791,023	54.00
60.00 LABORATORY	701,794	1,271,346	1,973,140	-200,240	1,772,900	60.00
65.00 RESPIRATORY THERAPY	0	529,165	529,165	-93,410	435,755	65.00
66.00 PHYSICAL THERAPY	245,689	9,823	255,512	-1,384	254,128	66.00
67.00 OCCUPATIONAL THERAPY	0	13,046	13,046	0	13,046	67.00
68.00 SPEECH PATHOLOGY	0	10,182	10,182	0	10,182	68.00
69.00 ELECTROCARDIOLOGY	186,787	133,130	319,917	46,597	366,514	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,502,638	1,502,638	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	205,782	205,782	72.00
73.00 DRUGS CHARGED TO PATIENTS	304,047	1,545,724	1,849,771	0	1,849,771	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	80,607	80,607	-40	80,567	90.00
90.01 SENIOR CARE	158,255	132,798	291,053	-72	290,981	90.01
91.00 EMERGENCY	1,087,045	236,644	1,323,689	-169,334	1,154,355	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	1,628,178	487,423	2,115,601	-61,340	2,054,261	95.00
101.00 HOME HEALTH AGENCY	530,114	123,977	654,091	-16,685	637,406	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE		1,366,997	1,366,997	-1,366,997	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	14,844,694	23,264,682	38,109,376	0	38,109,376	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	4,471,687	1,867,164	6,338,851	0	6,338,851	192.00
194.00 MARKETING	36,724	276,914	313,638	0	313,638	194.00
194.01 PHYSICIAN BILLING	155,968	50,185	206,153	0	206,153	194.01
194.02 MOB	0	0	0	0	0	194.02
200.00 TOTAL (SUM OF LINES 118-199)	19,509,073	25,458,945	44,968,018	0	44,968,018	200.00

Cost Center Description	Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS			
1.00 NEW CAP REL COSTS-BLDG & FIXT	-1,060,129	2,508,512	1.00
1.01 MOB	0	904,965	1.01
1.02 AMB DEPR	0	77,845	1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP	-110,994	2,016,095	2.00
2.01 AMB EQUIP	0	171,477	2.01
4.00 EMPLOYEE BENEFITS	-111,786	4,525,926	4.00
5.01 OTHER A&G	0	2,743,536	5.01
5.02 ADMITTING	0	400,291	5.02
5.03 PATIENT ACCOUNTING	-25,889	822,371	5.03
7.00 OPERATION OF PLANT	-3,646	1,490,323	7.00
7.01 AMB PLANT OPS	0	44,281	7.01
8.00 LAUNDRY & LINEN SERVICE	0	213,565	8.00
9.00 HOUSEKEEPING	0	495,653	9.00
10.00 DIETARY	-8,541	237,827	10.00
11.00 CAFETERIA	-123,932	290,853	11.00
13.00 NURSING ADMINISTRATION	-107,752	697,276	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	241,784	14.00
16.00 MEDICAL RECORDS & LIBRARY	-17,556	628,500	16.00
17.00 SOCIAL SERVICE	0	162,901	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS	0	2,604,882	30.00
31.00 INTENSIVE CARE UNIT	0	413,800	31.00
43.00 NURSERY	0	263,737	43.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	0	1,278,853	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 ANESTHESIOLOGY	-818,322	66,267	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	1,791,023	54.00
60.00 LABORATORY	-5,749	1,767,151	60.00
65.00 RESPIRATORY THERAPY	-5,505	430,250	65.00
66.00 PHYSICAL THERAPY	0	254,128	66.00
67.00 OCCUPATIONAL THERAPY	0	13,046	67.00
68.00 SPEECH PATHOLOGY	0	10,182	68.00
69.00 ELECTROCARDIOLOGY	-86,900	279,614	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,502,638	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	205,782	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	1,849,771	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00 CLINIC	0	80,567	90.00
90.01 SENIOR CARE	0	290,981	90.01
91.00 EMERGENCY	0	1,154,355	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS			
95.00 AMBULANCE SERVICES	-23,730	2,030,531	95.00
101.00 HOME HEALTH AGENCY	0	637,406	101.00
SPECIAL PURPOSE COST CENTERS			
113.00 INTEREST EXPENSE	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-2,510,431	35,598,945	118.00
NONREIMBURSABLE COST CENTERS			
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	6,338,851	192.00
194.00 MARKETING	0	313,638	194.00
194.01 PHYSICIAN BILLING	0	206,153	194.01
194.02 MOB	0	0	194.02
200.00 TOTAL (SUM OF LINES 118-199)	-2,510,431	42,457,587	200.00

		Increases			
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
A - EKG					
1.00	ELECTROCARDIOLOGY	69.00	2,512	44,200	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
TOTALS			2,512	44,200	
B - MED SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,502,638	1.00
2.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	205,782	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,037	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
TOTALS			0	1,709,457	
C - INTEREST					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,366,997	1.00
TOTALS			0	1,366,997	
D - CAFETERIA					
1.00	CAFETERIA	11.00	216,716	198,069	1.00
TOTALS			216,716	198,069	
E - NURSERY					
1.00	NURSERY	43.00	263,738	0	1.00
TOTALS			263,738	0	
F - OTHER CAPITAL COSTS					
1.00	NEW CAP REL COSTS-MVBLE	2.00	0	23,656	1.00
EQUIP					
TOTALS			0	23,656	
G - DEPRECIATION AND UTILITIES					
1.00		0.00	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE	2.00	0	27,186	2.00
3.00	EQUIP	0.00	0	0	3.00
TOTALS			0	27,186	
H - AMBULANCE DEPRECIATION					
1.00	AMB DEPR	1.02	0	77,845	1.00
2.00	AMB EQUIP	2.01	0	171,477	2.00
TOTALS			0	249,322	
500.00	Grand Total: Increases		482,966	3,618,887	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - EKG							
1.00	AMBULANCE SERVICES	95.00	141	0	0		1.00
2.00	EMERGENCY	91.00	1,383	0	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	988	0	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	44,200	0		4.00
	TOTALS		2,512	44,200			
B - MED SUPPLIES							
1.00		0.00	0	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	157,614	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	41,387	0		3.00
4.00	NURSERY	43.00	0	295	0		4.00
5.00	OPERATING ROOM	50.00	0	858,366	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	22,805	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	159,280	0		7.00
8.00	LABORATORY	60.00	0	200,240	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	49,210	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	1,384	0		10.00
12.00	ELECTROCARDIOLOGY	69.00	0	115	0		12.00
13.00	CLINIC	90.00	0	40	0		13.00
14.00	SENIOR CARE	90.01	0	72	0		14.00
15.00	EMERGENCY	91.00	0	157,450	0		15.00
16.00	AMBULANCE SERVICES	95.00	0	61,199	0		16.00
	TOTALS		0	1,709,457			
C - INTEREST							
1.00	INTEREST EXPENSE	113.00	0	1,366,997	9		1.00
	TOTALS		0	1,366,997			
D - CAFETERIA							
1.00	DIETARY	10.00	216,716	198,069	0		1.00
	TOTALS		216,716	198,069			
E - NURSERY							
1.00	ADULTS & PEDIATRICS	30.00	263,738	0	0		1.00
	TOTALS		263,738	0			
F - OTHER CAPITAL COSTS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	23,656	9		1.00
	TOTALS		0	23,656			
G - DEPRECIATION AND UTILITIES							
1.00	EMERGENCY	91.00	0	10,501	0		1.00
2.00		0.00	0	0	10		2.00
3.00	HOME HEALTH AGENCY	101.00	0	16,685	0		3.00
	TOTALS		0	27,186			
H - AMBULANCE DEPRECIATION							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	77,845	9		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	171,477	10		2.00
	TOTALS		0	249,322			
500.00	Grand Total: Decreases		482,966	3,618,887			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151331

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/22/2012 4:24 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,202,420	0	0	0	22,475 1.00
2.00	Land Improvements	3,547,740	0	0	0	1 2.00
3.00	Buildings and Fixtures	36,978,785	771,340	0	771,340	0 3.00
4.00	Building Improvements	0	0	0	0	0 4.00
5.00	Fixed Equipment	0	0	0	0	0 5.00
6.00	Movable Equipment	19,453,368	559,344	0	559,344	0 6.00
7.00	HIT designated Assets	0	0	0	0	0 7.00
8.00	Subtotal (sum of lines 1-7)	63,182,313	1,330,684	0	1,330,684	22,476 8.00
9.00	Reconciling Items	0	0	0	0	0 9.00
10.00	Total (line 8 minus line 9)	63,182,313	1,330,684	0	1,330,684	22,476 10.00

SUMMARY OF CAPITAL

Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,303,145	0	0	0	0 1.00
1.01	MOB	904,965	0	0	0	0 1.01
1.02	AMB DEPR	0	0	0	0	0 1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,247,724	0	0	0	0 2.00
2.01	AMB EQUIP	0	0	0	0	0 2.01
3.00	Total (sum of lines 1-2)	5,455,834	0	0	0	0 3.00

COMPUTATION OF RATIOS

Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0 1.00
1.01	MOB	0	0	0	0.000000	0 1.01
1.02	AMB DEPR	0	0	0	0.000000	0 1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0 2.00
2.01	AMB EQUIP	0	0	0	0.000000	0 2.01
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0 3.00

	Ending Balance	Fully Depreciated Assets	
	6.00	7.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	3,179,945	1.00
2.00	Land Improvements	3,547,739	2.00
3.00	Buildings and Fixtures	37,750,125	3.00
4.00	Building Improvements	0	4.00
5.00	Fixed Equipment	0	5.00
6.00	Movable Equipment	20,012,712	6.00
7.00	HIT designated Assets	0	7.00
8.00	Subtotal (sum of lines 1-7)	64,490,521	8.00
9.00	Reconciling Items	0	9.00
10.00	Total (line 8 minus line 9)	64,490,521	10.00

Cost Center Description		other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)
		14.00	15.00

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,303,145	1.00
1.01	MOB	0	904,965	1.01
1.02	AMB DEPR	0	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2,247,724	2.00
2.01	AMB EQUIP	0	0	2.01
3.00	Total (sum of lines 1-2)	0	5,455,834	3.00

Cost Center Description		Taxes	other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL DEPRECIATION	Lease
		6.00	7.00	8.00	9.00	10.00

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,508,512	0	1.00
1.01	MOB	0	0	0	904,965	0	1.01
1.02	AMB DEPR	0	0	0	77,845	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	2,271,380	-255,285	2.00
2.01	AMB EQUIP	0	0	0	0	171,477	2.01
3.00	Total (sum of lines 1-2)	0	0	0	5,762,702	-83,808	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151331

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/22/2012 4:24 pm

SUMMARY OF CAPITAL

Cost Center Description	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	2,508,512	1.00
1.01 MOB	0	0	0	0	904,965	1.01
1.02 AMB DEPR	0	0	0	0	77,845	1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,016,095	2.00
2.01 AMB EQUIP	0	0	0	0	171,477	2.01
3.00 Total (sum of lines 1-2)	0	0	0	0	5,678,894	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on worksheet A To/From which the Amount is to be Adjusted	
			Cost Center	Line #
			1.00 2.00 3.00	4.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-220,653	NEW CAP REL COSTS-BLDG & FIXT	1.00 1.00
1.01 Investment income - MOB (chapter 2)		0	MOB	1.01 1.01
1.02 Investment income - AMB DEPR (chapter 2)		0	AMB DEPR	1.02 1.02
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-107,576	NEW CAP REL COSTS-MVBLE EQUIP	2.00 2.00
2.01 Investment income - AMB EQUIP (chapter 2)		0	AMB EQUIP	2.01 2.01
3.00 Investment income - other (chapter 2)		0		0.00 3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-225	PATIENT ACCOUNTING	5.03 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)	A	-2,908	PATIENT ACCOUNTING	5.03 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	-687,197		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	B	-123,932	CAFETERIA	11.00 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	B	-17,556	MEDICAL RECORDS & LIBRARY	16.00 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
26.01 Depreciation - MOB		0	MOB	1.01 26.01
26.02 Depreciation - AMB DEPR		0	AMB DEPR	1.02 26.02
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00 27.00
27.01 Depreciation - AMB EQUIP		0	AMB EQUIP	2.01 27.01
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 LAB MISC REV	B	-949	LABORATORY	60.00 33.00
34.00		0		0.00 34.00
35.00		0		0.00 35.00
36.00 CPR&EMS REV	B	-5,952	PATIENT ACCOUNTING	5.03 36.00
37.00 MISC REV	B	-3,612	PATIENT ACCOUNTING	5.03 37.00
38.00 MED STAFF FEES	B	-5,625	PATIENT ACCOUNTING	5.03 38.00
39.00 DIETARY SALES TAX	A	-8,541	DIETARY	10.00 39.00
40.00 PATIENT PHONE SALARIES	A	-3,610	PATIENT ACCOUNTING	5.03 40.00
41.00 PATIENT PHONE DEPRECIATION	A	-3,418	NEW CAP REL COSTS-MVBLE EQUIP	2.00 41.00
42.00 CRNA CONTRACTED SERVICES	A	-348,082	ANESTHESIOLOGY	53.00 42.00
43.00 UNNECESSARY BORROWING	A	-409	NEW CAP REL COSTS-BLDG & FIXT	1.00 43.00
44.00 PLANT MAINTENANCE	A	-3,646	OPERATION OF PLANT	7.00 44.00

Provider CCN: 151331 Period: worksheet A-8
From 01/01/2011
To 12/31/2011 Date/Time Prepared:
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Cost Center Description		Basis/Code (2)	Amount	Expense Classification on worksheet A		
				To/From which the Amount is to be Adjusted		
		1.00	2.00	3.00	4.00	Line #
45.00	MISC AMB REV	B	-11,730	AMBULANCE SERVICES		95.00 45.00
45.01	UNNECESSARY BORROWING	A	-13,903	NEW CAP REL COSTS-BLDG & FIXT		1.00 45.01
45.02	INTEREST RATE SWAP	A	-823,286	NEW CAP REL COSTS-BLDG & FIXT		1.00 45.02
45.03	ANESTHESIA EMP BEN	A	-111,786	EMPLOYEE BENEFITS		4.00 45.03
45.04	LOBBYING EXPENSE	A	-3,957	PATIENT ACCOUNTING		5.03 45.04
45.05	2005 BOND ISSUANCE NON-ALLOW COST	A	-1,878	NEW CAP REL COSTS-BLDG & FIXT		1.00 45.05
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-2,510,431			50.00

Cost Center Description	Wkst. A-7 Ref.	
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	5.00 9	1.00
1.01 Investment income - MOB (chapter 2)	0	1.01
1.02 Investment income - AMB DEPR (chapter 2)	0	1.02
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	10	2.00
2.01 Investment income - AMB EQUIP (chapter 2)	0	2.01
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
26.01 Depreciation - MOB	0	26.01
26.02 Depreciation - AMB DEPR	0	26.02
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0	27.00
27.01 Depreciation - AMB EQUIP	0	27.01
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 LAB MISC REV	0	33.00
34.00	0	34.00
35.00	0	35.00
36.00 CPR&EMS REV	0	36.00
37.00 MISC REV	0	37.00
38.00 MED STAFF FEES	0	38.00
39.00 DIETARY SALES TAX	0	39.00
40.00 PATIENT PHONE SALARIES	0	40.00
41.00 PATIENT PHONE DEPRECIATION	10	41.00
42.00 CRNA CONTRACTED SERVICES	0	42.00
43.00 UNNECESSARY BORROWING	9	43.00
44.00 PLANT MAINTENANCE	0	44.00
45.00 MISC AMB REV	0	45.00
45.01 UNNECESSARY BORROWING	9	45.01
45.02 INTEREST RATE SWAP	9	45.02
45.03 ANESTHESIA EMP BEN	0	45.03
45.04 LOBBYING EXPENSE	0	45.04
45.05 2005 BOND ISSUANCE NON-ALLOW COST	9	45.05
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		50.00

Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
1.00	2.00	3.00	4.00	
1.00	13.00 NURSING ADMINISTRATION	107,752	107,752	1.00
2.00	53.00 ANESTHESIOLOGY	470,240	470,240	2.00
3.00	60.00 LABORATORY	48,000	4,800	3.00
4.00	65.00 RESPIRATORY THERAPY	5,505	5,505	4.00
5.00	69.00 ELECTROCARDIOLOGY	86,900	86,900	5.00
6.00	91.00 EMERGENCY	0	0	6.00
7.00	95.00 AMBULANCE SERVICES	12,000	12,000	7.00
8.00	0.00	0	0	8.00
9.00	0.00	0	0	9.00
10.00	0.00	0	0	10.00
200.00		730,397	687,197	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151331

Period:

worksheet A-8-2

From 01/01/2011

To 12/31/2011

Date/Time Prepared:

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	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	43,200	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	43,200					200.00

Provider CCN: 151331

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

worksheet A-8-2

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

	RCE Disallowance	Adjustment	
	17.00	18.00	
1.00	0	107,752	1.00
2.00	0	470,240	2.00
3.00	0	4,800	3.00
4.00	0	5,505	4.00
5.00	0	86,900	5.00
6.00	0	0	6.00
7.00	0	12,000	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	687,197	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY
OUTSIDE SUPPLIERS

Provider CCN: 151331

Period:

worksheet A-8-3 Par

From 01/01/2011

To 12/31/2011

Date/Time Prepared:

5/22/2012 4:24 pm

Physical Therapy

Cost

							1.00	
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00	
2.00	Line 1 multiplied by 15 hours per week					780	2.00	
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00	
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00	
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00	
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00	
7.00	Standard travel expense rate					0.00	7.00	
8.00	Optional travel expense rate per mile					0.00	8.00	
		Supervisor's	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	9.99	0.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	0.00	67.24	0.00	0.00	0.00	10.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	33.62	33.62	0.00			11.00	
12.00	Number of travel hours (provider site)	0	0	0			12.00	
12.01	Number of travel hours (offsite)	0	0	0			12.01	
13.00	Number of miles driven (provider site)	0	0	0			13.00	
13.01	Number of miles driven (offsite)	0	0	0			13.01	
							1.00	
Part II - SALARY EQUIVALENCY COMPUTATION								
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00	
15.00	Therapists (column 2, line 9 times column 2, line 10)					672	15.00	
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00	
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					672	17.00	
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00	
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00	
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					672	20.00	
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.								
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					67.27	21.00	
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					52,471	22.00	
23.00	Total salary equivalency (see instructions)					52,471	23.00	
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE								
Standard Travel Allowance								
24.00	Therapists (line 3 times column 2, line 11)					0	24.00	
25.00	Assistants (line 4 times column 3, line 11)					0	25.00	
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00	
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00	
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00	
Optional Travel Allowance and Optional Travel Expense								
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00	
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00	
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00	
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00	
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00	
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00	
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00	
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE								
Standard Travel Expense								
36.00	Therapists (line 5 times column 2, line 11)					0	36.00	
37.00	Assistants (line 6 times column 3, line 11)					0	37.00	
38.00	Subtotal (sum of lines 36 and 37)					0	38.00	
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00	
Optional Travel Allowance and Optional Travel Expense								
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00	
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00	
42.00	Subtotal (sum of lines 40 and 41)					0	42.00	
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00	
Total Travel Allowance and Travel Expense - Offsite Services; complete one of the following three lines 44, 45, or 46, as appropriate.								
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00	

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY
OUTSIDE SUPPLIERS

Provider CCN: 151331

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

worksheet A-8-3 Par

Date/Time Prepared:
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		Physical Therapy				Cost	
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
						1.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	67.24	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					52,471	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					52,471	63.00
64.00	Total cost of outside supplier services (from your records)					599	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					0	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					0	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY
OUTSIDE SUPPLIERS

Provider CCN: 151331 Period:
From 01/01/2011
To 12/31/2011

Worksheet A-8-3 Par

Date/Time Prepared:
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					Occupational Therapy	Cost
					1.00	

45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0 45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0 46.00

		Therapists	Assistants	Aides	Trainees	Total
		1.00	2.00	3.00	4.00	5.00

PART V - OVERTIME COMPUTATION

47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	63.74	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

1.00

Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57.00	Salary equivalency amount (from line 23)					49,717	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35)					0	58.00
59.00	Travel allowance and expense - offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					49,717	63.00
64.00	Total cost of outside supplier services (from your records)					26,093	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					0	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					0	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY
OUTSIDE SUPPLIERS

Provider CCN: 151331

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

Worksheet A-8-3 Par

Date/Time Prepared:
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Speech Pathology: Cost

1.00

PART I - GENERAL INFORMATION

1.00	Total number of weeks worked (excluding aides) (see instructions)								0	1.00
2.00	Line 1 multiplied by 15 hours per week								0	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)								0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)								0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)								0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)								0	6.00
7.00	Standard travel expense rate								5.50	7.00
8.00	Optional travel expense rate per mile								0.00	8.00

		Supervisors 1.00	Therapists 2.00	Assistants 3.00	Aides 4.00	Trainees 5.00				
9.00	Total hours worked	0.00	163.27	0.00	0.00	0.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	75.26	0.00	0.00	0.00	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	37.63	37.63	0.00						11.00
12.00	Number of travel hours (provider site)	0	0	0						12.00
12.01	Number of travel hours (offsite)	0	0	0						12.01
13.00	Number of miles driven (provider site)	0	0	0						13.00
13.01	Number of miles driven (offsite)	0	0	0						13.01

1.00

Part II - SALARY EQUIVALENCY COMPUTATION

14.00	Supervisors (column 1, line 9 times column 1, line 10)								0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)								12,288	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)								0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)								12,288	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)								0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)								0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)								12,288	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.										
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)								0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)								0	22.00
23.00	Total salary equivalency (see instructions)								12,288	23.00

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

Standard Travel Allowance											
24.00	Therapists (line 3 times column 2, line 11)									0	24.00
25.00	Assistants (line 4 times column 3, line 11)									0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)									0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)									0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)									0	28.00
Optional Travel Allowance and Optional Travel Expense											
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)									0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)									0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)									0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)									0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)									0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)									0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)									0	35.00

Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

Standard Travel Expense											
36.00	Therapists (line 5 times column 2, line 11)									0	36.00
37.00	Assistants (line 6 times column 3, line 11)									0	37.00
38.00	Subtotal (sum of lines 36 and 37)									0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)									0	39.00
Optional Travel Allowance and Optional Travel Expense											
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)									0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)									0	41.00
42.00	Subtotal (sum of lines 40 and 41)									0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)									0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.											
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)									0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)									0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY
OUTSIDE SUPPLIERS

Provider CCN: 151331

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

Worksheet A-8-3 Par

Date/Time Prepared:
5/22/2012 4:24 pm

Speech Pathology Cost

1.00 0 46.00

46.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						0	46.00
	Therapists	Assistants	Aides	Trainees	Total		
	1.00	2.00	3.00	4.00	5.00		

PART V - OVERTIME COMPUTATION

47.00 Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56) 0.00 0.00 0.00 0.00 0.00 47.00

48.00 Overtime rate (see instructions) 0.00 0.00 0.00 0.00 48.00

49.00 Total overtime (including base and overtime allowance) (multiply line 47 times line 48) 0.00 0.00 0.00 0.00 49.00

CALCULATION OF LIMIT

50.00 Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47) 0.00 0.00 0.00 0.00 0.00 50.00

51.00 Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions) 0.00 0.00 0.00 0.00 0.00 51.00

DETERMINATION OF OVERTIME ALLOWANCE

52.00 Adjusted hourly salary equivalency amount (see instructions) 75.26 0.00 0.00 0.00 52.00

53.00 Overtime cost limitation (line 51 times line 52) 0 0 0 0 53.00

54.00 Maximum overtime cost (enter the lesser of line 49 or line 53) 0 0 0 0 54.00

55.00 Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52) 0 0 0 0 55.00

56.00 Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.) 0 0 0 0 0 56.00

1.00

Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57.00 Salary equivalency amount (from line 23) 12,288 57.00

58.00 Travel allowance and expense - provider site (from lines 33, 34, or 35) 0 58.00

59.00 Travel allowance and expense - Offsite services (from lines 44, 45, or 46) 0 59.00

60.00 Overtime allowance (from column 5, line 56) 0 60.00

61.00 Equipment cost (see instructions) 0 61.00

62.00 Supplies (see instructions) 0 62.00

63.00 Total allowance (sum of lines 57-62) 12,288 63.00

64.00 Total cost of outside supplier services (from your records) 10,182 64.00

65.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero) 0 65.00

LINE 33 CALCULATION

100.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 0 100.00

100.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 0 100.01

100.02 Line 33 = line 28 = sum of lines 26 and 27 0 100.02

LINE 34 CALCULATION

101.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 0 101.00

101.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 0 101.01

101.02 Line 34 = sum of lines 27 and 31 0 101.02

LINE 35 CALCULATION

102.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 0 102.00

102.01 Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others 0 102.01

102.02 Line 35 = sum of lines 31 and 32 0 102.02

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			
		NEW BLDG & FIXT	MOB	AMB DEPR	NEW MVBLE EQUIP
		1.00	1.01	1.02	2.00
GENERAL SERVICE COST CENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	2,508,512	2,508,512			1.00
1.01 MOB	904,965	0	904,965		1.01
1.02 AMB DEPR	77,845	0	0	77,845	1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP	2,016,095			2,016,095	2.00
2.01 AMB EQUIP	171,477			0	2.01
4.00 EMPLOYEE BENEFITS	4,525,926	3,865	0	0	3,106 4.00
5.01 OTHER A&G	2,743,536	381,387	5,176	0	306,521 5.01
5.02 ADMITTING	400,291	0	0	0	0 5.02
5.03 PATIENT ACCOUNTING	822,371	0	0	0	0 5.03
7.00 OPERATION OF PLANT	1,490,323	303,146	0	0	243,639 7.00
7.01 AMB PLANT OPS	44,281	0	0	0	0 7.01
8.00 LAUNDRY & LINEN SERVICE	213,565	17,700	0	0	14,226 8.00
9.00 HOUSEKEEPING	495,653	37,913	0	0	30,470 9.00
10.00 DIETARY	237,827	110,318	0	0	88,662 10.00
11.00 CAFETERIA	290,853	55,110	0	0	44,292 11.00
13.00 NURSING ADMINISTRATION	697,276	9,275	0	0	7,455 13.00
14.00 CENTRAL SERVICES & SUPPLY	241,784	0	0	0	0 14.00
16.00 MEDICAL RECORDS & LIBRARY	628,500	61,545	0	0	49,464 16.00
17.00 SOCIAL SERVICE	162,901	3,710	0	0	2,982 17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS	2,604,882	444,303	0	0	357,090 30.00
31.00 INTENSIVE CARE UNIT	413,800	55,980	0	0	44,991 31.00
43.00 NURSERY	263,737	11,594	0	0	9,318 43.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	1,278,853	342,450	0	0	275,228 50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00 ANESTHESIOLOGY	66,267	0	0	0	0 53.00
54.00 RADIOLOGY-DIAGNOSTIC	1,791,023	179,418	0	0	144,199 54.00
60.00 LABORATORY	1,767,151	94,298	0	0	75,788 60.00
65.00 RESPIRATORY THERAPY	430,250	20,522	0	0	16,493 65.00
66.00 PHYSICAL THERAPY	254,128	66,647	0	0	53,564 66.00
67.00 OCCUPATIONAL THERAPY	13,046	0	0	0	0 67.00
68.00 SPEECH PATHOLOGY	10,182	0	0	0	0 68.00
69.00 ELECTROCARDIOLOGY	279,614	35,246	0	0	28,327 69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,502,638	84,173	0	0	67,650 71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	205,782	0	0	0	0 72.00
73.00 DRUGS CHARGED TO PATIENTS	1,849,771	23,691	0	0	19,040 73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	80,567	2,783	0	0	2,236 90.00
90.01 SENIOR CARE	290,981	3,092	30,896	0	2,485 90.01
91.00 EMERGENCY	1,154,355	130,800	14,418	0	105,124 91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES	2,030,531	0	0	77,845	0 95.00
101.00 HOME HEALTH AGENCY	637,406	0	15,765	0	0 101.00
SPECIAL PURPOSE COST CENTERS					
113.00 INTEREST EXPENSE					113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	35,598,945	2,478,966	66,255	77,845	1,992,350 118.00
NONREIMBURSABLE COST CENTERS					
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,749	0	0	12,657 190.00
192.00 PHYSICIANS' PRIVATE OFFICES	6,338,851	0	0	0	0 192.00
194.00 MARKETING	313,638	4,135	0	0	3,323 194.00
194.01 PHYSICIAN BILLING	206,153	9,662	0	0	7,765 194.01
194.02 MOB	0	0	838,710	0	0 194.02
200.00 Cross Foot Adjustments					200.00
201.00 Negative Cost Centers		0	0	0	0 201.00
202.00 TOTAL (sum lines 118-201)	42,457,587	2,508,512	904,965	77,845	2,016,095 202.00

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	OTHER A&G	ADMITTING	
	AMB EQUIP						
	2.01	4.00					
GENERAL SERVICE COST CENTERS							
1.00 NEW CAP REL COSTS-BLDG & FIXT							1.00
1.01 MOB							1.01
1.02 AMB DEPR							1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP							2.00
2.01 AMB EQUIP	171,477						2.01
4.00 EMPLOYEE BENEFITS	0	4,532,897					4.00
5.01 OTHER A&G	0	302,187	3,738,807	3,738,807	3,738,807		5.01
5.02 ADMITTING	0	86,699	486,990	486,990	47,025	534,015	5.02
5.03 PATIENT ACCOUNTING	0	80,406	902,777	902,777	87,175	0	5.03
7.00 OPERATION OF PLANT	0	50,918	2,088,026	2,088,026	201,626	0	7.00
7.01 AMB PLANT OPS	0	0	44,281	44,281	4,276	0	7.01
8.00 LAUNDRY & LINEN SERVICE	0	4,953	250,444	250,444	24,184	0	8.00
9.00 HOUSEKEEPING	0	92,800	656,836	656,836	63,426	0	9.00
10.00 DIETARY	0	30,909	467,716	467,716	45,164	0	10.00
11.00 CAFETERIA	0	52,038	442,293	442,293	42,709	0	11.00
13.00 NURSING ADMINISTRATION	0	157,171	871,177	871,177	84,123	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	53,006	294,790	294,790	28,466	0	14.00
16.00 MEDICAL RECORDS & LIBRARY	0	120,067	859,576	859,576	83,003	0	16.00
17.00 SOCIAL SERVICE	0	37,112	206,705	206,705	19,960	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	0	557,397	3,963,672	3,963,672	382,744	47,558	30.00
31.00 INTENSIVE CARE UNIT	0	91,636	606,407	606,407	58,556	6,138	31.00
43.00 NURSERY	0	63,329	347,978	347,978	33,602	5,790	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0	223,109	2,119,640	2,119,640	204,679	52,758	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	66,267	66,267	6,399	3,368	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	246,258	2,360,898	2,360,898	227,975	152,640	54.00
60.00 LABORATORY	0	168,515	2,105,752	2,105,752	203,338	79,799	60.00
65.00 RESPIRATORY THERAPY	0	0	467,265	467,265	45,121	8,112	65.00
66.00 PHYSICAL THERAPY	0	58,995	433,334	433,334	41,844	8,868	66.00
67.00 OCCUPATIONAL THERAPY	0	0	13,046	13,046	1,260	334	67.00
68.00 SPEECH PATHOLOGY	0	0	10,182	10,182	983	202	68.00
69.00 ELECTROCARDIOLOGY	0	45,455	388,642	388,642	37,528	15,209	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,654,461	1,654,461	159,760	29,331	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	205,782	205,782	19,871	2,589	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	73,008	1,965,510	1,965,510	189,796	35,635	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00 CLINIC	0	0	85,586	85,586	8,264	1,079	90.00
90.01 SENIOR CARE	0	38,000	365,454	365,454	35,289	2,651	90.01
91.00 EMERGENCY	0	260,690	1,665,387	1,665,387	160,815	55,536	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 AMBULANCE SERVICES	171,477	390,926	2,670,779	2,670,779	257,898	26,418	95.00
101.00 HOME HEALTH AGENCY	0	127,292	780,463	780,463	75,364	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00 INTEREST EXPENSE							113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	171,477	3,412,876	33,586,923	33,586,923	2,882,223	534,015	118.00
NONREIMBURSABLE COST CENTERS							
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	28,406	28,406	2,743	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	1,073,752	7,412,603	7,412,603	715,790	0	192.00
194.00 MARKETING	0	8,818	329,914	329,914	31,857	0	194.00
194.01 PHYSICIAN BILLING	0	37,451	261,031	261,031	25,206	0	194.01
194.02 MOB	0	0	838,710	838,710	80,988	0	194.02
200.00 Cross Foot Adjustments			0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	171,477	4,532,897	42,457,587	42,457,587	3,738,807	534,015	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151331

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

Worksheet B
Part I
Date/Time Prepared:
5/22/2012 4:24 pm

Cost Center Description	PATIENT ACCOUNTING	OPERATION OF PLANT	AMB PLANT OPS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
	5.03	7.00	7.01	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 MOB						1.01
1.02 AMB DEPR						1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 AMB EQUIP						2.01
4.00 EMPLOYEE BENEFITS						4.00
5.01 OTHER A&G						5.01
5.02 ADMITTING						5.02
5.03 PATIENT ACCOUNTING	989,952					5.03
7.00 OPERATION OF PLANT	0	2,289,652				7.00
7.01 AMB PLANT OPS	0	0	48,557			7.01
8.00 LAUNDRY & LINEN SERVICE	0	22,266	0	296,894		8.00
9.00 HOUSEKEEPING	0	47,693	0	25,617	793,572	9.00
10.00 DIETARY	0	138,776	0	3,510	49,615	10.00
11.00 CAFETERIA	0	69,327	0	0	24,786	11.00
13.00 NURSING ADMINISTRATION	0	11,668	0	0	4,171	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00 MEDICAL RECORDS & LIBRARY	0	77,422	0	0	27,680	16.00
17.00 SOCIAL SERVICE	0	4,667	0	0	1,669	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	88,163	558,926	0	132,057	199,821	30.00
31.00 INTENSIVE CARE UNIT	11,379	70,421	0	0	25,177	31.00
43.00 NURSERY	10,734	14,585	0	0	5,214	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	97,802	430,793	0	23,498	154,015	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	6,243	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	282,958	225,703	0	31,801	80,692	54.00
60.00 LABORATORY	147,931	118,625	0	0	42,410	60.00
65.00 RESPIRATORY THERAPY	15,038	25,815	0	478	9,229	65.00
66.00 PHYSICAL THERAPY	16,440	83,839	0	4,600	29,974	66.00
67.00 OCCUPATIONAL THERAPY	619	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	375	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	28,195	44,338	0	10,616	15,852	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	54,374	105,887	0	0	37,856	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	4,800	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	66,060	29,802	0	0	10,655	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	2,000	3,500	0	426	1,251	90.00
90.01 SENIOR CARE	4,914	3,889	0	14	1,390	90.01
91.00 EMERGENCY	102,953	164,543	0	45,574	58,827	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	48,974	0	48,557	11,963	0	95.00
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	989,952	2,252,485	48,557	290,154	780,284	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,811	0	0	7,083	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	6,740	0	192.00
194.00 MARKETING	0	5,202	0	0	1,860	194.00
194.01 PHYSICIAN BILLING	0	12,154	0	0	4,345	194.01
194.02 MOB	0	0	0	0	0	194.02
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	989,952	2,289,652	48,557	296,894	793,572	202.00

Cost Center Description	DIETARY 10.00	CAFETERIA 11.00	NURSING ADMINISTRATION 13.00	CENTRAL SERVICES & SUPPLY 14.00	MEDICAL RECORDS & LIBRARY 16.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 MOB						1.01
1.02 AMB DEPR						1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 AMB EQUIP						2.01
4.00 EMPLOYEE BENEFITS						4.00
5.01 OTHER A&G						5.01
5.02 ADMITTING						5.02
5.03 PATIENT ACCOUNTING						5.03
7.00 OPERATION OF PLANT						7.00
7.01 AMB PLANT OPS						7.01
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY	704,781					10.00
11.00 CAFETERIA	0	579,115				11.00
13.00 NURSING ADMINISTRATION	0	20,168	991,307			13.00
14.00 CENTRAL SERVICES & SUPPLY	0	17,015	0	340,271		14.00
16.00 MEDICAL RECORDS & LIBRARY	0	31,790	0	0	1,079,471	16.00
17.00 SOCIAL SERVICE	0	6,384	0	140	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	634,789	70,666	297,011	8,568	96,141	30.00
31.00 INTENSIVE CARE UNIT	69,992	49,708	208,921	1,041	12,408	31.00
43.00 NURSERY	0	12,770	53,670	0	11,706	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	38,669	162,527	13,526	106,652	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	9,043	0	623	6,808	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	51,411	0	3,843	308,498	54.00
60.00 LABORATORY	0	37,445	0	2,005	161,318	60.00
65.00 RESPIRATORY THERAPY	0	16,208	0	294	16,399	65.00
66.00 PHYSICAL THERAPY	0	10,240	0	688	17,928	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	675	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	409	68.00
69.00 ELECTROCARDIOLOGY	0	9,666	0	755	30,747	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	250,904	59,295	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	39,813	5,234	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	8,338	0	744	72,038	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	0	0	2,185	2,181	90.00
90.01 SENIOR CARE	0	7,974	0	190	5,359	90.01
91.00 EMERGENCY	0	43,224	181,672	4,807	112,269	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	0	0	0	10,145	53,406	95.00
101.00 HOME HEALTH AGENCY	0	0	87,506	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	704,781	440,719	991,307	340,271	1,079,471	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	123,934	0	0	0	192.00
194.00 MARKETING	0	2,085	0	0	0	194.00
194.01 PHYSICIAN BILLING	0	12,377	0	0	0	194.01
194.02 MOB	0	0	0	0	0	194.02
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	704,781	579,115	991,307	340,271	1,079,471	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151331

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

Worksheet B
Part I
Date/Time Prepared:
5/22/2012 4:24 pm

Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01 MOB					1.01
1.02 AMB DEPR					1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01 AMB EQUIP					2.01
4.00 EMPLOYEE BENEFITS					4.00
5.01 OTHER A&G					5.01
5.02 ADMITTING					5.02
5.03 PATIENT ACCOUNTING					5.03
7.00 OPERATION OF PLANT					7.00
7.01 AMB PLANT OPS					7.01
8.00 LAUNDRY & LINEN SERVICE					8.00
9.00 HOUSEKEEPING					9.00
10.00 DIETARY					10.00
11.00 CAFETERIA					11.00
13.00 NURSING ADMINISTRATION					13.00
14.00 CENTRAL SERVICES & SUPPLY					14.00
16.00 MEDICAL RECORDS & LIBRARY					16.00
17.00 SOCIAL SERVICE	239,525				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS	215,738	6,695,854	0	6,695,854	30.00
31.00 INTENSIVE CARE UNIT	23,787	1,143,935	0	1,143,935	31.00
43.00 NURSERY	0	496,049	0	496,049	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	3,404,559	0	3,404,559	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	98,751	0	98,751	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	3,726,419	0	3,726,419	54.00
60.00 LABORATORY	0	2,898,623	0	2,898,623	60.00
65.00 RESPIRATORY THERAPY	0	603,959	0	603,959	65.00
66.00 PHYSICAL THERAPY	0	647,755	0	647,755	66.00
67.00 OCCUPATIONAL THERAPY	0	15,934	0	15,934	67.00
68.00 SPEECH PATHOLOGY	0	12,151	0	12,151	68.00
69.00 ELECTROCARDIOLOGY	0	581,548	0	581,548	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,351,868	0	2,351,868	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	278,089	0	278,089	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	2,378,578	0	2,378,578	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	0	106,472	0	106,472	90.00
90.01 SENIOR CARE	0	427,124	0	427,124	90.01
91.00 EMERGENCY	0	2,595,607	0	2,595,607	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0		0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES	0	3,128,140	0	3,128,140	95.00
101.00 HOME HEALTH AGENCY	0	943,333	0	943,333	101.00
SPECIAL PURPOSE COST CENTERS					
113.00 INTEREST EXPENSE					113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	239,525	32,534,748	0	32,534,748	118.00
NONREIMBURSABLE COST CENTERS					
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	58,043	0	58,043	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	8,259,067	0	8,259,067	192.00
194.00 MARKETING	0	370,918	0	370,918	194.00
194.01 PHYSICIAN BILLING	0	315,113	0	315,113	194.01
194.02 MOB	0	919,698	0	919,698	194.02
200.00 Cross Foot Adjustments	0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	239,525	42,457,587	0	42,457,587	202.00

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	MOB	AMB DEPR	NEW MVBLE EQUIP	
	0	1.00	1.01	1.02	2.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 MOB						1.01
1.02 AMB DEPR						1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 AMB EQUIP						2.01
4.00 EMPLOYEE BENEFITS	0	3,865		0	3,106	4.00
5.01 OTHER A&G	0	381,387	5,176	0	306,521	5.01
5.02 ADMITTING	0	0	0	0	0	5.02
5.03 PATIENT ACCOUNTING	0	0	0	0	0	5.03
7.00 OPERATION OF PLANT	0	303,146	0	0	243,639	7.00
7.01 AMB PLANT OPS	0	0	0	0	0	7.01
8.00 LAUNDRY & LINEN SERVICE	0	17,700	0	0	14,226	8.00
9.00 HOUSEKEEPING	0	37,913	0	0	30,470	9.00
10.00 DIETARY	0	110,318	0	0	88,662	10.00
11.00 CAFETERIA	0	55,110	0	0	44,292	11.00
13.00 NURSING ADMINISTRATION	0	9,275	0	0	7,455	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00 MEDICAL RECORDS & LIBRARY	0	61,545	0	0	49,464	16.00
17.00 SOCIAL SERVICE	0	3,710	0	0	2,982	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	0	444,303	0	0	357,090	30.00
31.00 INTENSIVE CARE UNIT	0	55,980	0	0	44,991	31.00
43.00 NURSERY	0	11,594	0	0	9,318	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	342,450	0	0	275,228	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	179,418	0	0	144,199	54.00
60.00 LABORATORY	0	94,298	0	0	75,788	60.00
65.00 RESPIRATORY THERAPY	0	20,522	0	0	16,493	65.00
66.00 PHYSICAL THERAPY	0	66,647	0	0	53,564	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	35,246	0	0	28,327	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	84,173	0	0	67,650	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	23,691	0	0	19,040	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	2,783	0	0	2,236	90.00
90.01 SENIOR CARE	0	3,092	30,896	0	2,485	90.01
91.00 EMERGENCY	0	130,800	14,418	0	105,124	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	0	0	0	77,845	0	95.00
101.00 HOME HEALTH AGENCY	0	0	15,765	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	2,478,966	66,255	77,845	1,992,350	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,749	0	0	12,657	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 MARKETING	0	4,135	0	0	3,323	194.00
194.01 PHYSICIAN BILLING	0	9,662	0	0	7,765	194.01
194.02 MOB	0	0	838,710	0	0	194.02
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	2,508,512	904,965	77,845	2,016,095	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151331

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

Worksheet B
Part II
Date/Time Prepared:
5/22/2012 4:24 pm

Cost Center Description	CAPITAL RELATED COSTS	Subtotal	EMPLOYEE BENEFITS	OTHER A&G	ADMITTING	
	AMB EQUIP					
	2.01	2A	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 MOB						1.01
1.02 AMB DEPR						1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 AMB EQUIP						2.01
4.00 EMPLOYEE BENEFITS	0	6,971	6,971			4.00
5.01 OTHER A&G	0	693,084	464	693,548		5.01
5.02 ADMITTING	0	0	133	8,723	8,856	5.02
5.03 PATIENT ACCOUNTING	0	0	124	16,171	0	5.03
7.00 OPERATION OF PLANT	0	546,785	78	37,401	0	7.00
7.01 AMB PLANT OPS	0	0	0	793	0	7.01
8.00 LAUNDRY & LINEN SERVICE	0	31,926	8	4,486	0	8.00
9.00 HOUSEKEEPING	0	68,383	143	11,765	0	9.00
10.00 DIETARY	0	198,980	47	8,378	0	10.00
11.00 CAFETERIA	0	99,402	80	7,922	0	11.00
13.00 NURSING ADMINISTRATION	0	16,730	242	15,605	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	81	5,280	0	14.00
16.00 MEDICAL RECORDS & LIBRARY	0	111,009	185	15,397	0	16.00
17.00 SOCIAL SERVICE	0	6,692	57	3,702	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	0	801,393	857	70,997	784	30.00
31.00 INTENSIVE CARE UNIT	0	100,971	141	10,862	101	31.00
43.00 NURSERY	0	20,912	97	6,233	96	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	617,678	343	37,967	870	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	1,187	56	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	323,617	378	42,288	2,564	54.00
60.00 LABORATORY	0	170,086	259	37,718	1,316	60.00
65.00 RESPIRATORY THERAPY	0	37,015	0	8,370	134	65.00
66.00 PHYSICAL THERAPY	0	120,211	91	7,762	146	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	234	6	67.00
68.00 SPEECH PATHOLOGY	0	0	0	182	3	68.00
69.00 ELECTROCARDIOLOGY	0	63,573	70	6,961	251	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	151,823	0	29,635	484	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	3,686	43	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	42,731	112	35,206	588	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	5,019	0	1,533	18	90.00
90.01 SENIOR CARE	0	36,473	58	6,546	44	90.01
91.00 EMERGENCY	0	250,342	401	29,830	916	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	171,477	249,322	601	47,839	436	95.00
101.00 HOME HEALTH AGENCY	0	15,765	196	13,980	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	171,477	4,786,893	5,246	534,639	8,856	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	28,406	0	509	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	1,653	132,792	0	192.00
194.00 MARKETING	0	7,458	14	5,909	0	194.00
194.01 PHYSICIAN BILLING	0	17,427	58	4,676	0	194.01
194.02 MOB	0	838,710	0	15,023	0	194.02
200.00 Cross Foot Adjustments	0	0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	171,477	5,678,894	6,971	693,548	8,856	202.00

Cost Center Description	PATIENT ACCOUNTING	OPERATION OF PLANT	AMB PLANT OPS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
	5.03	7.00	7.01	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 MOB						1.01
1.02 AMB DEPR						1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 AMB EQUIP						2.01
4.00 EMPLOYEE BENEFITS						4.00
5.01 OTHER A&G						5.01
5.02 ADMITTING						5.02
5.03 PATIENT ACCOUNTING	16,295					5.03
7.00 OPERATION OF PLANT	0	584,264				7.00
7.01 AMB PLANT OPS	0	0	793			7.01
8.00 LAUNDRY & LINEN SERVICE	0	5,682	0	42,102		8.00
9.00 HOUSEKEEPING	0	12,170	0	3,633	96,094	9.00
10.00 DIETARY	0	35,412	0	498	6,008	10.00
11.00 CAFETERIA	0	17,691	0	0	3,001	11.00
13.00 NURSING ADMINISTRATION	0	2,977	0	0	505	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00 MEDICAL RECORDS & LIBRARY	0	19,756	0	0	3,352	16.00
17.00 SOCIAL SERVICE	0	1,191	0	0	202	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1,453	142,626	0	18,727	24,197	30.00
31.00 INTENSIVE CARE UNIT	188	17,970	0	0	3,049	31.00
43.00 NURSERY	177	3,722	0	0	631	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	1,612	109,928	0	3,332	18,650	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	103	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	4,642	57,594	0	4,510	9,771	54.00
60.00 LABORATORY	2,438	30,270	0	0	5,135	60.00
65.00 RESPIRATORY THERAPY	248	6,587	0	68	1,118	65.00
66.00 PHYSICAL THERAPY	271	21,394	0	652	3,630	66.00
67.00 OCCUPATIONAL THERAPY	10	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	6	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	465	11,314	0	1,505	1,919	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	896	27,020	0	0	4,584	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	79	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	1,089	7,605	0	0	1,290	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	33	893	0	60	152	90.00
90.01 SENIOR CARE	81	992	0	2	168	90.01
91.00 EMERGENCY	1,697	41,987	0	6,463	7,123	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	807	0	793	1,696	0	95.00
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	16,295	574,781	793	41,146	94,485	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,055	0	0	858	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	956	0	192.00
194.00 MARKETING	0	1,327	0	0	225	194.00
194.01 PHYSICIAN BILLING	0	3,101	0	0	526	194.01
194.02 MOB	0	0	0	0	0	194.02
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	16,295	584,264	793	42,102	96,094	202.00

Cost Center Description	DIETARY 10.00	CAFETERIA 11.00	NURSING ADMINISTRATION 13.00	CENTRAL SERVICES & SUPPLY 14.00	MEDICAL RECORDS & LIBRARY 16.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 MOB						1.01
1.02 AMB DEPR						1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 AMB EQUIP						2.01
4.00 EMPLOYEE BENEFITS						4.00
5.01 OTHER A&G						5.01
5.02 ADMITTING						5.02
5.03 PATIENT ACCOUNTING						5.03
7.00 OPERATION OF PLANT						7.00
7.01 AMB PLANT OPS						7.01
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY	249,323					10.00
11.00 CAFETERIA	0	128,096				11.00
13.00 NURSING ADMINISTRATION	0	4,461	40,520			13.00
14.00 CENTRAL SERVICES & SUPPLY	0	3,764	0	9,125		14.00
16.00 MEDICAL RECORDS & LIBRARY	0	7,032	0	0	156,731	16.00
17.00 SOCIAL SERVICE	0	1,412	0	4	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	224,563	15,631	12,140	230	13,960	30.00
31.00 INTENSIVE CARE UNIT	24,760	10,995	8,540	28	1,802	31.00
43.00 NURSERY	0	2,825	2,194	0	1,700	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	8,553	6,643	363	15,486	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	2,000	0	17	989	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	11,372	0	103	44,783	54.00
60.00 LABORATORY	0	8,283	0	54	23,424	60.00
65.00 RESPIRATORY THERAPY	0	3,585	0	8	2,381	65.00
66.00 PHYSICAL THERAPY	0	2,265	0	18	2,603	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	98	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	59	68.00
69.00 ELECTROCARDIOLOGY	0	2,138	0	20	4,464	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,727	8,610	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,068	760	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	1,844	0	20	10,460	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	0	0	59	317	90.00
90.01 SENIOR CARE	0	1,764	0	5	778	90.01
91.00 EMERGENCY	0	9,561	7,426	129	16,302	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	0	0	0	272	7,755	95.00
101.00 HOME HEALTH AGENCY	0	0	3,577	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	249,323	97,485	40,520	9,125	156,731	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	27,412	0	0	0	192.00
194.00 MARKETING	0	461	0	0	0	194.00
194.01 PHYSICIAN BILLING	0	2,738	0	0	0	194.01
194.02 MOB	0	0	0	0	0	194.02
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	249,323	128,096	40,520	9,125	156,731	202.00

Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01 MOB					1.01
1.02 AMB DEPR					1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01 AMB EQUIP					2.01
4.00 EMPLOYEE BENEFITS					4.00
5.01 OTHER A&G					5.01
5.02 ADMITTING					5.02
5.03 PATIENT ACCOUNTING					5.03
7.00 OPERATION OF PLANT					7.00
7.01 AMB PLANT OPS					7.01
8.00 LAUNDRY & LINEN SERVICE					8.00
9.00 HOUSEKEEPING					9.00
10.00 DIETARY					10.00
11.00 CAFETERIA					11.00
13.00 NURSING ADMINISTRATION					13.00
14.00 CENTRAL SERVICES & SUPPLY					14.00
16.00 MEDICAL RECORDS & LIBRARY					16.00
17.00 SOCIAL SERVICE	13,260				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS	11,943	1,339,501	0	1,339,501	30.00
31.00 INTENSIVE CARE UNIT	1,317	180,724	0	180,724	31.00
43.00 NURSERY	0	38,587	0	38,587	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	821,425	0	821,425	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	4,352	0	4,352	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	501,622	0	501,622	54.00
60.00 LABORATORY	0	278,983	0	278,983	60.00
65.00 RESPIRATORY THERAPY	0	59,514	0	59,514	65.00
66.00 PHYSICAL THERAPY	0	159,043	0	159,043	66.00
67.00 OCCUPATIONAL THERAPY	0	348	0	348	67.00
68.00 SPEECH PATHOLOGY	0	250	0	250	68.00
69.00 ELECTROCARDIOLOGY	0	92,680	0	92,680	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	229,779	0	229,779	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	5,636	0	5,636	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	100,945	0	100,945	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	0	8,084	0	8,084	90.00
90.01 SENIOR CARE	0	46,911	0	46,911	90.01
91.00 EMERGENCY	0	372,177	0	372,177	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES	0	309,521	0	309,521	95.00
101.00 HOME HEALTH AGENCY	0	33,518	0	33,518	101.00
SPECIAL PURPOSE COST CENTERS					
113.00 INTEREST EXPENSE					113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	13,260	4,583,600	0	4,583,600	118.00
NONREIMBURSABLE COST CENTERS					
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	34,828	0	34,828	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	162,813	0	162,813	192.00
194.00 MARKETING	0	15,394	0	15,394	194.00
194.01 PHYSICIAN BILLING	0	28,526	0	28,526	194.01
194.02 MOB	0	853,733	0	853,733	194.02
200.00 Cross Foot Adjustments		0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	13,260	5,678,894	0	5,678,894	202.00

Cost Center Description	CAPITAL RELATED COSTS				
	NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	AMB DEPR (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	AMB EQUIP (SQUARE FEET)
	1.00	1.01	1.02	2.00	2.01
GENERAL SERVICE COST CENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	129,817				1.00
1.01 MOB	0	34,270			1.01
1.02 AMB DEPR	0	0	11,032		1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP				129,817	2.00
2.01 AMB EQUIP				0	11,032 2.01
4.00 EMPLOYEE BENEFITS	200	0	0	200	0 4.00
5.01 OTHER A&G	19,737	196	0	19,737	0 5.01
5.02 ADMITTING	0	0	0	0	0 5.02
5.03 PATIENT ACCOUNTING	0	0	0	0	0 5.03
7.00 OPERATION OF PLANT	15,688	0	0	15,688	0 7.00
7.01 AMB PLANT OPS	0	0	0	0	0 7.01
8.00 LAUNDRY & LINEN SERVICE	916	0	0	916	0 8.00
9.00 HOUSEKEEPING	1,962	0	0	1,962	0 9.00
10.00 DIETARY	5,709	0	0	5,709	0 10.00
11.00 CAFETERIA	2,852	0	0	2,852	0 11.00
13.00 NURSING ADMINISTRATION	480	0	0	480	0 13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0	0 14.00
16.00 MEDICAL RECORDS & LIBRARY	3,185	0	0	3,185	0 16.00
17.00 SOCIAL SERVICE	192	0	0	192	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS	22,993	0	0	22,993	0 30.00
31.00 INTENSIVE CARE UNIT	2,897	0	0	2,897	0 31.00
43.00 NURSERY	600	0	0	600	0 43.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	17,722	0	0	17,722	0 50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 RADIOLOGY-DIAGNOSTIC	9,285	0	0	9,285	0 54.00
60.00 LABORATORY	4,880	0	0	4,880	0 60.00
65.00 RESPIRATORY THERAPY	1,062	0	0	1,062	0 65.00
66.00 PHYSICAL THERAPY	3,449	0	0	3,449	0 66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00 ELECTROCARDIOLOGY	1,824	0	0	1,824	0 69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,356	0	0	4,356	0 71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00 DRUGS CHARGED TO PATIENTS	1,226	0	0	1,226	0 73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	144	0	0	144	0 90.00
90.01 SENIOR CARE	160	1,170	0	160	0 90.01
91.00 EMERGENCY	6,769	546	0	6,769	0 91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES	0	0	11,032	0	11,032 95.00
101.00 HOME HEALTH AGENCY	0	597	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS					
113.00 INTEREST EXPENSE					113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	128,288	2,509	11,032	128,288	11,032 118.00
NONREIMBURSABLE COST CENTERS					
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	815	0	0	815	0 190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
194.00 MARKETING	214	0	0	214	0 194.00
194.01 PHYSICIAN BILLING	500	0	0	500	0 194.01
194.02 MOB	0	31,761	0	0	0 194.02
200.00 Cross Foot Adjustments					200.00
201.00 Negative Cost Centers					201.00
202.00 Cost to be allocated (per wkst. B, Part I)	2,508,512	904,965	77,845	2,016,095	171,477 202.00
203.00 Unit cost multiplier (wkst. B, Part I)	19.323448	26.406916	7.056291	15.530285	15.543600 203.00
204.00 Cost to be allocated (per wkst. B, Part II)					204.00
205.00 Unit cost multiplier (wkst. B, Part II)					205.00

Cost Center Description	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	OTHER A&G (ACCUM COST)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	
	4.00	5A.01	5.01	5.02	5.03	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 MOB						1.01
1.02 AMB DEPR						1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 AMB EQUIP						2.01
4.00 EMPLOYEE BENEFITS	18,877,537					4.00
5.01 OTHER A&G	1,258,479	-3,738,807	38,718,780			5.01
5.02 ADMITTING	361,064	0	486,990	100,093,735		5.02
5.03 PATIENT ACCOUNTING	334,857	0	902,777	0	100,093,735	5.03
7.00 OPERATION OF PLANT	212,051	0	2,088,026	0	0	7.00
7.01 AMB PLANT OPS	0	0	44,281	0	0	7.01
8.00 LAUNDRY & LINEN SERVICE	20,629	0	250,444	0	0	8.00
9.00 HOUSEKEEPING	386,470	0	656,836	0	0	9.00
10.00 DIETARY	128,722	0	467,716	0	0	10.00
11.00 CAFETERIA	216,716	0	442,293	0	0	11.00
13.00 NURSING ADMINISTRATION	654,551	0	871,177	0	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	220,749	0	294,790	0	0	14.00
16.00 MEDICAL RECORDS & LIBRARY	500,025	0	859,576	0	0	16.00
17.00 SOCIAL SERVICE	154,554	0	206,705	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,321,316	0	3,963,672	8,914,324	8,914,324	30.00
31.00 INTENSIVE CARE UNIT	381,626	0	606,407	1,150,513	1,150,513	31.00
43.00 NURSERY	263,738	0	347,978	1,085,379	1,085,379	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	929,154	0	2,119,640	9,888,948	9,888,948	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	66,267	631,241	631,241	53.00
54.00 RADIOLOGY-DIAGNOSTIC	1,025,560	0	2,360,898	28,607,884	28,607,884	54.00
60.00 LABORATORY	701,794	0	2,105,752	14,957,658	14,957,658	60.00
65.00 RESPIRATORY THERAPY	0	0	467,265	1,520,542	1,520,542	65.00
66.00 PHYSICAL THERAPY	245,689	0	433,334	1,662,300	1,662,300	66.00
67.00 OCCUPATIONAL THERAPY	0	0	13,046	62,603	62,603	67.00
68.00 SPEECH PATHOLOGY	0	0	10,182	37,951	37,951	68.00
69.00 ELECTROCARDIOLOGY	189,299	0	388,642	2,850,881	2,850,881	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,654,461	5,497,904	5,497,904	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	205,782	485,321	485,321	72.00
73.00 DRUGS CHARGED TO PATIENTS	304,047	0	1,965,510	6,679,500	6,679,500	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	0	85,586	202,256	202,256	90.00
90.01 SENIOR CARE	158,255	0	365,454	496,868	496,868	90.01
91.00 EMERGENCY	1,085,662	0	1,665,387	10,409,762	10,409,762	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	1,628,037	0	2,670,779	4,951,900	4,951,900	95.00
101.00 HOME HEALTH AGENCY	530,114	0	780,463	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	14,213,158	-3,738,807	29,848,116	100,093,735	100,093,735	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	28,406	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	4,471,687	0	7,412,603	0	0	192.00
194.00 MARKETING	36,724	0	329,914	0	0	194.00
194.01 PHYSICIAN BILLING	155,968	0	261,031	0	0	194.01
194.02 MOB	0	0	838,710	0	0	194.02
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per wkst. B, Part I)	4,532,897		3,738,807	534,015	989,952	202.00
203.00 Unit cost multiplier (wkst. B, Part I)	0.240121		0.096563	0.005335	0.009890	203.00
204.00 Cost to be allocated (per wkst. B, Part II)	6,971		693,548	8,856	16,295	204.00
205.00 Unit cost multiplier (wkst. B, Part II)	0.000369		0.017912	0.000088	0.000163	205.00

Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	AMB PLANT OPS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
	7.00	7.01	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1 00
1.01 MOB						1.01
1.02 AMB DEPR						1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2 00
2.01 AMB EQUIP						2.01
4.00 EMPLOYEE BENEFITS						4 00
5.01 OTHER A&G						5.01
5.02 ADMITTING						5.02
5.03 PATIENT ACCOUNTING						5.03
7.00 OPERATION OF PLANT	94,192					7.00
7.01 AMB PLANT OPS	0	11,032				7.01
8.00 LAUNDRY & LINEN SERVICE	916	0	273,460			8.00
9.00 HOUSEKEEPING	1,962	0	23,595	91,314		9.00
10.00 DIETARY	5,709	0	3,233	5,709	5,508	10.00
11.00 CAFETERIA	2,852	0	0	2,852	0	11.00
13.00 NURSING ADMINISTRATION	480	0	0	480	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00 MEDICAL RECORDS & LIBRARY	3,185	0	0	3,185	0	16.00
17.00 SOCIAL SERVICE	192	0	0	192	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	22,993	0	121,634	22,993	4,961	30.00
31.00 INTENSIVE CARE UNIT	2,897	0	0	2,897	547	31.00
43.00 NURSERY	600	0	0	600	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	17,722	0	21,643	17,722	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	9,285	0	29,291	9,285	0	54.00
60.00 LABORATORY	4,880	0	0	4,880	0	60.00
65.00 RESPIRATORY THERAPY	1,062	0	440	1,062	0	65.00
66.00 PHYSICAL THERAPY	3,449	0	4,237	3,449	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	1,824	0	9,778	1,824	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,356	0	0	4,356	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	1,226	0	0	1,226	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	144	0	392	144	0	90.00
90.01 SENIOR CARE	160	0	13	160	0	90.01
91.00 EMERGENCY	6,769	0	41,977	6,769	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	0	11,032	11,019	0	0	95.00
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	92,663	11,032	267,252	89,785	5,508	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	815	0	0	815	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	6,208	0	0	192.00
194.00 MARKETING	214	0	0	214	0	194.00
194.01 PHYSICIAN BILLING	500	0	0	500	0	194.01
194.02 MOB	0	0	0	0	0	194.02
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	2,289,652	48,557	296,894	793,572	704,781	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	24.308349	4.401468	1.085694	8.690584	127.955882	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	584,264	793	42,102	96,094	249,323	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	6.202905	0.071882	0.153960	1.052347	45.265614	205.00

Cost Center Description	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	
	11.00	13.00	14.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 MOB						1.01
1.02 AMB DEPR						1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01 AMB EQUIP						2.01
4.00 EMPLOYEE BENEFITS						4.00
5.01 OTHER A&G						5.01
5.02 ADMITTING						5.02
5.03 PATIENT ACCOUNTING						5.03
7.00 OPERATION OF PLANT						7.00
7.01 AMB PLANT OPS						7.01
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA	462,266					11.00
13.00 NURSING ADMINISTRATION	16,099	188,268				13.00
14.00 CENTRAL SERVICES & SUPPLY	13,582	0	1,758,775			14.00
16.00 MEDICAL RECORDS & LIBRARY	25,376	0	0	100,093,735		16.00
17.00 SOCIAL SERVICE	5,096	0	726	0	5,508	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	56,408	56,408	44,286	8,914,324	4,961	30.00
31.00 INTENSIVE CARE UNIT	39,678	39,678	5,382	1,150,513	547	31.00
43.00 NURSERY	10,193	10,193	0	1,085,379	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	30,867	30,867	69,915	9,888,948	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	7,218	0	3,220	631,241	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	41,038	0	19,866	28,607,884	0	54.00
60.00 LABORATORY	29,890	0	10,361	14,957,658	0	60.00
65.00 RESPIRATORY THERAPY	12,938	0	1,519	1,520,542	0	65.00
66.00 PHYSICAL THERAPY	8,174	0	3,558	1,662,300	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	62,603	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	37,951	0	68.00
69.00 ELECTROCARDIOLOGY	7,716	0	3,900	2,850,881	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,296,856	5,497,904	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	205,782	485,321	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	6,656	0	3,844	6,679,500	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	0	11,293	202,256	0	90.00
90.01 SENIOR CARE	6,365	0	984	496,868	0	90.01
91.00 EMERGENCY	34,503	34,503	24,848	10,409,762	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	0	0	52,435	4,951,900	0	95.00
101.00 HOME HEALTH AGENCY	0	16,619	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	351,797	188,268	1,758,775	100,093,735	5,508	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	98,925	0	0	0	0	192.00
194.00 MARKETING	1,664	0	0	0	0	194.00
194.01 PHYSICIAN BILLING	9,880	0	0	0	0	194.01
194.02 MOB	0	0	0	0	0	194.02
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per wkst. B, Part I)	579,115	991,307	340,271	1,079,471	239,525	202.00
203.00 Unit cost multiplier (wkst. B, Part I)	1.252774	5.265404	0.193470	0.010785	43.486747	203.00
204.00 Cost to be allocated (per wkst. B, Part II)	128,096	40,520	9,125	156,731	13,260	204.00
205.00 Unit cost multiplier (wkst. B, Part II)	0.277105	0.215225	0.005188	0.001566	2.407407	205.00

Cost Center Description	Total Cost (From Wkst. B, Part I, col. 26) 1.00	Therapy Limit Adj. 2.00	Title XVIII Hospital		Total Costs 5.00		
			Total Costs 3.00	Costs			
				RCE Disallowance 4.00			Total Costs
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	6,695,854		6,695,854	0	0	30.00	
31.00 INTENSIVE CARE UNIT	1,143,935		1,143,935	0	0	31.00	
43.00 NURSERY	496,049		496,049	0	0	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	3,404,559		3,404,559	0	0	50.00	
52.00 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00	
53.00 ANESTHESIOLOGY	98,751		98,751	0	0	53.00	
54.00 RADIOLOGY-DIAGNOSTIC	3,726,419		3,726,419	0	0	54.00	
60.00 LABORATORY	2,898,623		2,898,623	0	0	60.00	
65.00 RESPIRATORY THERAPY	603,959	0	603,959	0	0	65.00	
66.00 PHYSICAL THERAPY	647,755	0	647,755	0	0	66.00	
67.00 OCCUPATIONAL THERAPY	15,934	0	15,934	0	0	67.00	
68.00 SPEECH PATHOLOGY	12,151	0	12,151	0	0	68.00	
69.00 ELECTROCARDIOLOGY	581,548		581,548	0	0	69.00	
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,351,868		2,351,868	0	0	71.00	
72.00 IMPL. DEV. CHARGED TO PATIENT	278,089		278,089	0	0	72.00	
73.00 DRUGS CHARGED TO PATIENTS	2,378,578		2,378,578	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS							
90.00 CLINIC	106,472		106,472	0	0	90.00	
90.01 SENIOR CARE	427,124		427,124	0	0	90.01	
91.00 EMERGENCY	2,595,607		2,595,607	0	0	91.00	
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	727,119		727,119	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS							
95.00 AMBULANCE SERVICES	3,128,140		3,128,140	0	0	95.00	
101.00 HOME HEALTH AGENCY	943,333		943,333	0	0	101.00	
SPECIAL PURPOSE COST CENTERS							
113.00 INTEREST EXPENSE						113.00	
200.00 Subtotal (see instructions)	33,261,867	0	33,261,867	0	0	200.00	
201.00 Less Observation Beds	727,119		727,119			201.00	
202.00 Total (see instructions)	32,534,748	0	32,534,748	0	0	202.00	

Cost Center Description	Title XVIII Hospital Cost				
	Inpatient	Charges		Cost or Other Ratio	TEFRA Inpatient Ratio
		Outpatient	Total (col. 6 + col. 7)		
6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS	8,208,609		8,208,609		30.00
31.00 INTENSIVE CARE UNIT	1,150,513		1,150,513		31.00
43.00 NURSERY	1,085,379		1,085,379		43.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	2,607,743	7,281,205	9,888,948	0.344279	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00 ANESTHESIOLOGY	199,196	432,045	631,241	0.156439	53.00
54.00 RADIOLOGY-DIAGNOSTIC	2,816,594	25,791,290	28,607,884	0.130258	54.00
60.00 LABORATORY	2,871,728	12,085,930	14,957,658	0.193789	60.00
65.00 RESPIRATORY THERAPY	1,245,887	274,655	1,520,542	0.397200	65.00
66.00 PHYSICAL THERAPY	346,973	1,315,327	1,662,300	0.389674	66.00
67.00 OCCUPATIONAL THERAPY	23,766	38,837	62,603	0.254525	67.00
68.00 SPEECH PATHOLOGY	11,018	26,933	37,951	0.320176	68.00
69.00 ELECTROCARDIOLOGY	399,903	2,450,978	2,850,881	0.203989	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,853,401	2,644,503	5,497,904	0.427775	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	203,587	281,734	485,321	0.573000	72.00
73.00 DRUGS CHARGED TO PATIENTS	2,871,077	3,808,423	6,679,500	0.356101	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	1,138	201,118	202,256	0.526422	90.00
90.01 SENIOR CARE	0	496,868	496,868	0.859633	90.01
91.00 EMERGENCY	239,110	10,170,652	10,409,762	0.249344	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	705,715	705,715	1.030330	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES	0	4,951,900	4,951,900	0.631705	95.00
101.00 HOME HEALTH AGENCY	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS					
113.00 INTEREST EXPENSE					113.00
200.00 Subtotal (see instructions)	27,135,622	72,958,113	100,093,735		200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)	27,135,622	72,958,113	100,093,735		202.00

Cost Center Description		PPS Inpatient Ratio	Title XVIII Hospital	Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS			30.00
31.00	INTENSIVE CARE UNIT			31.00
43.00	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.000000		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	ANESTHESIOLOGY	0.000000		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	LABORATORY	0.000000		60.00
65.00	RESPIRATORY THERAPY	0.000000		65.00
66.00	PHYSICAL THERAPY	0.000000		66.00
67.00	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	SPEECH PATHOLOGY	0.000000		68.00
69.00	ELECTROCARDIOLOGY	0.000000		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0.000000		90.00
90.01	SENIOR CARE	0.000000		90.01
91.00	EMERGENCY	0.000000		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	0.000000		95.00
101.00	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

Cost Center Description	Total Cost (From Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Hospital Costs		Total Costs	Cost
			Total Costs	RCE Disallowance		
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	6,695,854		6,695,854	0	0	30.00
31.00 INTENSIVE CARE UNIT	1,143,935		1,143,935	0	0	31.00
43.00 NURSERY	496,049		496,049	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	3,404,559		3,404,559	0	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00 ANESTHESIOLOGY	98,751		98,751	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	3,726,419		3,726,419	0	0	54.00
60.00 LABORATORY	2,898,623		2,898,623	0	0	60.00
65.00 RESPIRATORY THERAPY	603,959	0	603,959	0	0	65.00
66.00 PHYSICAL THERAPY	647,755	0	647,755	0	0	66.00
67.00 OCCUPATIONAL THERAPY	15,934	0	15,934	0	0	67.00
68.00 SPEECH PATHOLOGY	12,151	0	12,151	0	0	68.00
69.00 ELECTROCARDIOLOGY	581,548		581,548	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,351,868		2,351,868	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	278,089		278,089	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	2,378,578		2,378,578	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	106,472		106,472	0	0	90.00
90.01 SENIOR CARE	427,124		427,124	0	0	90.01
91.00 EMERGENCY	2,595,607		2,595,607	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	727,119		727,119	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	3,128,140		3,128,140	0	0	95.00
101.00 HOME HEALTH AGENCY	943,333		943,333	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	33,261,867	0	33,261,867	0	0	200.00
201.00 Less Observation Beds	727,119		727,119			201.00
202.00 Total (see instructions)	32,534,748	0	32,534,748	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151331

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

Worksheet C
Part I
Date/Time Prepared:
5/22/2012 4:24 pm

Cost Center Description	Title XIX			Hospital	Cost	TEFRA Inpatient Ratio
	Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio		
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	8,208,609		8,208,609			30.00
31.00 INTENSIVE CARE UNIT	1,150,513		1,150,513			31.00
43.00 NURSERY	1,085,379		1,085,379			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	2,607,743	7,281,205	9,888,948	0.344279	0.000000	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00 ANESTHESIOLOGY	199,196	432,045	631,241	0.156439	0.000000	53.00
54.00 RADIOLOGY-DIAGNOSTIC	2,816,594	25,791,290	28,607,884	0.130258	0.000000	54.00
60.00 LABORATORY	2,871,728	12,085,930	14,957,658	0.193789	0.000000	60.00
65.00 RESPIRATORY THERAPY	1,245,887	274,655	1,520,542	0.397200	0.000000	65.00
66.00 PHYSICAL THERAPY	346,973	1,315,327	1,662,300	0.389674	0.000000	66.00
67.00 OCCUPATIONAL THERAPY	23,766	38,837	62,603	0.254525	0.000000	67.00
68.00 SPEECH PATHOLOGY	11,018	26,933	37,951	0.320176	0.000000	68.00
69.00 ELECTROCARDIOLOGY	399,903	2,450,978	2,850,881	0.203989	0.000000	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,853,401	2,644,503	5,497,904	0.427775	0.000000	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	203,587	281,734	485,321	0.573000	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	2,871,077	3,808,423	6,679,500	0.356101	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	1,138	201,118	202,256	0.526422	0.000000	90.00
90.01 SENIOR CARE	0	496,868	496,868	0.859633	0.000000	90.01
91.00 EMERGENCY	239,110	10,170,652	10,409,762	0.249344	0.000000	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	705,715	705,715	1.030330	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	0	4,951,900	4,951,900	0.631705	0.000000	95.00
101.00 HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	27,135,622	72,958,113	100,093,735			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	27,135,622	72,958,113	100,093,735			202.00

Cost Center Description	PPS Inpatient Ratio	Title XIX Hospital Cost
	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS		
30.00 ADULTS & PEDIATRICS		30.00
31.00 INTENSIVE CARE UNIT		31.00
43.00 NURSERY		43.00
ANCILLARY SERVICE COST CENTERS		
50.00 OPERATING ROOM	0.000000	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00 ANESTHESIOLOGY	0.000000	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00 LABORATORY	0.000000	60.00
65.00 RESPIRATORY THERAPY	0.000000	65.00
66.00 PHYSICAL THERAPY	0.000000	66.00
67.00 OCCUPATIONAL THERAPY	0.000000	67.00
68.00 SPEECH PATHOLOGY	0.000000	68.00
69.00 ELECTROCARDIOLOGY	0.000000	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS		
90.00 CLINIC	0.000000	90.00
90.01 SENIOR CARE	0.000000	90.01
91.00 EMERGENCY	0.000000	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS		
95.00 AMBULANCE SERVICES	0.000000	95.00
101.00 HOME HEALTH AGENCY		101.00
SPECIAL PURPOSE COST CENTERS		
113.00 INTEREST EXPENSE		113.00
200.00 Subtotal (see instructions)		200.00
201.00 Less Observation Beds		201.00
202.00 Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151331

Period: Worksheet D
 From 01/01/2011 Part II
 To 12/31/2011 Date/Time Prepared:
 5/22/2012 4:24 pm

Cost Center Description	Title XVIII Hospital Cost				
	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	821,425	9,888,948	0.083065	601,225	49,941
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0
53.00 ANESTHESIOLOGY	4,352	631,241	0.006894	54,180	374
54.00 RADIOLOGY-DIAGNOSTIC	501,622	28,607,884	0.017534	1,421,125	24,918
60.00 LABORATORY	278,983	14,957,658	0.018652	1,609,073	30,012
65.00 RESPIRATORY THERAPY	59,514	1,520,542	0.039140	963,574	37,714
66.00 PHYSICAL THERAPY	159,043	1,662,300	0.095676	264,860	25,341
67.00 OCCUPATIONAL THERAPY	348	62,603	0.005559	15,931	89
68.00 SPEECH PATHOLOGY	250	37,951	0.006587	7,954	52
69.00 ELECTROCARDIOLOGY	92,680	2,850,881	0.032509	184,736	6,006
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	229,779	5,497,904	0.041794	1,506,792	62,975
72.00 IMPL. DEV. CHARGED TO PATIENT	5,636	485,321	0.011613	85,072	988
73.00 DRUGS CHARGED TO PATIENTS	100,945	6,679,500	0.015113	1,883,573	28,466
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	8,084	202,256	0.039969	0	0
90.01 SENIOR CARE	46,911	496,868	0.094413	0	0
91.00 EMERGENCY	372,177	10,409,762	0.035753	2,746	98
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	705,715	0.000000	0	0
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES					95.00
200.00 Total (lines 50-199)	2,681,749	84,697,334		8,600,841	266,974

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151331

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

worksheet D Part IV Date/Time Prepared: 5/22/2012 4:24 pm

Cost Center Description	Title XVIII				Hospital All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)
	Non Physician Anesthetist Cost	Nursing School	Allied Health			
	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
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0 52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	0 53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0 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
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
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	0	0	0	0	0 90.00
90.01 SENIOR CARE	0	0	0	0	0	0 90.01
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
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151331

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

Worksheet D
Part IV
Date/Time Prepared:
5/22/2012 4:24 pm

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Title XVIII		Hospital		
		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	9,888,948	0.000000	0.000000	601,225	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00 ANESTHESIOLOGY	0	631,241	0.000000	0.000000	54,180	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	28,607,884	0.000000	0.000000	1,421,125	54.00
60.00 LABORATORY	0	14,957,658	0.000000	0.000000	1,609,073	60.00
65.00 RESPIRATORY THERAPY	0	1,520,542	0.000000	0.000000	963,574	65.00
66.00 PHYSICAL THERAPY	0	1,662,300	0.000000	0.000000	264,860	66.00
67.00 OCCUPATIONAL THERAPY	0	62,603	0.000000	0.000000	15,931	67.00
68.00 SPEECH PATHOLOGY	0	37,951	0.000000	0.000000	7,954	68.00
69.00 ELECTROCARDIOLOGY	0	2,850,881	0.000000	0.000000	184,736	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,497,904	0.000000	0.000000	1,506,792	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	485,321	0.000000	0.000000	85,072	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	6,679,500	0.000000	0.000000	1,883,573	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	202,256	0.000000	0.000000	0	90.00
90.01 SENIOR CARE	0	496,868	0.000000	0.000000	0	90.01
91.00 EMERGENCY	0	10,409,762	0.000000	0.000000	2,746	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	705,715	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	84,697,334			8,600,841	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151331

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

Worksheet D
Part IV
Date/Time Prepared:
5/22/2012 4:24 pm

Cost Center Description	Title XVIII					Cost
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	0 50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0 52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	0 53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0 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
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
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	0	0	0	0	0 90.00
90.01 SENIOR CARE	0	0	0	0	0	0 90.01
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
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES						95.00
200.00 Total (Lines 50-199)	0	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151331

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

Worksheet D
Part IV
Date/Time Prepared:
5/22/2012 4:24 pm

Cost Center Description	Title XVIII		Hospital	Cost
	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
	23.00	24.00		
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	0		50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 ANESTHESIOLOGY	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00 LABORATORY	0	0		60.00
65.00 RESPIRATORY THERAPY	0	0		65.00
66.00 PHYSICAL THERAPY	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0		68.00
69.00 ELECTROCARDIOLOGY	0	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 CLINIC	0	0		90.00
90.01 SENIOR CARE	0	0		90.01
91.00 EMERGENCY	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 AMBULANCE SERVICES				95.00
200.00 Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151331

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

Worksheet D
Part V
Date/Time Prepared:
5/22/2012 4:24 pm

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see instructions)	Charges		Hospital Cost
			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	0.344279	0	2,254,203	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00 ANESTHESIOLOGY	0.156439	0	62,135	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.130258	0	8,272,564	0	54.00
60.00 LABORATORY	0.193789	0	3,412,750	0	60.00
65.00 RESPIRATORY THERAPY	0.397200	0	70,925	0	65.00
66.00 PHYSICAL THERAPY	0.389674	0	357,707	0	66.00
67.00 OCCUPATIONAL THERAPY	0.254525	0	7,860	0	67.00
68.00 SPEECH PATHOLOGY	0.320176	0	5,265	0	68.00
69.00 ELECTROCARDIOLOGY	0.203989	0	1,240,773	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.427775	0	654,923	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.573000	0	85,269	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.356101	0	2,223,061	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	0.526422	0	0	0	90.00
90.01 SENIOR CARE	0.859633	0	467,150	0	90.01
91.00 EMERGENCY	0.249344	0	1,916,231	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.030330	0	289,221	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES	0.631705	0	0	0	95.00
200.00 Subtotal (see instructions)		0	21,320,037	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	21,320,037	0	202.00

Cost Center Description	Title XVIII			Hospital	Cost
	PPS Services (see instructions)	Costs Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	776,075	0		50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00 ANESTHESIOLOGY	0	9,720	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	1,077,568	0		54.00
60.00 LABORATORY	0	661,353	0		60.00
65.00 RESPIRATORY THERAPY	0	28,171	0		65.00
66.00 PHYSICAL THERAPY	0	139,389	0		66.00
67.00 OCCUPATIONAL THERAPY	0	2,001	0		67.00
68.00 SPEECH PATHOLOGY	0	1,686	0		68.00
69.00 ELECTROCARDIOLOGY	0	253,104	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	280,160	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	48,859	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	791,634	0		73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	0	0	0		90.00
90.01 SENIOR CARE	0	401,578	0		90.01
91.00 EMERGENCY	0	477,801	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	297,993	0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES		0			95.00
200.00 Subtotal (see instructions)	0	5,247,092	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	5,247,092	0		202.00

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see instructions)	Charges		Cost
			Reimbursed Services Subject To Ded. & Coins. (see instructions)	Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	
	1.00	2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.344279	0	0	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00 ANESTHESIOLOGY	0.156439	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.130258	0	0	0	54.00
60.00 LABORATORY	0.193789	0	0	0	60.00
65.00 RESPIRATORY THERAPY	0.397200	0	0	0	65.00
66.00 PHYSICAL THERAPY	0.389674	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0.254525	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0.320176	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0.203989	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.427775	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.573000	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.356101	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	0.526422	0	0	0	90.00
90.01 SENIOR CARE	0.859633	0	0	0	90.01
91.00 EMERGENCY	0.249344	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.030330	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES	0.631705	0	0	0	95.00
200.00 Subtotal (see instructions)		0	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151331

Period: From 01/01/2011

Worksheet D

Component CCN: 152331

To 12/31/2011

Part V
Date/Time Prepared:
5/22/2012 4:24 pm

Cost Center Description	Costs			Swing Beds - SNF	Cost
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	0	0		50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00 ANESTHESIOLOGY	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00 LABORATORY	0	0	0		60.00
65.00 RESPIRATORY THERAPY	0	0	0		65.00
66.00 PHYSICAL THERAPY	0	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	0	0	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	0	0	0		90.00
90.01 SENIOR CARE	0	0	0		90.01
91.00 EMERGENCY	0	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES		0			95.00
200.00 Subtotal (see instructions)	0	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151331

Period: From 01/01/2011 To 12/31/2011
 Worksheet D Part V
 Date/Time Prepared: 5/22/2012 4:24 pm

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Title XIX Charges		Hospital Cost	
		PPS Reimbursed Services (see instructions)	Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	Cost
	1.00	2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.344279	0	975,967	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00 ANESTHESIOLOGY	0.156439	0	88,371	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.130258	0	3,592,657	0	54.00
60.00 LABORATORY	0.193789	0	1,641,043	0	60.00
65.00 RESPIRATORY THERAPY	0.397200	0	61,807	0	65.00
66.00 PHYSICAL THERAPY	0.389674	0	190,387	0	66.00
67.00 OCCUPATIONAL THERAPY	0.254525	0	5,868	0	67.00
68.00 SPEECH PATHOLOGY	0.320176	0	3,738	0	68.00
69.00 ELECTROCARDIOLOGY	0.203989	0	261,746	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.427775	0	528,504	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.573000	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.356101	0	896,775	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	0.526422	0	28,582	0	90.00
90.01 SENIOR CARE	0.859633	0	0	0	90.01
91.00 EMERGENCY	0.249344	0	2,059,965	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.030330	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES	0.631705	0	776,723	0	95.00
200.00 Subtotal (see instructions)		0	11,112,133	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	11,112,133	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151331

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

worksheet D
Part V
Date/Time Prepared:
5/22/2012 4:24 pm

Cost Center Description	Title XIX Hospital Cost			
	PPS Services (see instructions)	Costs Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)	Cost
	5.00	6.00	7.00	
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	336,005	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	13,825	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	467,972	0	54.00
60.00 LABORATORY	0	318,016	0	60.00
65.00 RESPIRATORY THERAPY	0	24,550	0	65.00
66.00 PHYSICAL THERAPY	0	74,189	0	66.00
67.00 OCCUPATIONAL THERAPY	0	1,494	0	67.00
68.00 SPEECH PATHOLOGY	0	1,197	0	68.00
69.00 ELECTROCARDIOLOGY	0	53,393	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	226,081	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	319,342	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 CLINIC	0	15,046	0	90.00
90.01 SENIOR CARE	0	0	0	90.01
91.00 EMERGENCY	0	513,640	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 AMBULANCE SERVICES		490,660		95.00
200.00 Subtotal (see instructions)	0	2,855,410	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	2,855,410	0	202.00

Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			5,588 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			5,555 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)			5,555 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			3 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			27 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)			2,605 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)			3 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			181.54 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			181.54 20.00
21.00	Total general inpatient routine service cost (see instructions)			6,695,854 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)			4,902 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)			8,514 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			6,687,340 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			9,990,012 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			9,990,012 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.669403 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)			1,798.38 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)			6,687,340 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)			1,203.84 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			3,136,003 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)			3,136,003 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151331

Period: From 01/01/2011

worksheet D-1

To 12/31/2011

Date/Time Prepared: 5/22/2012 4:24 pm

Cost Center Description	Total Inpatient Cost	Title XVIII		Hospital Program Days	Cost	
		Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)		Program Cost (col. 3 x col. 4)	
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	0	0
43.00 INTENSIVE CARE UNIT	1,143,935	527	2,170.65	355	770,581	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					2,607,367	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,513,951	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)					3,612	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)					3,612	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)					604	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,203.84	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					727,119	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151331

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

worksheet D-1

Date/Time Prepared:
5/22/2012 4:24 pm

Cost Center Description	Cost	Title XVIII		Hospital Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		Routine Cost (from line 27)	column 1 + column 2			
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	0	0	0.000000	0	0	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

Cost Center Description	Title XVIII	Hospital	Cost
	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		2,757,129	30.00
31.00 INTENSIVE CARE UNIT		698,640	31.00
43.00 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	0.344279	601,225	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00 ANESTHESIOLOGY	0.156439	54,180	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.130258	1,421,125	54.00
60.00 LABORATORY	0.193789	1,609,073	60.00
65.00 RESPIRATORY THERAPY	0.397200	963,574	65.00
66.00 PHYSICAL THERAPY	0.389674	264,860	66.00
67.00 OCCUPATIONAL THERAPY	0.254525	15,931	67.00
68.00 SPEECH PATHOLOGY	0.320176	7,954	68.00
69.00 ELECTROCARDIOLOGY	0.203989	184,736	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.427775	1,506,792	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.573000	85,072	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.356101	1,883,573	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00 CLINIC	0.526422	0	90.00
90.01 SENIOR CARE	0.859633	0	90.01
91.00 EMERGENCY	0.249344	2,746	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.030330	0	92.00
OTHER REIMBURSABLE COST CENTERS			
95.00 AMBULANCE SERVICES			95.00
200.00 Total (sum of lines 50-94 and 96-98)		8,600,841	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)		8,600,841	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151331

Period: From 01/01/2011

Worksheet D-3

Component CCN: 152331

To 12/31/2011

Date/Time Prepared: 5/22/2012 4:24 pm

Cost Center Description	Title XVIII		Swing Beds - SNF		Cost
	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	1.00	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS			0:		30.00
31.00 INTENSIVE CARE UNIT			0:		31.00
43.00 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.344279:		0:	0:	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0.000000:		0:	0:	52.00
53.00 ANESTHESIOLOGY	0.156439:		0:	0:	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.130258:		0:	0:	54.00
60.00 LABORATORY	0.193789:		65:	13:	60.00
65.00 RESPIRATORY THERAPY	0.397200:		335:	133:	65.00
66.00 PHYSICAL THERAPY	0.389674:		1,333:	519:	66.00
67.00 OCCUPATIONAL THERAPY	0.254525:		508:	129:	67.00
68.00 SPEECH PATHOLOGY	0.320176:		0:	0:	68.00
69.00 ELECTROCARDIOLOGY	0.203989:		0:	0:	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.427775:		975:	417:	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.573000:		0:	0:	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.356101:		639:	228:	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	0.526422:		0:	0:	90.00
90.01 SENIOR CARE	0.859633:		0:	0:	90.01
91.00 EMERGENCY	0.249344:		0:	0:	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.030330:		0:	0:	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50-94 and 96-98)			3,855:	1,439:	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)			3,855:	1,439:	202.00

Cost Center Description	Title XIX	Hospital	Cost	
	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		2,316,821		30.00
31.00 INTENSIVE CARE UNIT		134,088		31.00
43.00 NURSERY		602,124		43.00
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0.344279	688,054	236,883	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00 ANESTHESIOLOGY	0.156439	37,880	5,926	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.130258	265,801	34,623	54.00
60.00 LABORATORY	0.193789	499,777	96,851	60.00
65.00 RESPIRATORY THERAPY	0.397200	264,970	105,246	65.00
66.00 PHYSICAL THERAPY	0.389674	20,099	7,832	66.00
67.00 OCCUPATIONAL THERAPY	0.254525	1,922	489	67.00
68.00 SPEECH PATHOLOGY	0.320176	789	253	68.00
69.00 ELECTROCARDIOLOGY	0.203989	35,409	7,223	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.427775	413,340	176,817	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.573000	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.356101	376,553	134,091	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 CLINIC	0.526422	0	0	90.00
90.01 SENIOR CARE	0.859633	0	0	90.01
91.00 EMERGENCY	0.249344	78,271	19,516	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.030330	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 AMBULANCE SERVICES				95.00
200.00 Total (sum of lines 50-94 and 96-98)		2,682,865	825,750	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00 Net Charges (line 200 minus line 201)		2,682,865		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151331 Period: From 01/01/2011 To 12/31/2011
 Component CCN: 152331 Date/Time Prepared: 5/22/2012 4:24 pm
 Worksheet 0-3

Cost Center Description	Title XIX		Swing Beds - SNF		Cost
	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00				0	30.00
31.00				0	31.00
43.00				0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	0.344279			0	50.00
52.00	0.000000			0	52.00
53.00	0.156439			0	53.00
54.00	0.130258			0	54.00
60.00	0.193789			0	60.00
65.00	0.397200			0	65.00
66.00	0.389674			0	66.00
67.00	0.254525			0	67.00
68.00	0.320176			0	68.00
69.00	0.203989			0	69.00
71.00	0.427775			0	71.00
72.00	0.573000			0	72.00
73.00	0.356101			0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	0.526422			0	90.00
90.01	0.859633			0	90.01
91.00	0.249344			0	91.00
92.00	1.030330			0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00					95.00
200.00				0	200.00
201.00				0	201.00
202.00				0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 151331

Period:

From 01/01/2011

To 12/31/2011

worksheet E

Part B

Date/Time Prepared:

5/22/2012 4:24 pm

Title XVIII

Hospital

Cost

1.00

PART B - MEDICAL AND OTHER HEALTH SERVICES

1.00	Medical and other services (see instructions)	5,247,092	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)	5,247,092	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)	5,299,563	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00

COMPUTATION OF REIMBURSEMENT SETTLEMENT

25.00	Deductibles and coinsurance (for CAH, see instructions)	45,768	25.00
26.00	Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)	3,583,382	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	1,670,413	27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,670,413	30.00
31.00	Primary payer payments	1,107	31.00
32.00	Subtotal (line 30 minus line 31)	1,669,306	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)	787,050	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	787,050	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	676,924	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	2,456,356	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	2,456,356	40.00
41.00	Interim payments	2,341,412	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)	114,944	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

Health Financial Systems
CALCULATION OF REIMBURSEMENT SETTLEMENT

HARRISON COUNTY HOSPITAL

Provider CCN: 151331

In Lieu of Form CMS-2552-10

Period: Worksheet E
From 01/01/2011 Part B
To 12/31/2011 Date/Time Prepared:
5/22/2012 4:24 pm

Title XVIII

Hospital

Cost

Overrides

1.00

WORKSHEET OVERRIDE VALUES

112.00|override of Ancillary service charges (line 12)

0.112.00

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1.00	Total interim payments paid to provider	1.00	2.00	3.00	4.00	
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		6,509,989		2,616,754	1.00
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)		0		0	2.00
3.01	Program to Provider					3.00
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
3.50	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	08/30/2011	223,092	08/30/2011	173,685	3.50
3.51		12/06/2011	97,108	12/06/2011	101,657	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)		-320,200		-275,342	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)		6,189,789		2,341,412	4.00
5.00	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
5.01	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
5.50	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		114,944	6.01
6.02	SETTLEMENT TO PROGRAM		82,476		0	6.02
7.00	Total Medicare program liability (see instructions)		6,107,313		2,456,356	7.00
8.00	Name of Contractor		0	Contractor Number	Date (Mo/Day/Yr)	8.00
				1.00	2.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151331

Period:

worksheet E-2

From 01/01/2011

Component CCN: 15Z331

To 12/31/2011

Date/Time Prepared:
5/22/2012 4:24 pm

		Title XVIII		Swing Beds - SNF	Cost
		Part A	Part B		
		1.00	2.00		
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)			3,648	0 1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from wkst. D-3, column 3, line 200 for Part A, and sum of wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)			1,453	0 3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)				0.00 4.00
5.00	Program days			3	0 5.00
6.00	Interns and residents not in approved teaching program (see instructions)				0 6.00
7.00	Utilization review - physician compensation - SNF optional method only			0	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)			5,101	0 8.00
9.00	Primary payer payments (see instructions)			0	0 9.00
10.00	Subtotal (line 8 minus line 9)			5,101	0 10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			0	0 11.00
12.00	Subtotal (line 10 minus line 11)			5,101	0 12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)			0	0 13.00
14.00	80% of Part B costs (line 12 x 80%)				0 14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)			5,101	0 15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	0 16.00
17.00	Reimbursable bad debts (see instructions)			0	0 17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0	0 18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)			5,101	0 19.00
20.00	Interim payments			0	0 20.00
21.00	Tentative settlement (for contractor use only)			0	0 21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)			5,101	0 22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2			0	0 23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151331 Period: Worksheet E-2
 From 01/01/2011
 Component CCN: 152331 To 12/31/2011 Date/Time Prepared: 5/22/2012 4:24 pm

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 151331 Period: worksheet E-3
 From 01/01/2011 Part V
 To 12/31/2011 Date/Time Prepared: 5/22/2012 4:24 pm

	Title XVIII	Hospital	Cost	
			1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHS)				
1.00	Inpatient services		6,513,951	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 thru 3)		6,513,951	4.00
5.00	Primary payer payments		5,492	5.00
6.00	Total cost (line 4 less line 5) . For CAH (see instructions)		6,573,599	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
7.00	Reasonable charges		0	7.00
8.00	Routine service charges		0	8.00
9.00	Ancillary service charges		0	9.00
10.00	Organ acquisition charges, net of revenue		0	10.00
11.00	Total reasonable charges		0	
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		6,573,599	19.00
20.00	Deductibles (exclude professional component)		597,388	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		5,976,211	22.00
23.00	Coinsurance		9,622	23.00
24.00	Subtotal (line 22 minus line 23)		5,966,589	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		140,724	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		140,724	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		101,622	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26)		6,107,313	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		6,107,313	30.00
31.00	Interim payments		6,189,789	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)		-82,476	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		697,133	34.00

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

Provider CCN: 151331

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

Worksheet G

Date/Time Prepared: 5/22/2012 4:24 pm

	General Fund 1.00	Specific Purpose Fund 2.00	Endowment Fund 3.00	Plant Fund 4.00	
CURRENT ASSETS					
1.00	Cash on hand in banks	2,678,804	0	0	0 1.00
2.00	Temporary investments	7,750,111	0	0	0 2.00
3.00	Notes receivable	0	0	0	0 3.00
4.00	Accounts receivable	16,925,449	0	0	0 4.00
5.00	Other receivable	712	0	0	0 5.00
6.00	Allowances for uncollectible notes and accounts receivable	-11,553,546	0	0	0 6.00
7.00	Inventory	829,741	0	0	0 7.00
8.00	Prepaid expenses	772,105	0	0	0 8.00
9.00	Other current assets	276,797	0	0	0 9.00
10.00	Due from other funds	363,319	0	0	0 10.00
11.00	Total current assets (sum of lines 1-10)	18,043,492	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	64,490,521	0	0	0 15.00
16.00	Accumulated depreciation	-24,934,144	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)	39,556,377	0	0	0 30.00
OTHER ASSETS					
31.00	Investments	1,824,924	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	5,176,013	0	0	0 34.00
35.00	Total other assets (sum of lines 31-34)	7,000,937	0	0	0 35.00
36.00	Total assets (sum of lines 11, 30, and 35)	64,600,806	0	0	0 36.00
CURRENT LIABILITIES					
37.00	Accounts payable	1,176,052	0	0	0 37.00
38.00	Salaries, wages, and fees payable	1,750,736	0	0	0 38.00
39.00	Payroll taxes payable	840,385	0	0	0 39.00
40.00	Notes and loans payable (short term)	353,100	0	0	0 40.00
41.00	Deferred income	0	0	0	0 41.00
42.00	Accelerated payments	0	0	0	42.00
43.00	Due to other funds	0	0	0	0 43.00
44.00	Other current liabilities	2,028,439	0	0	0 44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,148,712	0	0	0 45.00
LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0 46.00
47.00	Notes payable	13,007,984	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)	13,007,984	0	0	0 50.00
51.00	Total liabilities (sum of lines 45 and 50)	19,156,696	0	0	0 51.00
CAPITAL ACCOUNTS					
52.00	General fund balance	45,444,110			52.00
53.00	Specific purpose fund		0		53.00
54.00	Donor created - endowment fund balance - restricted			0	54.00
55.00	Donor created - endowment fund balance - unrestricted			0	55.00
56.00	Governing body created - endowment fund balance			0	56.00
57.00	Plant fund balance - invested in plant				0 57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0 58.00
59.00	Total fund balances (sum of lines 52 thru 58)	45,444,110	0	0	0 59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	64,600,806	0	0	0 60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151331

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

Worksheet G-1

Date/Time Prepared:
5/22/2012 4:24 pm

	General Fund		Special Purpose Fund		
	1.00	2.00	3.00	4.00	
1.00 Fund balances at beginning of period		51,925,019		0	1.00
2.00 Net income (loss) (from wkst. G-3, line 29)		-6,480,911			2.00
3.00 Total (sum of line 1 and line 2)		45,444,108		0	3.00
4.00 Additions (credit adjustments) (specify)	2		0		4.00
5.00	0		0		5.00
6.00	0		0		6.00
7.00	0		0		7.00
8.00	0		0		8.00
9.00	0		0		9.00
10.00 Total additions (sum of line 4-9)	2			0	10.00
11.00 Subtotal (line 3 plus line 10)		45,444,110		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)		45,444,110		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151331

Period:

worksheet G-1

From 01/01/2011

To 12/31/2011

Date/Time Prepared:

5/22/2012 4:24 pm

	Endowment Fund		Plant Fund		
	5.00	6.00	7.00	8.00	
1.00 Fund balances at beginning of period			0		1.00
2.00 Net income (loss) (from wkst. G-3, line 29)					2.00
3.00 Total (sum of line 1 and line 2)			0		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)		0		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)		0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151331

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

Worksheet G-2 Parts

Date/Time Prepared:
5/22/2012 4:24 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	9,990,012		9,990,012	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	9,990,012		9,990,012	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	1,160,204		1,160,204	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	1,160,204		1,160,204	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11,150,216		11,150,216	17.00
18.00	Ancillary services	16,689,984	66,602,512	83,292,496	18.00
19.00	Outpatient services	1,138	697,986	699,124	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		663,283	663,283	22.00
23.00	AMBULANCE SERVICES	0	4,951,900	4,951,900	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	0	9,670,840	9,670,840	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	27,841,338	82,586,521	110,427,859	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		44,968,018		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	INTEREST EXPENSE	1,366,997			37.00
38.00		904,965			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)		2,271,962		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		42,696,056		43.00

Health Financial Systems
STATEMENT OF REVENUES AND EXPENSES

HARRISON COUNTY HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 151331 Period: worksheet G-3
From 01/01/2011
To 12/31/2011 Date/Time Prepared:
5/22/2012 4:24 pm

	1.00	
1.00 Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	110,427,859	1.00
2.00 Less contractual allowances and discounts on patients' accounts	63,483,997	2.00
3.00 Net patient revenues (line 1 minus line 2)	46,943,862	3.00
4.00 Less total operating expenses (from wkst. G-2, Part II, line 43)	42,696,056	4.00
5.00 Net income from service to patients (line 3 minus line 4)	4,247,806	5.00
OTHER INCOME		
6.00 Contributions, donations, bequests, etc	0	6.00
7.00 Income from investments	0	7.00
8.00 Revenues from telephone and telegraph service	0	8.00
9.00 Revenue from television and radio service	0	9.00
10.00 Purchase discounts	0	10.00
11.00 Rebates and refunds of expenses	0	11.00
12.00 Parking lot receipts	0	12.00
13.00 Revenue from laundry and linen service	0	13.00
14.00 Revenue from meals sold to employees and guests	0	14.00
15.00 Revenue from rental of living quarters	0	15.00
16.00 Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00 Revenue from sale of drugs to other than patients	0	17.00
18.00 Revenue from sale of medical records and abstracts	0	18.00
19.00 Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00 Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00 Rental of vending machines	0	21.00
22.00 Rental of hospital space	0	22.00
23.00 Governmental appropriations	0	23.00
24.00 OTHER REVENUE	1,497,478	24.00
24.01 MOB	0	24.01
25.00 Total other income (sum of lines 6-24)	1,497,478	25.00
26.00 Total (line 5 plus line 25)	5,745,284	26.00
27.00 BAD DEBT	6,306,359	27.00
27.01 SWAP	4,905,351	27.01
27.02 NON OPERATING REVENUE	32,679	27.02
27.03 NON OP REV	981,806	27.03
28.00 Total other expenses (sum of line 27 and subscripts)	12,226,195	28.00
29.00 Net income (or loss) for the period (line 26 minus line 28)	-6,480,911	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151331

Period:

Worksheet H

HHA CCN: 157242

From 01/01/2011

To 12/31/2011

Date/Time Prepared:

5/22/2012 4:24 pm

Home Health

PPS

	Salaries 1.00	Employee Benefits 2.00	Transportation (see instructions) 3.00	Contracted/Pur- chased Services 4.00	Other Costs 5.00	
GENERAL SERVICE COST CENTERS						
1.00			0		0	1.00
2.00			0		0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	115,906	0	45,790	0	59,356	5.00
HHA REIMBURSABLE SERVICES						
6.00	206,179	0	0	0	0	6.00
7.00	176,111	0	0	887	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	31,918	0	0	0	0	11.00
12.00	0	0	0	0	17,944	12.00
13.00	0	0	0	0	0	13.00
14.00	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES						
15.00	0	0	0	0	0	15.00
16.00	0	0	0	0	0	16.00
17.00	0	0	0	0	0	17.00
18.00	0	0	0	0	0	18.00
19.00	0	0	0	0	0	19.00
20.00	0	0	0	0	0	20.00
21.00	0	0	0	0	0	21.00
22.00	0	0	0	0	0	22.00
23.00	0	0	0	0	0	23.00
24.00	530,114	0	45,790	887	77,300	24.00

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

Health Financial Systems
 ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HARRISON COUNTY HOSPITAL

Provider CCN: 151331
 HHA CCN: 157242
 Period: From 01/01/2011 To 12/31/2011

In Lieu of Form CMS-2552-10
 worksheet H
 Date/Time Prepared: 5/22/2012 4:24 pm
 PPS

		Home Health Agency I					
		Total (sum of cols. 1 thru 5)	Reclassificati on	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	221,052	-16,685	204,367	0	204,367	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	206,179	0	206,179	0	206,179	6.00
7.00	Physical Therapy	176,998	0	176,998	0	176,998	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	31,918	0	31,918	0	31,918	11.00
12.00	Supplies (see instructions)	17,944	0	17,944	0	17,944	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)	654,091	-16,685	637,406	0	637,406	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: 151331
HHA CCN: 157242

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

Worksheet H-1
Part I
Date/Time Prepared:
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Home Health
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	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs				
		Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	
	0	1.00	2.00	3.00	4.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0			1.00
2.00	Capital Related - Movable Equipment	0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	204,367	0	0	0	5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	206,179	0	0	0	6.00
7.00	Physical Therapy	176,998	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	10.00
11.00	Home Health Aide	31,918	0	0	0	11.00
12.00	Supplies (see instructions)	17,944	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)	637,406	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 151331 Period: 01/01/2011 To 12/31/2011
 HHA CCN: 157242 Date/Time Prepared: 5/22/2012 4:24 pm
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	Subtotal (cols. 0-4) 4A.00	Administrative & General 5.00	Total (cols. 4A + 5) 6.00	
GENERAL SERVICE COST CENTERS				
1.00	0			1.00
2.00	0			2.00
3.00	0			3.00
4.00				4.00
5.00	204,367	204,367		5.00
HHA REIMBURSABLE SERVICES				
6.00	206,179	97,304	303,483	6.00
7.00	176,998	83,532	260,530	7.00
8.00	0	0	0	8.00
9.00	0	0	0	9.00
10.00	0	0	0	10.00
11.00	31,918	15,063	46,981	11.00
12.00	17,944	8,468	26,412	12.00
13.00	0	0	0	13.00
14.00	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES				
15.00	0	0	0	15.00
16.00	0	0	0	16.00
17.00	0	0	0	17.00
18.00	0	0	0	18.00
19.00	0	0	0	19.00
20.00	0	0	0	20.00
21.00	0	0	0	21.00
22.00	0	0	0	22.00
23.00	0	0	0	23.00
24.00	433,039		637,406	24.00

	Capital Related Costs					
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	
	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	-204,367	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	-204,367	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

		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	433,039	5.00
HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	206,179	6.00
7.00	Physical Therapy	176,998	7.00
8.00	Occupational Therapy	0	8.00
9.00	Speech Pathology	0	9.00
10.00	Medical Social Services	0	10.00
11.00	Home Health Aide	31,918	11.00
12.00	Supplies (see instructions)	17,944	12.00
13.00	Drugs	0	13.00
14.00	DMF	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)	433,039	24.00
25.00	Cost To Be Allocated (per worksheet H-1, Part I)	204,367	25.00
26.00	Unit Cost Multiplier	0.471937	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151331 | Period: From 01/01/2011 To 12/31/2011
 HHA CCN: 157242 | Worksheet H-2 Part I
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		CAPITAL RELATED COSTS					
		HHA Trial Balance (1)	NEW BLDG & FIXT 1.00	MOB 1.01	AMB DEPR 1.02	NEW MVBLE EQUIP 2.00	
1.00	Administrative and General	0	0	15,765	0	0	1.00
2.00	Skilled Nursing Care	303,483	0	0	0	0	2.00
3.00	Physical Therapy	260,530	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	46,981	0	0	0	0	7.00
8.00	Supplies (see instructions)	26,412	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)	637,406	0	15,765	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151331

Period:

worksheet H-2

HHA CCN: 157242

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

Part I

Date/Time Prepared:
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		CAPITAL RELATED COSTS AMB EQUIP	EMPLOYEE BENEFITS	Subtotal	OTHER A&G	ADMITTING	
		2.01	4.00	4A	5.01	5.02	
1.00	Administrative and General	0	127,292	143,057	13,814	0	1.00
2.00	Skilled Nursing Care	0	0	303,483	29,305	0	2.00
3.00	Physical Therapy	0	0	260,530	25,158	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	46,981	4,537	0	7.00
8.00	Supplies (see instructions)	0	0	26,412	2,550	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	127,292	780,463	75,364	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.000000			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: 151331

Period:

Worksheet H-2

From 01/01/2011

Part I

HHA CCN: 157242

To 12/31/2011

Date/Time Prepared:

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		PATIENT ACCOUNTING	OPERATION OF PLANT	AMB PLANT OPS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.03	7.00	7.01	8.00	9.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

(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: 151331

Period:

Worksheet H-2

From 01/01/2011

Part I

HHA CCN: 157242

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		Home Health Agency I				PPS	
		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
		10.00	11.00	13.00	14.00	16.00	
1.00	Administrative and General	0	0	87,506	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	4.00
4.00	Occupational Therapy	0	0	0	0	0	5.00
5.00	Speech Pathology	0	0	0	0	0	6.00
6.00	Medical Social Services	0	0	0	0	0	7.00
7.00	Home Health Aide	0	0	0	0	0	8.00
8.00	Supplies (see instructions)	0	0	0	0	0	9.00
9.00	Drugs	0	0	0	0	0	10.00
10.00	DME	0	0	0	0	0	11.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	12.00
12.00	Respiratory Therapy	0	0	0	0	0	13.00
13.00	Private Duty Nursing	0	0	0	0	0	14.00
14.00	Clinic	0	0	0	0	0	15.00
15.00	Health Promotion Activities	0	0	0	0	0	16.00
16.00	Day Care Program	0	0	0	0	0	17.00
17.00	Home Delivered Meals Program	0	0	0	0	0	18.00
18.00	Homemaker Service	0	0	0	0	0	19.00
19.00	All others (specify)	0	0	0	0	0	20.00
20.00	Total (sum of lines 1-19) (2)	0	0	87,506	0	0	21.00
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.						

(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. 8, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151331

Period:

worksheet H-2

HHA CCN: 157242

From 01/01/2011

Part I

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		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		17.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	0	244,377	0	244,377		1.00
2.00	Skilled Nursing Care	0	332,788	0	332,788	116,354	2.00
3.00	Physical Therapy	0	285,688	0	285,688	99,885	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	51,518	0	51,518	18,012	7.00
8.00	Supplies (see instructions)	0	28,962	0	28,962	10,126	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	943,333	0	943,333	244,377	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.					0.349631	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

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HHA CCN: 157242	To 12/31/2011	Part I
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	Total HHA Costs	
	28.00	
1.00 Administrative and General		1.00
2.00 Skilled Nursing Care	449,142	2.00
3.00 Physical Therapy	385,573	3.00
4.00 Occupational Therapy	0	4.00
5.00 Speech Pathology	0	5.00
6.00 Medical Social Services	0	6.00
7.00 Home Health Aide	69,530	7.00
8.00 Supplies (see instructions)	39,088	8.00
9.00 Drugs	0	9.00
10.00 DME	0	10.00
11.00 Home Dialysis Aide Services	0	11.00
12.00 Respiratory Therapy	0	12.00
13.00 Private Duty Nursing	0	13.00
14.00 Clinic	0	14.00
15.00 Health Promotion Activities	0	15.00
16.00 Day Care Program	0	16.00
17.00 Home Delivered Meals Program	0	17.00
18.00 Homemaker Service	0	18.00
19.00 All Others (specify)	0	19.00
20.00 Total (sum of lines 1-19) (2)	943,333	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.

		CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	AMB DEPR (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	AMB EQUIP (SQUARE FEET)	
		1.00	1.01	1.02	2.00	2.01	
1.00	Administrative and General	0	597	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	597	0	0	0	20.00
21.00	Total cost to be allocated	0	15,765	0	0	0	21.00
22.00	unit cost multiplier	0.000000	26.407035	0.000000	0.000000	0.000000	22.00

		Home Health Agency I PPS				
		Reconciliation	OTHER A&G (ACCUM COST)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	
EMPLOYEE BENEFITS (GROSS SALARIES) 4.00		5A.01	5.01	5.02	5.03	
1.00	Administrative and General	530,114	0	143,057	0	0 1.00
2.00	Skilled Nursing Care	0	0	303,483	0	0 2.00
3.00	Physical Therapy	0	0	260,530	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	46,981	0	0 7.00
8.00	Supplies (see instructions)	0	0	26,412	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)	530,114		780,463	0	0 20.00
21.00	Total cost to be allocated	127,292		75,364	0	0 21.00
22.00	Unit cost multiplier	0.240122		0.096563	0.000000	0.000000 22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151331
 HHA CCN: 157242

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

	OPERATION OF PLANT (SQUARE FEET)	AMB PLANT OPS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
	7.00	7.01	8.00	9.00	10.00	
1.00	Administrative and General	0	0	0	0	0 1.00
2.00	Skilled Nursing Care	0	0	0	0	0 2.00
3.00	Physical Therapy	0	0	0	0	0 3.00
4.00	Occupational Therapy	0	0	0	0	0 4.00
5.00	Speech Pathology	0	0	0	0	0 5.00
6.00	Medical Social Services	0	0	0	0	0 6.00
7.00	Home Health Aide	0	0	0	0	0 7.00
8.00	Supplies (see instructions)	0	0	0	0	0 8.00
9.00	Drugs	0	0	0	0	0 9.00
10.00	DME	0	0	0	0	0 10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0 11.00
12.00	Respiratory Therapy	0	0	0	0	0 12.00
13.00	Private Duty Nursing	0	0	0	0	0 13.00
14.00	Clinic	0	0	0	0	0 14.00
15.00	Health Promotion Activities	0	0	0	0	0 15.00
16.00	Day Care Program	0	0	0	0	0 16.00
17.00	Home Delivered Meals Program	0	0	0	0	0 17.00
18.00	Homemaker Service	0	0	0	0	0 18.00
19.00	All Others (specify)	0	0	0	0	0 19.00
20.00	Total (sum of lines 1-19)	0	0	0	0	0 20.00
21.00	Total cost to be allocated	0	0	0	0	0 21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000 22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCH: 151331
HHA CCN: 157242

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

Worksheet H-2 Part II
Date/Time Prepared: 5/22/2012 4:24 pm

Home Health Agency I PPS

	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)		
	11.00	13.00	14.00	16.00	17.00		
1.00	Administrative and General	0	16,619	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	OME	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	16,619	0	0	0	20.00
21.00	Total cost to be allocated	0	87,506	0	0	0	21.00
22.00	unit cost multiplier	0.000000	5.265419	0.000000	0.000000	0.000000	22.00

Health Financial Systems
 APPORTIONMENT OF PATIENT SERVICE COSTS

HARRISON COUNTY HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 151331 Period: worksheet H-3
 From 01/01/2011 Parts I-II
 HHA CCN: 157242 To 12/31/2011 Date/Time Prepared:
 5/22/2012 4:24 pm

Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Title XVIII		Home Health Agency I	PPS
			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	449,142		449,142	2,238 1.00
2.00	Physical Therapy	3.00	385,573	0	385,573	1,136 2.00
3.00	Occupational Therapy	4.00	0	0	0	637 3.00
4.00	Speech Pathology	5.00	0	0	0	0 4.00
5.00	Medical Social Services	6.00	0	0	0	0 5.00
6.00	Home Health Aide	7.00	69,530		69,530	1,340 6.00
7.00	Total (sum of lines 1-6)		904,245	0	904,245	5,351 7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits	
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles
	0	1.00	2.00	3.00	4.00

Limitation Cost Computation						
8.00	Skilled Nursing Care	15999		547	1,110	8.00
9.00	Physical Therapy	15999		368	454	9.00
10.00	Occupational Therapy	15999		228	220	10.00
11.00	Speech Pathology	15999		0	0	11.00
12.00	Medical Social Services	15999		17	15	12.00
13.00	Home Health Aide	15999		204	535	13.00
14.00	Total (sum of lines 8-13)			1,364	2,334	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)

Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	8.00	39,088	0	39,088	17,944 15.00
16.00	Cost of Drugs	9.00	0	0	0	0 16.00

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

1.00	Physical Therapy	66.00	0.389674	0	0	1.00
2.00	Occupational Therapy	67.00	0.254525	0	0	2.00
3.00	Speech Pathology	68.00	0.320176	0	0	3.00
4.00	Cost of Medical Supplies	71.00	0.427775	0	0	4.00
5.00	Cost of Drugs	73.00	0.356101	0	0	5.00

Title XVIII Home Health Agency I

Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Program Visits			
		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	5.00	6.00	7.00	8.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION					
Cost Per Visit Computation					
1.00 Skilled Nursing Care	200.69	547	1,110		1.00
2.00 Physical Therapy	339.41	368	454		2.00
3.00 Occupational Therapy	0.00	228	220		3.00
4.00 Speech Pathology	0.00	0	0		4.00
5.00 Medical Social Services	0.00	17	15		5.00
6.00 Home Health Aide	51.89	204	535		6.00
7.00 Total (sum of lines 1-6)		1,364	2,334		7.00
Cost Center Description					
	5.00	6.00	7.00	8.00	9.00
Limitation Cost Computation					
8.00 Skilled Nursing Care					8.00
9.00 Physical Therapy					9.00
10.00 Occupational Therapy					10.00
11.00 Speech Pathology					11.00
12.00 Medical Social Services					12.00
13.00 Home Health Aide					13.00
14.00 Total (sum of lines 8-13)					14.00
Program Covered Charges					
Cost Center Description	Ratio (col. 3 ÷ col. 4)	Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	5.00	6.00	7.00	8.00	
Supplies and Drugs Cost Computations					
15.00 Cost of Medical Supplies	2.178333	1,880	13,405	0	15.00
16.00 Cost of Drugs	0.000000	0	0	0	16.00
Cost Center Description					
		Transfer to Part I as Indicated			
		4.00			
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS					
1.00 Physical Therapy		col. 2, line 2.00			1.00
2.00 Occupational Therapy		col. 2, line 3.00			2.00
3.00 Speech Pathology		col. 2, line 4.00			3.00
4.00 Cost of Medical Supplies		col. 2, line 15.00			4.00
5.00 Cost of Drugs		col. 2, line 16.00			5.00

		Title XVIII		Home Health Agency I	
		Cost of Services			
Cost Center Description	Part A	Part B		Total Program Cost (sum of cols. 9-10)	
		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	109,777	222,766	332,543	1.00
2.00	Physical Therapy	124,903	154,092	278,995	2.00
3.00	Occupational Therapy	0	0	0	3.00
4.00	Speech Pathology	0	0	0	4.00
5.00	Medical Social Services	0	0	0	5.00
6.00	Home Health Aide	10,586	27,761	38,347	6.00
7.00	Total (sum of lines 1-6)	245,266	404,619	649,885	7.00
Cost Center Description		10.00	11.00	12.00	
Limitation Cost Computation					
8.00	Skilled Nursing Care				8.00
9.00	Physical Therapy				9.00
10.00	Occupational Therapy				10.00
11.00	Speech Pathology				11.00
12.00	Medical Social Services				12.00
13.00	Home Health Aide				13.00
14.00	Total (sum of lines 8-13)				14.00
		Cost of Services			
Cost Center Description	Part A	Part B			
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	9.00	10.00	11.00		
Supplies and Drugs Cost Computations					
15.00	Cost of Medical Supplies	4,095	29,201	0	15.00
16.00	Cost of Drugs	0	0	0	16.00

		Title XVIII		Home Health Agency I		PPS	
		Part A	Part B				
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			
		1.00	2.00	3.00			
PART I - COMPUTATION OF THE LESSEr OF REASONABLE COST OR CUSTOMARY CHARGES							
1.00	Reasonable Cost of Part A & Part B Services	0	0	0			1.00
2.00	Reasonable cost of services (see instructions)	178,969	336,913	0			2.00
3.00	Total charges						
Customary Charges							
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0			3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0			4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000			5.00
6.00	Total customary charges (see instructions)	178,969	336,913	0			6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	178,969	336,913	0			7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0			8.00
9.00	Primary payer amounts	0	0	0			9.00
			Part A Services	Part B Services			
			1.00	2.00			
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT							
10.00	Total reasonable cost (see instructions)		0	0			10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		198,948	281,122			11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	8,337			12.00
13.00	Total PPS Reimbursement - LUPA Episodes		3,234	6,163			13.00
14.00	Total PPS Reimbursement - PEP Episodes		3,798	1,351			14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	2,372			15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0			16.00
17.00	Total Other Payments		0	0			17.00
18.00	DME Payments		0	0			18.00
19.00	Oxygen Payments		0	0			19.00
20.00	Prosthetic and Orthotic Payments		0	0			20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0			21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		205,980	299,345			22.00
23.00	Excess reasonable cost (from line 8)		0	0			23.00
24.00	Subtotal (line 22 minus line 23)		205,980	299,345			24.00
25.00	Coinsurance billed to program patients (from your records)		0	0			25.00
26.00	Net cost (line 24 minus line 25)		205,980	299,345			26.00
27.00	Reimbursable bad debts (from your records)		0	0			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)		205,980	299,345			29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0			30.00
31.00	Subtotal (line 29 plus/minus line 30)		205,980	299,345			31.00
32.00	Interim payments (see instructions)		205,980	299,345			32.00
33.00	Tentative settlement (for contractor use only)		0	0			33.00
34.00	Balance due provider/program (line 31 minus lines 32 and 33)		0	0			34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	0			35.00

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

Provider CCN: 151331
HHA CCN: 157242

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

Worksheet H-5
Date/Time Prepared: 5/22/2012 4:24 pm
PPS

Home Health Agency I

	Inpatient Part A		Part B		
	mm/dd/yyyy 1.00	Amount 2.00	mm/dd/yyyy 3.00	Amount 4.00	
1.00		205,980		299,345	1.00
2.00		0		0	2.00
3.00					3.00
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
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		0		0	3.99
4.00		205,980		299,345	4.00
5.00					5.00
5.01		0		0	5.01
5.02		0		0	5.02
5.03		0		0	5.03
5.50		0		0	5.50
5.51		0		0	5.51
5.52		0		0	5.52
5.99		0		0	5.99
6.00					6.00
6.01		0		0	6.01
6.02		0		0	6.02
7.00		205,980		299,345	7.00
8.00		0			8.00