

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet S Parts I-III Date/Time Prepared: 5/29/2012 8:55 pm
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**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/29/2012 Time: 8:55 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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

(Signed) \_\_\_\_\_  
Officer or Administrator of Provider(s)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-25,630	27,854	0	296,431	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	0	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	-25,630	27,854	0	296,431	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: 150030		Period: From 01/01/2011 To 12/31/2011		Worksheet S-2 Part I Date/Time Prepared: 5/29/2012 8:55 pm					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1000 NORTH 16TH STREET			PO Box:						1.00	
2.00	City: NEW CASTLE			State: IN		Zip Code: 47392-		County: HENRY		2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		HENRY COUNTY MEMORIAL HOSPITAL	150030	99915	1	07/01/1996	N	P	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						N	N	N		7.00
8.00	Swing Beds - NF						N		N		8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA		HCMH HOME CARE	157430	99915		06/14/1995	N	P	N	12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice		HOSP-BASED HOSPICE	151564	99915		08/31/1998				14.00
15.00	Hospital-Based Health Clinic - RHC							N	N	N	15.00
16.00	Hospital-Based Health Clinic - FQHC							N	N	N	16.00
17.00	Hospital-Based (CMHC) 1										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2011	12/31/2011		20.00	
21.00	Type of Control (see instructions)						9		21.00		
Inpatient PPS Information											
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00	
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.						3	N		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	478	412	0	0	1,041	0		24.00		
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.	0	0	0	0	0	0		25.00		
							Urban/Rural	S	Date of Geogr		
							1.00		2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.							1		26.00	
27.00	For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification (in column 2).							1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							0		35.00	
							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	

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		Beginning:	Ending:			
		1.00	2.00			
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	1			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.	01/01/2011	12/31/2011		38.00	
		V	XVIII	XIX		
		1.00	2.00	3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00	
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01	
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00	
		Program Name	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

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		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
65.00	If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. Use subscripted lines 65.01 through 65.50 for each additional primary care program. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4.			0.00	0.00	0.000000		65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
				1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000		66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000		67.00
						1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				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

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			1.00	2.00	3.00	
<b>Inpatient Rehabilitation Facility PPS</b>						
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			
<b>Long Term Care Hospital PPS</b>						
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.		N		80.00	
<b>TEFRA Providers</b>						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(i)? Enter "Y" for yes and "N" for no.		N		86.00	
			V	XIX		
			1.00	2.00		
<b>Title V or XIX Inpatient Services</b>						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00	
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	97.00	
<b>Rural Providers</b>						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N		106.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00	
			Physical	Occupational	Speech	Respiratory
			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.		N	N	N	N
			1.00		2.00	
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.		N		115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118.00	
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.		250,000	7,500,000	119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.		N		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	
<b>Transplant Center Information</b>						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00	

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		1.00	2.00				
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.						134.00
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y				140.00
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:			141.00
142.00	Street:	PO Box:		Zip Code:			142.00
143.00	City:	State:					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.		N				147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N				148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N				149.00
				Part A	Part B		
				1.00	2.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital		N		N		155.00
156.00	Subprovider - IPF		N		N		156.00
157.00	Subprovider - IRF		N		N		157.00
158.00	SUBPROVIDER		N		N		158.00
159.00	SNF		N		N		159.00
160.00	HOME HEALTH AGENCY		N		N		160.00
161.00	CMHC				N		161.00
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
							1.00
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part II Date/Time Prepared: 5/29/2012 8:55 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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	A	04/20/2012	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
		Part A			
		Description	Y/N	Date	
		0	1.00	2.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/18/2012		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N			20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 150030

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
5/29/2012 8:55 pm

		Part A			
		Description	Y/N	Date	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	1.00 N	2.00	21.00
					1.00
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		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
<b>Interest Expense</b>					
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
<b>Purchased Services</b>					
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		33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		N		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
<b>Home Office Costs</b>					
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		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		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 150030

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
5/29/2012 8:55 pm

		Part B		
		Y/N	Date	
		3.00	4.00	
<b>PS&amp;R Data</b>				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/18/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150030

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/29/2012 8:55 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours		
	Line Number					
	1.00	2.00	3.00	4.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	80	29,200	0.00		1.00
2.00 HMO						2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		80	29,200	0.00		7.00
8.00 INTENSIVE CARE UNIT	31.00	10	3,650	0.00		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00					13.00
14.00 Total (see instructions)		90	32,850	0.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0			17.00
18.00 SUBPROVIDER	42.00	0	0			18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00					26.25
27.00 Total (sum of lines 14-26)		90				27.00
28.00 Observation Bed Days						28.00
28.02 SUBPROVIDER - IRF	41.00					28.02
28.03 SUBPROVIDER	42.00					28.03
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150030

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/29/2012 8:55 pm

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	5,162	472	9,010		1.00
2.00 HMO		644	1,389			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	5,162	472	9,010		7.00
8.00 INTENSIVE CARE UNIT	0	1,158	0	1,577		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	0		0	816		13.00
14.00 Total (see instructions)	0	6,320	472	11,403		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0		17.00
18.00 SUBPROVIDER	0	0	0	0		18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	3,478	271	5,381		22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE		627	89	6,274		24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0	0	0	0		26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		107	1,058		28.00
28.02 SUBPROVIDER - IRF				0		28.02
28.03 SUBPROVIDER				0		28.03
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)			70	101		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150030

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/29/2012 8:55 pm

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	1,415	1.00
2.00 HMO					0	2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	451.80	0.00	0	1,415	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0.00	0.00	0	0	17.00
18.00 SUBPROVIDER	0.00	0.00	0.00	0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00	4.64	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00	2.72	0.00			24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00	0.00	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00 Total (sum of lines 14-26)	0.00	459.16	0.00			27.00
28.00 Observation Bed Days						28.00
28.02 SUBPROVIDER - IRF						28.02
28.03 SUBPROVIDER						28.03
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150030

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
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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)	163	2,828		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)	163	2,828		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF	0	0		17.00
18.00 SUBPROVIDER	0	0		18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
28.02 SUBPROVIDER - IRF				28.02
28.03 SUBPROVIDER				28.03
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 150030		Period: From 01/01/2011 To 12/31/2011		Worksheet S-3 Part II Date/Time Prepared: 5/29/2012 8:55 pm	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4		
	1.00	2.00	3.00	4.00	5.00		
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	23,611,840	-252,028	23,359,812	955,046.00	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	3.00
4.00	Physician-Part A		0	0	0	0.00	4.00
4.01	Physicians - Part A - direct teaching		0	0	0	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	7.00
7.01	Contracted interns and residents (in approved programs)		0	0	0	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	9.00
10.00	Excluded area salaries (see instructions)		890,312	203,297	1,093,609	40,962.00	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract labor (see instructions)		829,499	0	829,499	21,354.00	11.00
12.00	Management and administrative services		0	0	0	0.00	12.00
13.00	Contract labor: physician-Part A		80,004	0	80,004	664.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	14.00
15.00	Home office: physician Part A		0	0	0	0.00	15.00
16.00	Teaching physician salaries (see instructions)		0	0	0	0.00	16.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24		9,153,983	0	9,153,983		17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV Line 25		0	0	0		18.00
19.00	Excluded areas		226,249	0	226,249		19.00
20.00	Non-physician anesthetist Part A		0	0	0		20.00
21.00	Non-physician anesthetist Part B		0	0	0		21.00
22.00	Physician Part A		0	0	0		22.00
23.00	Physician Part B		0	0	0		23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0		24.00
25.00	Interns & residents (in an approved program)		0	0	0		25.00
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits	4.00	196,134	0	196,134	8,467.00	26.00
27.00	Administrative & General	5.00	4,592,842	-183,695	4,409,147	145,574.00	27.00
28.00	Administrative & General under contract (see inst.)		791,781	0	791,781	4,926.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	29.00
30.00	Operation of Plant	7.00	885,457	0	885,457	41,215.00	30.00
31.00	Laundry & Linen Service	8.00	143,398	-26,050	117,348	10,660.00	31.00
32.00	Housekeeping	9.00	454,773	-31,134	423,639	40,396.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	33.00
34.00	Dietary	10.00	690,814	-412,629	278,185	20,120.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	35.00
36.00	Cafeteria	11.00	0	266,516	266,516	19,274.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	37.00
38.00	Nursing Administration	13.00	1,325,660	0	1,325,660	34,838.00	38.00
39.00	Central Services and Supply	14.00	381,352	-68,333	313,019	15,928.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	846,126	0	846,126	41,051.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet S-3 Part II Date/Time Prepared: 5/29/2012 8:55 pm
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		Average Hourly Wage (col. 4 ÷ col. 5)	
		6.00	
<b>PART II - WAGE DATA</b>			
<b>SALARIES</b>			
1.00	Total salaries (see instructions)	24.46	1.00
2.00	Non-physician anesthetist Part A	0.00	2.00
3.00	Non-physician anesthetist Part B	0.00	3.00
4.00	Physician-Part A	0.00	4.00
4.01	Physicians - Part A - direct teaching	0.00	4.01
5.00	Physician-Part B	0.00	5.00
6.00	Non-physician-Part B	0.00	6.00
7.00	Interns & residents (in an approved program)	0.00	7.00
7.01	Contracted interns and residents (in approved programs)	0.00	7.01
8.00	Home office personnel	0.00	8.00
9.00	SNF	0.00	9.00
10.00	Excluded area salaries (see instructions)	26.70	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>			
11.00	Contract labor (see instructions)	38.85	11.00
12.00	Management and administrative services	0.00	12.00
13.00	Contract labor: physician-Part A	120.49	13.00
14.00	Home office salaries & wage-related costs	0.00	14.00
15.00	Home office: physician Part A	0.00	15.00
16.00	Teaching physician salaries (see instructions)	0.00	16.00
<b>WAGE-RELATED COSTS</b>			
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24		17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV Line 25		18.00
19.00	Excluded areas		19.00
20.00	Non-physician anesthetist Part A		20.00
21.00	Non-physician anesthetist Part B		21.00
22.00	Physician Part A		22.00
23.00	Physician Part B		23.00
24.00	Wage-related costs (RHC/FOHC)		24.00
25.00	Interns & residents (in an approved program)		25.00
<b>OVERHEAD COSTS - DIRECT SALARIES</b>			
26.00	Employee Benefits	23.16	26.00
27.00	Administrative & General	30.29	27.00
28.00	Administrative & General under contract (see inst.)	160.74	28.00
29.00	Maintenance & Repairs	0.00	29.00
30.00	Operation of Plant	21.48	30.00
31.00	Laundry & Linen Service	11.01	31.00
32.00	Housekeeping	10.49	32.00
33.00	Housekeeping under contract (see instructions)	0.00	33.00
34.00	Dietary	13.83	34.00
35.00	Dietary under contract (see instructions)	0.00	35.00
36.00	Cafeteria	13.83	36.00
37.00	Maintenance of Personnel	0.00	37.00
38.00	Nursing Administration	38.05	38.00
39.00	Central Services and Supply	19.65	39.00
40.00	Pharmacy	0.00	40.00
41.00	Medical Records & Medical Records Library	20.61	41.00
42.00	Social Service	0.00	42.00
43.00	Other General Service	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150030

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/29/2012 8:55 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>						
1.00	Net salaries (see instructions)	24,403,621	-252,028	24,151,593	959,972.00	1.00
2.00	Excluded area salaries (see instructions)	890,312	203,297	1,093,609	40,962.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	23,513,309	-455,325	23,057,984	919,010.00	3.00
4.00	Subtotal other wages & related costs (see inst.)	909,503	0	909,503	22,018.00	4.00
5.00	Subtotal wage-related costs (see inst.)	9,153,983	0	9,153,983	0.00	5.00
6.00	Total (sum of lines 3 thru 5)	33,576,795	-455,325	33,121,470	941,028.00	6.00
7.00	Total overhead cost (see instructions)	10,308,337	-455,325	9,853,012	382,449.00	7.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet S-3 Part III Date/Time Prepared: 5/29/2012 8:55 pm
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		Average Hourly Wage (col. 4 ÷ col. 5)	
		6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY			
1.00	Net salaries (see instructions)	25.16	1.00
2.00	Excluded area salaries (see instructions)	26.70	2.00
3.00	Subtotal salaries (line 1 minus line 2)	25.09	3.00
4.00	Subtotal other wages & related costs (see inst.)	41.31	4.00
5.00	Subtotal wage-related costs (see inst.)	39.70	5.00
6.00	Total (sum of lines 3 thru 5)	35.20	6.00
7.00	Total overhead cost (see instructions)	25.76	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet S-3 Part IV Date/Time Prepared: 5/29/2012 8:55 pm
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		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Qualified and Non-Qualified Pension Plan Cost	1,263,871	3.00
4.00	Prior Year Pension Service Cost	0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
5.00	401K/TSA Plan Administration Fees	7,414	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
<b>HEALTH AND INSURANCE COST</b>			
8.00	Health Insurance (Purchased or Self Funded)	5,674,715	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	119,369	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	22,390	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)	198,841	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	171,890	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
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	1,621,636	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	73,857	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
<b>OTHER</b>			
21.00	Executive Deferred Compensation	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,153,983	24.00
<b>Part B - Other than Core Related Cost</b>			
25.00	EXCLUDED BENEFITS	226,249	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150030

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

Worksheet S-3  
Part V  
Date/Time Prepared:  
5/29/2012 8:55 pm

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

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet S-4
		Component CCN: 157430		Date/Time Prepared: 5/29/2012 8:55 pm
			Home Health Agency I	PPS

		1.00					
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	216.00	0.00	0.00	0.00	2.00
		Number of Employees (Full Time Equivalent)					
		Enter the number of hours in your normal work week			Staff	Contract	Total
		0			1.00	2.00	3.00
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	0.00					3.00
4.00	Director(s) and Assistant Director(s)	0.00					4.00
5.00	Other Administrative Personnel	0.00					5.00
6.00	Direct Nursing Service	0.00					6.00
7.00	Nursing Supervisor	0.00					7.00
8.00	Physical Therapy Service	0.00					8.00
9.00	Physical Therapy Supervisor	0.00					9.00
10.00	Occupational Therapy Service	0.00					10.00
11.00	Occupational Therapy Supervisor	0.00					11.00
12.00	Speech Pathology Service	0.00					12.00
13.00	Speech Pathology Supervisor	0.00					13.00
14.00	Medical Social Service	0.00					14.00
15.00	Medical Social Service Supervisor	0.00					15.00
16.00	Home Health Aide	0.00					16.00
17.00	Home Health Aide Supervisor	0.00					17.00
18.00	Other (specify)	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).	99915					20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	1,191	0	75	23	1,289	21.00
22.00	Skilled Nursing Visit Charges	262,239	0	16,425	5,256	283,920	22.00
23.00	Physical Therapy Visits	1,229	0	50	20	1,299	23.00
24.00	Physical Therapy Visit Charges	269,805	0	10,950	4,380	285,135	24.00
25.00	Occupational Therapy Visits	427	0	3	14	444	25.00
26.00	Occupational Therapy Visit Charges	89,630	0	630	2,940	93,200	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	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	439	0	0	7	446	31.00
32.00	Home Health Aide Visit Charges	45,861	0	0	721	46,582	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,286	0	128	64	3,478	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	667,535	0	28,005	13,297	708,837	35.00
36.00	Total Number of Episodes (standard/non outlier)	213		43	5	261	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	4,614	0	315	0	4,929	38.00

HOSPITAL IDENTIFICATION DATA		Provider CCN: 150030 Component CCN: 151564		Period: From 01/01/2011 To 12/31/2011		Worksheet S-9 Parts I & II Date/Time Prepared: 5/29/2012 8:55 pm	
		Unduplicated Days				Hospice I	
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	
		1.00	2.00	3.00	4.00	5.00	
<b>PART I - ENROLLMENT DAYS</b>							
1.00	Continuous Home Care	0	0	0	0	0	1.00
2.00	Routine Home Care	2,918	89	351	0	260	2.00
3.00	Inpatient Respite Care	12	0	0	0	0	3.00
4.00	General Inpatient Care	145	0	0	0	4	4.00
5.00	Total Hospice Days	3,075	89	351	0	264	5.00
<b>Part II - CENSUS DATA</b>							
6.00	Number of Patients Receiving Hospice Care	88	5	35	0	7	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00			7.00
8.00	Average Length of Stay (line 5/line 6)	34.94	17.80	10.03	0.00	37.71	8.00
9.00	Unduplicated Census Count	80	4	31	0	7	9.00

HOSPITAL IDENTIFICATION DATA		Provider CCN: 150030 Component CCN: 151564	Period: From 01/01/2011 To 12/31/2011	Worksheet S-9 Parts I & II Date/Time Prepared: 5/29/2012 8:55 pm
		Hospice I		

		Unduplicated Days	
		Total (sum of cols. 1, 2 & 5)	
		6.00	
<b>PART I - ENROLLMENT DAYS</b>			
1.00	Continuous Home Care	0	1.00
2.00	Routine Home Care	3,267	2.00
3.00	Inpatient Respite Care	12	3.00
4.00	General Inpatient Care	149	4.00
5.00	Total Hospice Days	3,428	5.00
<b>Part II - CENSUS DATA</b>			
6.00	Number of Patients Receiving Hospice Care	100	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare		7.00
8.00	Average Length of Stay (line 5/line 6)	34.28	8.00
9.00	Unduplicated Census Count	91	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet S-10 Date/Time Prepared: 5/29/2012 8:55 pm
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			1.00		
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)		0.343195	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		2,916,009	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		3,069,899	5.00	
6.00	Medicaid charges		22,361,442	6.00	
7.00	Medicaid cost (line 1 times line 6)		7,674,335	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)		1,688,427	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)		1,688,427	19.00	
			1.00		
			2.00		
			3.00		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	3,387,982	0	3,387,982	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,162,738	0	1,162,738	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,162,738	0	1,162,738	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		7,914,494	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		359,765	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		7,554,729	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		2,592,745	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		3,755,483	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		5,443,910	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150030

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

Worksheet A  
Date/Time Prepared:  
5/29/2012 8:55 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 NEW CAP REL COSTS-BLDG & FIXT		4,572,274	4,572,274	-52,263	4,520,011	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		0	0	656,812	656,812	2.00
3.00 OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00 EMPLOYEE BENEFITS	196,134	7,856,789	8,052,923	252,028	8,304,951	4.00
5.00 ADMINISTRATIVE & GENERAL	4,592,842	5,000,138	9,592,980	-183,695	9,409,285	5.00
7.00 OPERATION OF PLANT	885,457	1,613,819	2,499,276	-43	2,499,233	7.00
8.00 LAUNDRY & LINEN SERVICE	143,398	116,548	259,946	-47,222	212,724	8.00
9.00 HOUSEKEEPING	454,773	245,887	700,660	-47,968	652,692	9.00
10.00 DIETARY	690,814	534,775	1,225,589	-732,055	493,534	10.00
11.00 CAFETERIA	0	0	0	472,833	472,833	11.00
13.00 NURSING ADMINISTRATION	1,325,660	219,080	1,544,740	0	1,544,740	13.00
14.00 CENTRAL SERVICES & SUPPLY	381,352	295,718	677,070	-68,433	608,637	14.00
15.00 PHARMACY	0	2,974,398	2,974,398	-150,521	2,823,877	15.00
16.00 MEDICAL RECORDS & LIBRARY	846,126	266,541	1,112,667	0	1,112,667	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	3,542,326	451,722	3,994,048	-600,535	3,393,513	30.00
31.00 INTENSIVE CARE UNIT	1,021,026	126,427	1,147,453	-1,320	1,146,133	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	0	0	0	516,897	516,897	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	1,909,717	993,414	2,903,131	-187,006	2,716,125	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	75,643	75,643	52.00
54.00 RADIOLOGY-DIAGNOSTIC	1,555,737	951,667	2,507,404	-263,849	2,243,555	54.00
57.00 CT SCAN	163,822	662,390	826,212	0	826,212	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	76,779	475,979	552,758	0	552,758	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	1,477,405	1,667,748	3,145,153	0	3,145,153	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	438,060	124,948	563,008	-27,475	535,533	65.00
66.00 PHYSICAL THERAPY	975,547	843,620	1,819,167	-344	1,818,823	66.00
68.00 SPEECH PATHOLOGY	57,968	4,058	62,026	0	62,026	68.00
69.00 ELECTROCARDIOLOGY	109,722	53,597	163,319	0	163,319	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,658,078	3,658,078	-2,899,054	759,024	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,899,054	2,899,054	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 CARDIAC REHABILITATION	98,184	9,068	107,252	0	107,252	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 EMERGENCY	1,778,679	444,190	2,222,869	0	2,222,869	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00 HOME HEALTH AGENCY	448,919	124,573	573,492	0	573,492	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 INTEREST EXPENSE		0	0	0	0	113.00
114.00 UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00 HOSPICE	304,139	280,829	584,968	-18,159	566,809	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	23,474,586	34,568,275	58,042,861	-406,675	57,636,186	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	137,254	107,755	245,009	0	245,009	192.00
194.00 MCH	0	0	0	0	0	194.00
194.01 RENTAL	0	0	0	52,263	52,263	194.01
194.02 CMHS	0	0	0	0	0	194.02
194.03 MCH	0	0	0	0	0	194.03
194.04 WIC	0	0	0	0	0	194.04
194.05 OTHER NONREIMBURSABLE COSTS	0	349,606	349,606	0	349,606	194.05
194.06 LIFELINE	0	0	0	0	0	194.06
194.07 PHILLIPS HALL	0	0	0	0	0	194.07
194.08 OB DRG	0	0	0	0	0	194.08
194.09 THE WATERS	0	0	0	354,412	354,412	194.09
200.00 TOTAL (SUM OF LINES 118-199)	23,611,840	35,025,636	58,637,476	0	58,637,476	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150030

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

Worksheet A  
Date/Time Prepared:  
5/29/2012 8:55 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	4,520,011	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	656,812	2.00
3.00	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	EMPLOYEE BENEFITS	565,948	8,870,899	4.00
5.00	ADMINISTRATIVE & GENERAL	-209,773	9,199,512	5.00
7.00	OPERATION OF PLANT	0	2,499,233	7.00
8.00	LAUNDRY & LINEN SERVICE	0	212,724	8.00
9.00	HOUSEKEEPING	0	652,692	9.00
10.00	DIETARY	-15,430	478,104	10.00
11.00	CAFETERIA	-347,266	125,567	11.00
13.00	NURSING ADMINISTRATION	0	1,544,740	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	608,637	14.00
15.00	PHARMACY	-313,830	2,510,047	15.00
16.00	MEDICAL RECORDS & LIBRARY	-17,670	1,094,997	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	-1,409	3,392,104	30.00
31.00	INTENSIVE CARE UNIT	0	1,146,133	31.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	516,897	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	0	2,716,125	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	75,643	52.00
54.00	RADIOLOGY-DIAGNOSTIC	-29,181	2,214,374	54.00
57.00	CT SCAN	-465,398	360,814	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	-310,060	242,698	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	-9,933	3,135,220	60.00
60.01	BLOOD LABORATORY	0	0	60.01
65.00	RESPIRATORY THERAPY	-7,009	528,524	65.00
66.00	PHYSICAL THERAPY	-638,507	1,180,316	66.00
68.00	SPEECH PATHOLOGY	0	62,026	68.00
69.00	ELECTROCARDIOLOGY	0	163,319	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	759,024	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	2,899,054	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	CARDIAC REHABILITATION	0	107,252	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	RURAL HEALTH CLINIC	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	EMERGENCY	0	2,222,869	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
101.00	HOME HEALTH AGENCY	-6,010	567,482	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	INTEREST EXPENSE	0	0	113.00
114.00	UTILIZATION REVIEW-SNF	0	0	114.00
116.00	HOSPICE	0	566,809	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-1,805,528	55,830,658	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	245,009	192.00
194.00	MCH	0	0	194.00
194.01	RENTAL	0	52,263	194.01
194.02	CMHS	0	0	194.02
194.03	MCH	0	0	194.03
194.04	WIC	0	0	194.04
194.05	OTHER NONREIMBURSABLE COSTS	0	349,606	194.05
194.06	LIFELINE	0	0	194.06
194.07	PHILLIPS HALL	0	0	194.07
194.08	OB DRS	0	0	194.08
194.09	THE WATERS	0	354,412	194.09
200.00	TOTAL (SUM OF LINES 118-199)	-1,805,528	56,831,948	200.00

Provider CCN: 150030

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

Worksheet A-6  
Date/Time Prepared:  
5/29/2012 8:55 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - OB NURSERY L&amp;D</b>					
1.00	NURSERY	43.00	457,242	59,655	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	66,913	8,730	2.00
	TOTALS		524,155	68,385	
<b>B - CAFETERIA</b>					
1.00	CAFETERIA	11.00	266,516	206,317	1.00
	TOTALS		266,516	206,317	
<b>C - WATERS EXCLUSIONS</b>					
1.00	THE WATERS	194.09	203,297	151,115	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		203,297	151,115	
<b>D - DEPRECIATION POB</b>					
1.00	RENTAL	194.01		52,263	1.00
	TOTALS		0	52,263	
<b>E - EQUIPMENT RENTAL</b>					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00		656,812	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
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
	TOTALS		0	656,812	
<b>F - IMPLANTABLE DEVICES</b>					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	2,899,054	1.00
	TOTALS		0	2,899,054	
<b>G - VERO RECLASS</b>					
1.00	EMPLOYEE BENEFITS	4.00	0	252,028	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	252,028	
500.00	Grand Total: Increases		993,968	4,285,974	500.00

RECLASSIFICATIONS

Provider CCN: 150030

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

Worksheet A-6  
Date/Time Prepared:  
5/29/2012 8:55 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - OB NURSERY L&amp;D</b>							
1.00		30.00	524,155	68,385	0		1.00
2.00		0.00	0	0	0		2.00
	<b>TOTALS</b>		524,155	68,385			
<b>B - CAFETERIA</b>							
1.00		10.00	266,516	206,317	0		1.00
	<b>TOTALS</b>		266,516	206,317			
<b>C - WATERS EXCLUSIONS</b>							
1.00	LAUNDRY & LINEN SERVICE	8.00	26,050	21,172	0		1.00
2.00	HOUSEKEEPING	9.00	31,134	16,834	0		2.00
3.00	DIETARY	10.00	146,113	113,109	0		3.00
	<b>TOTALS</b>		203,297	151,115			
<b>D - DEPRECIATION POB</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00		52,263	9		1.00
	<b>TOTALS</b>		0	52,263			
<b>E - EQUIPMENT RENTAL</b>							
1.00	OPERATION OF PLANT	7.00		43	9		1.00
2.00		14.00		100	0		2.00
3.00		15.00		150,521	0		3.00
4.00		30.00		7,995	0		4.00
5.00		31.00		1,320	0		5.00
6.00		50.00		187,006	0		6.00
7.00		54.00		263,849	0		7.00
8.00		65.00		27,475	0		8.00
9.00		66.00		344	0		9.00
10.00		116.00		18,159	0		10.00
	<b>TOTALS</b>		0	656,812			
<b>F - IMPLANTABLE DEVICES</b>							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,899,054	0		1.00
	<b>TOTALS</b>		0	2,899,054			
<b>G - VERO RECLASS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	183,695	0	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	68,333	0	0		2.00
	<b>TOTALS</b>		252,028	0			
500.00	<b>Grand Total: Decreases</b>		1,245,996	4,033,946			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150030

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
5/29/2012 8:55 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	46,000	0	0	0	1.00
2.00	Land Improvements	1,643,952	0	0	0	2.00
3.00	Buildings and Fixtures	35,741,823	3,166,659	0	3,166,659	3.00
4.00	Building Improvements	237,996	0	0	0	4.00
5.00	Fixed Equipment	15,250,322	82,229	0	82,229	5.00
6.00	Movable Equipment	23,393,117	2,286,830	0	2,286,830	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	76,313,210	5,535,718	0	5,535,718	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	76,313,210	5,535,718	0	5,535,718	10.00
<b>SUMMARY OF CAPITAL</b>						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	4,119,522	0	452,752	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,119,522	0	452,752	0	3.00
<b>COMPUTATION OF RATIOS</b>						
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	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150030

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
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		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	46,000	0		1.00	
2.00	Land Improvements	1,643,952	0		2.00	
3.00	Buildings and Fixtures	38,456,496	0		3.00	
4.00	Building Improvements	237,996	0		4.00	
5.00	Fixed Equipment	15,332,551	0		5.00	
6.00	Movable Equipment	25,085,454	0		6.00	
7.00	HIT designated Assets	0	0		7.00	
8.00	Subtotal (sum of lines 1-7)	80,802,449	0		8.00	
9.00	Reconciling Items	0	0		9.00	
10.00	Total (line 8 minus line 9)	80,802,449	0		10.00	
<b>SUMMARY OF CAPITAL</b>						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	4,572,274		1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00	
3.00	Total (sum of lines 1-2)	0	4,572,274		3.00	
<b>ALLOCATION OF OTHER CAPITAL</b>						
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
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	4,067,259	0
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	656,812	0
3.00	Total (sum of lines 1-2)	0	0	0	4,724,071	0

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150030

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
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Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	452,752	0	0	0	4,520,011	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	656,812	2.00
3.00	Total (sum of lines 1-2)	452,752	0	0	0	5,176,823	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150030

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

Worksheet A-8  
Date/Time Prepared:  
5/29/2012 8:55 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center		Line #
			1.00	2.00	3.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			NEW CAP REL COSTS-MVBLE EQUIP		2.00
3.00 Investment income - other (chapter 2)		0			0.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-10,897	ADMINISTRATIVE & GENERAL		5.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-14,169	ADMINISTRATIVE & GENERAL		5.00
8.00 Television and radio service (chapter 21)		0			0.00
9.00 Parking lot (chapter 21)		0			0.00
10.00 Provider-based physician adjustment	A-8-2	-9,933			10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00
12.00 Related organization transactions (chapter 10)	A-8-1	-1,473,540			12.00
13.00 Laundry and linen service		0			0.00
14.00 Cafeteria-employees and guests	B	-347,266	CAFETERIA		11.00
15.00 Rental of quarters to employee and others		0			0.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00
17.00 Sale of drugs to other than patients		0			0.00
18.00 Sale of medical records and abstracts	B	-17,670	MEDICAL RECORDS & LIBRARY		16.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00
20.00 Vending machines		0			0.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		RESPIRATORY THERAPY		65.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY		66.00
25.00 Utilization review - physicians' compensation (chapter 21)			UTILIZATION REVIEW-SNF		114.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT		1.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP		2.00
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***		19.00
29.00 Physicians' assistant			0		0.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***		67.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		SPEECH PATHOLOGY		68.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	0			0.00
33.00 OTHER OP REV - HUMAN RESOURSEC - MIS	B	-415	EMPLOYEE BENEFITS		4.00
34.00 OTHER OP REV	B	1,892	ADMINISTRATIVE & GENERAL		5.00
35.00 OTHER OP REV - COPIES RECEIPTS	B	-16	ADMINISTRATIVE & GENERAL		5.00
36.00 OTHER OP REV - PHY REAPP FEES	B	-25,700	ADMINISTRATIVE & GENERAL		5.00
37.00 OTHER OP REV - DIETARY - MISC DIETAR	B	-9,354	DIETARY		10.00
38.00 OTHER OP REV - DIETARY - OUTSIDE SAL	B	-6,076	DIETARY		10.00
39.00 OTHER OP REV - PHARMACY	B	-313,830	PHARMACY		15.00
40.00 OTHER OP REV - WOMEN & CH UNIT - HLT	B	-29	ADULTS & PEDIATRICS		30.00
41.00 OTHER OP REV - PCU - HLTH PROG REC	B	-1,380	ADULTS & PEDIATRICS		30.00
42.00 OTHER OP REV - ATH TRAINING - HLTH P	B	-15,798	PHYSICAL THERAPY		66.00
43.00 OTHER OP REV - ATH TRAINING - OUTSID	B	-35,165	PHYSICAL THERAPY		66.00
44.00 OTHER OP REV - AQUATICS - HLTH PROG	B	-14,222	PHYSICAL THERAPY		66.00
45.00 OTHER OP REV - PHYSICAL THER - HLTH	B	-395	PHYSICAL THERAPY		66.00
45.01 OTHER OP REV - PHYSICAL THER - EE	B	-28,203	PHYSICAL THERAPY		66.00
45.02 OTHER OP REV - PHYSICAL THER - FIT F	B	-41,563	PHYSICAL THERAPY		66.00
45.03 PUBLIC RELATIONS	A	-1,512	ADMINISTRATIVE & GENERAL		5.00
45.04 AHA & IHA DUES	A	-6,650	ADMINISTRATIVE & GENERAL		5.00
45.05 BENEFIT EXPENSE	A	566,363	EMPLOYEE BENEFITS		4.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,805,528			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150030

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

Worksheet A-8

Date/Time Prepared:  
5/29/2012 8:55 pm

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	OTHER OP REV - HUMAN RESOURCEC - MIS	0	33.00
34.00	OTHER OP REV	0	34.00
35.00	OTHER OP REV - COPIES RECEIPTS	0	35.00
36.00	OTHER OP REV - PHY REAPP FEES	0	36.00
37.00	OTHER OP REV - DIETARY - MI SC DIETAR	0	37.00
38.00	OTHER OP REV - DIETARY - OUTSIDE SAL	0	38.00
39.00	OTHER OP REV - PHARMACY	0	39.00
40.00	OTHER OP REV - WOMEN & CH UNIT - HLT	0	40.00
41.00	OTHER OP REV - PCU - HLTH PROG REC	0	41.00
42.00	OTHER OP REV - ATH TRAINING - HLTH P	0	42.00
43.00	OTHER OP REV - ATH TRAINING - OUTSID	0	43.00
44.00	OTHER OP REV - AQUATICS - HLTH PROG	0	44.00
45.00	OTHER OP REV - PHYSICAL THER - HLTH	0	45.00
45.01	OTHER OP REV - PHYSICAL THER - EE	0	45.01
45.02	OTHER OP REV - PHYSICAL THER - FIT F	0	45.02
45.03	PUBLIC RELATIONS	0	45.03
45.04	AHA & IHA DUES	0	45.04
45.05	BENEFIT EXPENSE	0	45.05
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

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

Provider CCN: 150030

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

Worksheet A-8-1

Date/Time Prepared:  
5/29/2012 8:55 pm

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	5.00	ADMINISTRATIVE & GENERAL	ADMIN & GENERAL	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	XRAY	2.00
3.00	57.00	CT SCAN	CT SCAN	3.00
4.00	65.00	RESPIRATORY THERAPY	RESPIRATORY THERAPY	4.00
4.01	66.00	PHYSICAL THERAPY	PHYSICAL THERAPY	4.01
4.02	58.00	MAGNETIC RESONANCE IMAGING (MRI)	MRI	4.02
4.03	101.00	HOME HEALTH AGENCY	HOME HEALTH AGENCY	4.03
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5.00

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

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

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

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

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

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

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

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

Provider CCN: 150030

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

Worksheet A-8-1

Date/Time Prepared: 5/29/2012 8:55 pm

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>						
1.00	0	152,721	-152,721	0		1.00
2.00	3,093	32,274	-29,181	0		2.00
3.00	121,527	586,925	-465,398	0		3.00
4.00	29,813	36,822	-7,009	0		4.00
4.01	221,830	724,991	-503,161	0		4.01
4.02	139,940	450,000	-310,060	0		4.02
4.03	18,683	24,693	-6,010	0		4.03
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	534,886	2,008,426	-1,473,540		5.00

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

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150030

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

Worksheet A-8-2

Date/Time Prepared:  
5/29/2012 8:55 pm

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		60.00	LABORATORY	80,004	0	1.00
2.00		0.00		0	0	2.00
3.00		0.00		0	0	3.00
4.00		0.00		0	0	4.00
5.00		0.00		0	0	5.00
6.00		0.00		0	0	6.00
7.00		0.00		0	0	7.00
8.00		0.00		0	0	8.00
9.00		0.00		0	0	9.00
10.00		0.00		0	0	10.00
200.00				80,004	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150030

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

Worksheet A-8-2

Date/Time Prepared:  
5/29/2012 8:55 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	80,004	219,500	664	70,071	3,504	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	80,004		664	70,071	3,504	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150030

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

Worksheet A-8-2

Date/Time Prepared:  
5/29/2012 8:55 pm

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 16.00	
1.00	0	0	0	0	70,071	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	70,071	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150030

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

Worksheet A-8-2

Date/Time Prepared:  
5/29/2012 8:55 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	9,933	9,933	1.00
2.00	0	0	2.00
3.00	0	0	3.00
4.00	0	0	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	9,933	9,933	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150030

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2012 8:55 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 NEW CAP REL COSTS-BLDG & FIXT	4,520,011	4,520,011				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	656,812		656,812			2.00
4.00 EMPLOYEE BENEFITS	8,870,899	23,717	3,225	8,897,841		4.00
5.00 ADMINISTRATIVE & GENERAL	9,199,512	540,238	73,464	1,693,680	11,506,894	5.00
7.00 OPERATION OF PLANT	2,499,233	1,200,408	163,236	340,130	4,203,007	7.00
8.00 LAUNDRY & LINEN SERVICE	212,724	59,616	8,107	45,077	325,524	8.00
9.00 HOUSEKEEPING	652,692	37,711	5,128	162,732	858,263	9.00
10.00 DIETARY	478,104	125,784	17,105	106,859	727,852	10.00
11.00 CAFETERIA	125,567	34,365	4,673	102,377	266,982	11.00
13.00 NURSING ADMINISTRATION	1,544,740	57,263	7,787	509,224	2,119,014	13.00
14.00 CENTRAL SERVICES & SUPPLY	608,637	124,652	16,951	120,240	870,480	14.00
15.00 PHARMACY	2,510,047	27,220	3,701	0	2,540,968	15.00
16.00 MEDICAL RECORDS & LIBRARY	1,094,997	92,378	12,562	325,022	1,524,959	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	3,392,104	508,400	69,134	1,159,367	5,129,005	30.00
31.00 INTENSIVE CARE UNIT	1,146,133	202,165	27,491	392,206	1,767,995	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	516,897	53,464	7,270	175,640	753,271	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	2,716,125	283,599	38,565	733,578	3,771,867	50.00
52.00 DELIVERY ROOM & LABOR ROOM	75,643	27,168	3,694	25,703	132,208	52.00
54.00 RADIOLOGY-DIAGNOSTIC	2,214,374	206,556	28,088	597,604	3,046,622	54.00
57.00 CT SCAN	360,814	7,633	1,038	62,929	432,414	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	242,698	9,323	1,268	29,493	282,782	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	3,135,220	138,541	18,839	567,514	3,860,114	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	528,524	41,039	5,581	168,272	743,416	65.00
66.00 PHYSICAL THERAPY	1,180,316	19,256	2,619	374,736	1,576,927	66.00
68.00 SPEECH PATHOLOGY	62,026	3,363	457	22,267	88,113	68.00
69.00 ELECTROCARDIOLOGY	163,319	0	0	42,147	205,466	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	759,024	0	0	0	759,024	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	2,899,054	0	0	0	2,899,054	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 CARDIAC REHABILITATION	107,252	12,390	1,685	37,715	159,042	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 EMERGENCY	2,222,869	153,161	20,827	683,242	3,080,099	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00 HOME HEALTH AGENCY	567,482	0	0	172,443	739,925	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00 HOSPICE	566,809	0	0	116,829	683,638	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	55,830,658	3,989,410	542,495	8,767,026	55,054,925	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,583	0	0	17,583	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	245,009	85,494	11,626	52,723	394,852	192.00
194.00 MCH	0	0	0	0	0	194.00
194.01 RENTAL	52,263	0	44,555	0	96,818	194.01
194.02 CMHS	0	0	0	0	0	194.02
194.03 MCH	0	0	0	0	0	194.03
194.04 WIC	0	0	0	0	0	194.04
194.05 OTHER NONREIMBURSABLE COSTS	349,606	0	0	0	349,606	194.05
194.06 LIFELINE	0	0	0	0	0	194.06
194.07 PHILLIPS HALL	0	0	0	0	0	194.07
194.08 OB DRS	0	0	0	0	0	194.08
194.09 THE WATERS	354,412	427,524	58,136	78,092	918,164	194.09
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)	56,831,948	4,520,011	656,812	8,897,841	56,831,948	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150030

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2012 8:55 pm

Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
	5.00	7.00	8.00	9.00	10.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	EMPLOYEE BENEFITS					4.00	
5.00	ADMINISTRATIVE & GENERAL	11,506,894				5.00	
7.00	OPERATION OF PLANT	1,067,038	5,270,045			7.00	
8.00	LAUNDRY & LINEN SERVICE	82,642	140,872	549,038		8.00	
9.00	HOUSEKEEPING	217,892	89,111	24,112	1,189,378	9.00	
10.00	DIETARY	184,783	297,228	5,545	26,544	1,241,952	10.00
11.00	CAFETERIA	67,780	81,204	0	11,502	0	11.00
13.00	NURSING ADMINISTRATION	537,965	135,313	0	13,493	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	220,993	294,551	0	12,608	0	14.00
15.00	PHARMACY	645,088	64,321	0	6,857	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	387,149	218,288	0	8,627	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	1,302,123	1,201,346	132,281	351,040	1,058,704	30.00
31.00	INTENSIVE CARE UNIT	448,850	477,714	28,474	40,700	183,248	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	191,237	126,336	0	5,530	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	957,583	670,142	102,752	107,060	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	33,564	64,198	0	12,166	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	773,461	488,091	39,236	70,120	0	54.00
57.00	CT SCAN	109,779	18,036	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	71,791	22,031	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	979,986	327,370	1,072	31,631	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	188,735	96,976	0	19,244	0	65.00
66.00	PHYSICAL THERAPY	400,342	45,502	14,538	124,313	0	66.00
68.00	SPEECH PATHOLOGY	22,370	7,947	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	52,163	0	0	8,848	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	192,697	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	735,997	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	CARDIAC REHABILITATION	40,377	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	781,960	361,919	84,805	76,092	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	HOME HEALTH AGENCY	187,848	0	0	12,829	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00	HOSPICE	173,559	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	11,055,752	5,228,496	432,815	939,204	1,241,952	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,464	41,549	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	100,243	0	0	2,433	0	192.00
194.00	MCH	0	0	0	0	0	194.00
194.01	RENTAL	24,580	0	199	218,101	0	194.01
194.02	CMHS	0	0	0	0	0	194.02
194.03	MCH	0	0	0	0	0	194.03
194.04	WIC	0	0	0	0	0	194.04
194.05	OTHER NONREIMBURSABLE COSTS	88,756	0	16,726	0	0	194.05
194.06	LIFELINE	0	0	0	0	0	194.06
194.07	PHILLIPS HALL	0	0	1,602	29,640	0	194.07
194.08	OB DRS	0	0	9,159	0	0	194.08
194.09	THE WATERS	233,099	0	88,537	0	0	194.09
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)	11,506,894	5,270,045	549,038	1,189,378	1,241,952	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150030

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2012 8:55 pm

Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA	427,468					11.00
13.00 NURSING ADMINISTRATION	23,701	2,829,486				13.00
14.00 CENTRAL SERVICES & SUPPLY	10,839	0	1,409,471			14.00
15.00 PHARMACY	0	0	2,971	3,260,205		15.00
16.00 MEDICAL RECORDS & LIBRARY	27,932	0	625	0	2,167,580	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	89,101	1,042,923	44,648	0	366,890	30.00
31.00 INTENSIVE CARE UNIT	25,031	292,985	13,051	0	164,876	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	10,627	124,382	0	0	44,455	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	55,850	653,710	120,825	0	517,136	50.00
52.00 DELIVERY ROOM & LABOR ROOM	1,556	18,218	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	43,384	0	69,576	0	174,442	54.00
57.00 CT SCAN	3,778	0	13,638	0	54,021	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	2,038	0	4,511	0	32,637	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	46,327	0	175,312	0	231,276	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	11,518	134,816	1,491	0	23,634	65.00
66.00 PHYSICAL THERAPY	6,622	0	7,147	0	18,007	66.00
68.00 SPEECH PATHOLOGY	17,503	0	24	0	563	68.00
69.00 ELECTROCARDIOLOGY	3,608	0	1,955	0	25,885	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	74,278	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	911,599	0	59,648	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	3,260,205	0	73.00
76.00 CARDIAC REHABILITATION	2,943	34,449	336	0	1,688	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 EMERGENCY	45,110	528,003	39,259	0	361,263	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00 HOME HEALTH AGENCY	0	0	1,704	0	7,315	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 INTEREST EXPENSE						113.00
114.00 UTILIZATION REVIEW-SNF						114.00
116.00 HOSPICE	0	0	799	0	9,566	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	427,468	2,829,486	1,409,471	3,260,205	2,167,580	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 MCH	0	0	0	0	0	194.00
194.01 RENTAL	0	0	0	0	0	194.01
194.02 CMHS	0	0	0	0	0	194.02
194.03 MCH	0	0	0	0	0	194.03
194.04 WIC	0	0	0	0	0	194.04
194.05 OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	194.05
194.06 LI FELINE	0	0	0	0	0	194.06
194.07 PHILLIPS HALL	0	0	0	0	0	194.07
194.08 OB DRS	0	0	0	0	0	194.08
194.09 THE WATERS	0	0	0	0	0	194.09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	427,468	2,829,486	1,409,471	3,260,205	2,167,580	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150030

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/29/2012 8:55 pm

Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00 EMPLOYEE BENEFITS				4.00
5.00 ADMINISTRATIVE & GENERAL				5.00
7.00 OPERATION OF PLANT				7.00
8.00 LAUNDRY & LINEN SERVICE				8.00
9.00 HOUSEKEEPING				9.00
10.00 DIETARY				10.00
11.00 CAFETERIA				11.00
13.00 NURSING ADMINISTRATION				13.00
14.00 CENTRAL SERVICES & SUPPLY				14.00
15.00 PHARMACY				15.00
16.00 MEDICAL RECORDS & LIBRARY				16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00 ADULTS & PEDIATRICS	10,718,061	0	10,718,061	30.00
31.00 INTENSIVE CARE UNIT	3,442,924	0	3,442,924	31.00
41.00 SUBPROVIDER - IRF	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	42.00
43.00 NURSERY	1,255,838	0	1,255,838	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 OPERATING ROOM	6,956,925	0	6,956,925	50.00
52.00 DELIVERY ROOM & LABOR ROOM	261,910	0	261,910	52.00
54.00 RADIOLOGY-DIAGNOSTIC	4,704,932	0	4,704,932	54.00
57.00 CT SCAN	631,666	0	631,666	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	415,790	0	415,790	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 LABORATORY	5,653,088	0	5,653,088	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
65.00 RESPIRATORY THERAPY	1,219,830	0	1,219,830	65.00
66.00 PHYSICAL THERAPY	2,193,398	0	2,193,398	66.00
68.00 SPEECH PATHOLOGY	136,520	0	136,520	68.00
69.00 ELECTROCARDIOLOGY	297,925	0	297,925	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,025,999	0	1,025,999	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	4,606,298	0	4,606,298	72.00
73.00 DRUGS CHARGED TO PATIENTS	3,260,205	0	3,260,205	73.00
76.00 CARDIAC REHABILITATION	238,835	0	238,835	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00 EMERGENCY	5,358,510	0	5,358,510	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
101.00 HOME HEALTH AGENCY	949,621	0	949,621	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00 INTEREST EXPENSE				113.00
114.00 UTILIZATION REVIEW-SNF				114.00
116.00 HOSPICE	867,562	0	867,562	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	54,195,837	0	54,195,837	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	63,596	0	63,596	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	497,528	0	497,528	192.00
194.00 MCH	0	0	0	194.00
194.01 RENTAL	339,698	0	339,698	194.01
194.02 CMHS	0	0	0	194.02
194.03 MCH	0	0	0	194.03
194.04 WIC	0	0	0	194.04
194.05 OTHER NONREIMBURSABLE COSTS	455,088	0	455,088	194.05
194.06 LIFELINE	0	0	0	194.06
194.07 PHILLIPS HALL	31,242	0	31,242	194.07
194.08 OB DRS	9,159	0	9,159	194.08
194.09 THE WATERS	1,239,800	0	1,239,800	194.09
200.00 Cross Foot Adjustments	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	56,831,948	0	56,831,948	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150030

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

Worksheet B  
Part II  
Date/Time Prepared:  
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	0	23,717	3,225	26,942	26,942 4.00
5.00	ADMINISTRATIVE & GENERAL	0	540,238	73,464	613,702	5,130 5.00
7.00	OPERATION OF PLANT	0	1,200,408	163,236	1,363,644	1,030 7.00
8.00	LAUNDRY & LINEN SERVICE	0	59,616	8,107	67,723	136 8.00
9.00	HOUSEKEEPING	0	37,711	5,128	42,839	493 9.00
10.00	DIETARY	0	125,784	17,105	142,889	324 10.00
11.00	CAFETERIA	0	34,365	4,673	39,038	310 11.00
13.00	NURSING ADMINISTRATION	0	57,263	7,787	65,050	1,542 13.00
14.00	CENTRAL SERVICES & SUPPLY	0	124,652	16,951	141,603	364 14.00
15.00	PHARMACY	0	27,220	3,701	30,921	0 15.00
16.00	MEDICAL RECORDS & LIBRARY	0	92,378	12,562	104,940	984 16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS	0	508,400	69,134	577,534	3,510 30.00
31.00	INTENSIVE CARE UNIT	0	202,165	27,491	229,656	1,187 31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0 41.00
42.00	SUBPROVIDER	0	0	0	0	0 42.00
43.00	NURSERY	0	53,464	7,270	60,734	532 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	0	283,599	38,565	322,164	2,221 50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	27,168	3,694	30,862	78 52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	206,556	28,088	234,644	1,809 54.00
57.00	CT SCAN	0	7,633	1,038	8,671	191 57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	9,323	1,268	10,591	89 58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00	LABORATORY	0	138,541	18,839	157,380	1,718 60.00
60.01	BLOOD LABORATORY	0	0	0	0	0 60.01
65.00	RESPIRATORY THERAPY	0	41,039	5,581	46,620	509 65.00
66.00	PHYSICAL THERAPY	0	19,256	2,619	21,875	1,135 66.00
68.00	SPEECH PATHOLOGY	0	3,363	457	3,820	67 68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	128 69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00	CARDIAC REHABILITATION	0	12,390	1,685	14,075	114 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
91.00	EMERGENCY	0	153,161	20,827	173,988	2,069 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	HOME HEALTH AGENCY	0	0	0	0	522 101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	INTEREST EXPENSE					113.00
114.00	UTILIZATION REVIEW-SNF					114.00
116.00	HOSPICE	0	0	0	0	354 116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	3,989,410	542,495	4,531,905	26,546 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,583	0	17,583	0 190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	85,494	11,626	97,120	160 192.00
194.00	MCH	0	0	0	0	0 194.00
194.01	RENTAL	0	0	44,555	44,555	0 194.01
194.02	CMHS	0	0	0	0	0 194.02
194.03	MCH	0	0	0	0	0 194.03
194.04	WIC	0	0	0	0	0 194.04
194.05	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0 194.05
194.06	LIFELINE	0	0	0	0	0 194.06
194.07	PHILLIPS HALL	0	0	0	0	0 194.07
194.08	OB DRS	0	0	0	0	0 194.08
194.09	THE WATERS	0	427,524	58,136	485,660	236 194.09
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	TOTAL (sum lines 118-201)	0	4,520,011	656,812	5,176,823	26,942 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150030		Period: From 01/01/2011 To 12/31/2011		Worksheet B Part II Date/Time Prepared: 5/29/2012 8:55 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	618,832					5.00
7.00	OPERATION OF PLANT	57,384	1,422,058				7.00
8.00	LAUNDRY & LINEN SERVICE	4,444	38,013	110,316			8.00
9.00	HOUSEKEEPING	11,718	24,045	4,845	83,940		9.00
10.00	DIETARY	9,937	80,203	1,114	1,873	236,340	10.00
11.00	CAFETERIA	3,645	21,912	0	812	0	11.00
13.00	NURSING ADMINISTRATION	28,931	36,513	0	952	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	11,885	79,481	0	890	0	14.00
15.00	PHARMACY	34,692	17,356	0	484	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	20,820	58,902	0	609	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	70,035	324,168	26,578	24,776	201,468	30.00
31.00	INTENSIVE CARE UNIT	24,138	128,905	5,721	2,872	34,872	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	10,284	34,090	0	390	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	51,497	180,830	20,646	7,556	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	1,805	17,323	0	859	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	41,596	131,705	7,884	4,949	0	54.00
57.00	CT SCAN	5,904	4,867	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	3,861	5,945	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	52,702	88,337	215	2,232	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	10,150	26,168	0	1,358	0	65.00
66.00	PHYSICAL THERAPY	21,530	12,278	2,921	8,773	0	66.00
68.00	SPEECH PATHOLOGY	1,203	2,145	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	2,805	0	0	624	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,363	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	39,581	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	CARDIAC REHABILITATION	2,171	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	42,053	97,660	17,040	5,370	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	HOME HEALTH AGENCY	10,102	0	0	905	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	INTEREST EXPENSE						113.00
114.00	UTILIZATION REVIEW-SNF						114.00
116.00	HOSPICE	9,334	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	594,570	1,410,846	86,964	66,284	236,340	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	240	11,212	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	5,391	0	0	172	0	192.00
194.00	MCH	0	0	0	0	0	194.00
194.01	RENTAL	1,322	0	40	15,392	0	194.01
194.02	CMHS	0	0	0	0	0	194.02
194.03	MCH	0	0	0	0	0	194.03
194.04	WIC	0	0	0	0	0	194.04
194.05	OTHER NONREIMBURSABLE COSTS	4,773	0	3,361	0	0	194.05
194.06	LIFELINE	0	0	0	0	0	194.06
194.07	PHILLIPS HALL	0	0	322	2,092	0	194.07
194.08	OB DRS	0	0	1,840	0	0	194.08
194.09	THE WATERS	12,536	0	17,789	0	0	194.09
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	618,832	1,422,058	110,316	83,940	236,340	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150030		Period: From 01/01/2011 To 12/31/2011		Worksheet B Part II Date/Time Prepared: 5/29/2012 8:55 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	65,717					11.00
13.00	NURSING ADMINISTRATION	3,644	136,632				13.00
14.00	CENTRAL SERVICES & SUPPLY	1,666	0	235,889			14.00
15.00	PHARMACY	0	0	497	83,950		15.00
16.00	MEDICAL RECORDS & LIBRARY	4,294	0	105	0	190,654	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	13,698	50,360	7,472	0	32,271	30.00
31.00	INTENSIVE CARE UNIT	3,848	14,148	2,184	0	14,502	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	1,634	6,006	0	0	3,910	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	8,586	31,567	20,221	0	45,487	50.00
52.00	DELIVERY ROOM & LABOR ROOM	239	880	0	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	6,670	0	11,644	0	15,343	54.00
57.00	CT SCAN	581	0	2,282	0	4,752	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	313	0	755	0	2,871	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	7,122	0	29,340	0	20,342	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	1,771	6,510	250	0	2,079	65.00
66.00	PHYSICAL THERAPY	1,018	0	1,196	0	1,584	66.00
68.00	SPEECH PATHOLOGY	2,691	0	4	0	49	68.00
69.00	ELECTROCARDIOLOGY	555	0	327	0	2,277	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	6,533	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	152,567	0	5,246	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	83,950	0	73.00
76.00	CARDIAC REHABILITATION	452	1,664	56	0	148	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	EMERGENCY	6,935	25,497	6,570	0	31,776	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	HOME HEALTH AGENCY	0	0	285	0	643	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	INTEREST EXPENSE						113.00
114.00	UTILIZATION REVIEW-SNF						114.00
116.00	HOSPICE	0	0	134	0	841	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	65,717	136,632	235,889	83,950	190,654	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	MCH	0	0	0	0	0	194.00
194.01	RENTAL	0	0	0	0	0	194.01
194.02	CMHS	0	0	0	0	0	194.02
194.03	MCH	0	0	0	0	0	194.03
194.04	WIC	0	0	0	0	0	194.04
194.05	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	194.05
194.06	LIFELINE	0	0	0	0	0	194.06
194.07	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	OB DRS	0	0	0	0	0	194.08
194.09	THE WATERS	0	0	0	0	0	194.09
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	65,717	136,632	235,889	83,950	190,654	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet B Part II Date/Time Prepared: 5/29/2012 8:55 pm
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Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00 EMPLOYEE BENEFITS				4.00
5.00 ADMINISTRATIVE & GENERAL				5.00
7.00 OPERATION OF PLANT				7.00
8.00 LAUNDRY & LINEN SERVICE				8.00
9.00 HOUSEKEEPING				9.00
10.00 DIETARY				10.00
11.00 CAFETERIA				11.00
13.00 NURSING ADMINISTRATION				13.00
14.00 CENTRAL SERVICES & SUPPLY				14.00
15.00 PHARMACY				15.00
16.00 MEDICAL RECORDS & LIBRARY				16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00 ADULTS & PEDIATRICS	1,331,870	0	1,331,870	30.00
31.00 INTENSIVE CARE UNIT	462,033	0	462,033	31.00
41.00 SUBPROVIDER - IRF	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	42.00
43.00 NURSERY	117,580	0	117,580	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 OPERATING ROOM	690,775	0	690,775	50.00
52.00 DELIVERY ROOM & LABOR ROOM	52,046	0	52,046	52.00
54.00 RADIOLOGY-DIAGNOSTIC	456,244	0	456,244	54.00
57.00 CT SCAN	27,248	0	27,248	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	24,425	0	24,425	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 LABORATORY	359,388	0	359,388	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
65.00 RESPIRATORY THERAPY	95,415	0	95,415	65.00
66.00 PHYSICAL THERAPY	72,310	0	72,310	66.00
68.00 SPEECH PATHOLOGY	9,979	0	9,979	68.00
69.00 ELECTROCARDIOLOGY	6,716	0	6,716	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	16,896	0	16,896	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	197,394	0	197,394	72.00
73.00 DRUGS CHARGED TO PATIENTS	83,950	0	83,950	73.00
76.00 CARDIAC REHABILITATION	18,680	0	18,680	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00 EMERGENCY	408,958	0	408,958	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
101.00 HOME HEALTH AGENCY	12,457	0	12,457	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00 INTEREST EXPENSE				113.00
114.00 UTILIZATION REVIEW-SNF				114.00
116.00 HOSPICE	10,663	0	10,663	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	4,455,027	0	4,455,027	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	29,035	0	29,035	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	102,843	0	102,843	192.00
194.00 MCH	0	0	0	194.00
194.01 RENTAL	61,309	0	61,309	194.01
194.02 CMHS	0	0	0	194.02
194.03 MCH	0	0	0	194.03
194.04 WIC	0	0	0	194.04
194.05 OTHER NONREIMBURSABLE COSTS	8,134	0	8,134	194.05
194.06 LIFELINE	0	0	0	194.06
194.07 PHILLIPS HALL	2,414	0	2,414	194.07
194.08 OB DRS	1,840	0	1,840	194.08
194.09 THE WATERS	516,221	0	516,221	194.09
200.00 Cross Foot Adjustments	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	5,176,823	0	5,176,823	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150030

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

Worksheet B-1  
Date/Time Prepared: 5/29/2012 8:55 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 NEW CAP REL COSTS-BLDG & FIXT	259,376						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		277,169					2.00
4.00 EMPLOYEE BENEFITS	1,361	1,361	23,163,678				4.00
5.00 ADMINISTRATIVE & GENERAL	31,001	31,001	4,409,147	-11,506,894	45,325,054		5.00
7.00 OPERATION OF PLANT	68,884	68,884	885,457	0	4,203,007		7.00
8.00 LAUNDRY & LINEN SERVICE	3,421	3,421	117,348	0	325,524		8.00
9.00 HOUSEKEEPING	2,164	2,164	423,639	0	858,263		9.00
10.00 DIETARY	7,218	7,218	278,185	0	727,852		10.00
11.00 CAFETERIA	1,972	1,972	266,516	0	266,982		11.00
13.00 NURSING ADMINISTRATION	3,286	3,286	1,325,660	0	2,119,014		13.00
14.00 CENTRAL SERVICES & SUPPLY	7,153	7,153	313,019	0	870,480		14.00
15.00 PHARMACY	1,562	1,562	0	0	2,540,968		15.00
16.00 MEDICAL RECORDS & LIBRARY	5,301	5,301	846,126	0	1,524,959		16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 ADULTS & PEDIATRICS	29,174	29,174	3,018,171	0	5,129,005		30.00
31.00 INTENSIVE CARE UNIT	11,601	11,601	1,021,026	0	1,767,995		31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0		41.00
42.00 SUBPROVIDER	0	0	0	0	0		42.00
43.00 NURSERY	3,068	3,068	457,242	0	753,271		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 OPERATING ROOM	16,274	16,274	1,909,717	0	3,771,867		50.00
52.00 DELIVERY ROOM & LABOR ROOM	1,559	1,559	66,913	0	132,208		52.00
54.00 RADIOLOGY-DIAGNOSTIC	11,853	11,853	1,555,737	0	3,046,622		54.00
57.00 CT SCAN	438	438	163,822	0	432,414		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	535	535	76,779	0	282,782		58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0		59.00
60.00 LABORATORY	7,950	7,950	1,477,405	0	3,860,114		60.00
60.01 BLOOD LABORATORY	0	0	0	0	0		60.01
65.00 RESPIRATORY THERAPY	2,355	2,355	438,060	0	743,416		65.00
66.00 PHYSICAL THERAPY	1,105	1,105	975,547	0	1,576,927		66.00
68.00 SPEECH PATHOLOGY	193	193	57,968	0	88,113		68.00
69.00 ELECTROCARDIOLOGY	0	0	109,722	0	205,466		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	759,024		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	2,899,054		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0		73.00
76.00 CARDIAC REHABILITATION	711	711	98,184	0	159,042		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 RURAL HEALTH CLINIC	0	0	0	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0		89.00
91.00 EMERGENCY	8,789	8,789	1,778,679	0	3,080,099		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)							92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00 HOME HEALTH AGENCY	0	0	448,919	0	739,925		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00 INTEREST EXPENSE							113.00
114.00 UTILIZATION REVIEW-SNF							114.00
116.00 HOSPICE	0	0	304,139	0	683,638		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	228,928	228,928	22,823,127	-11,506,894	43,548,031		118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,009	0	0	0	17,583		190.00
192.00 PHYSICIANS' PRIVATE OFFICES	4,906	4,906	137,254	0	394,852		192.00
194.00 MCH	0	0	0	0	0		194.00
194.01 RENTAL	0	18,802	0	0	96,818		194.01
194.02 CMHS	0	0	0	0	0		194.02
194.03 MCH	0	0	0	0	0		194.03
194.04 WIC	0	0	0	0	0		194.04
194.05 OTHER NONREIMBURSABLE COSTS	0	0	0	0	349,606		194.05
194.06 LIFELINE	0	0	0	0	0		194.06
194.07 PHILLIPS HALL	0	0	0	0	0		194.07
194.08 OB DRS	0	0	0	0	0		194.08
194.09 THE WATERS	24,533	24,533	203,297	0	918,164		194.09
200.00 Cross Foot Adjustments							200.00
201.00 Negative Cost Centers							201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	4,520,011	656,812	8,897,841		11,506,894		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	17.426481	2.369717	0.384129		0.253875		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			26,942		618,832		204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.001163		0.013653		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150030

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

Worksheet B-1  
Date/Time Prepared:  
5/29/2012 8:55 pm

Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	
	7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT	127,980					7.00
8.00 LAUNDRY & LINEN SERVICE	3,421	653,061				8.00
9.00 HOUSEKEEPING	2,164	28,680	5,377			9.00
10.00 DIETARY	7,218	6,595	120	10,688		10.00
11.00 CAFETERIA	1,972	0	52	0	30,210	11.00
13.00 NURSING ADMINISTRATION	3,286	0	61	0	1,675	13.00
14.00 CENTRAL SERVICES & SUPPLY	7,153	0	57	0	766	14.00
15.00 PHARMACY	1,562	0	31	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	5,301	0	39	0	1,974	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	29,174	157,344	1,587	9,111	6,297	30.00
31.00 INTENSIVE CARE UNIT	11,601	33,869	184	1,577	1,769	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	3,068	0	25	0	751	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	16,274	122,220	484	0	3,947	50.00
52.00 DELIVERY ROOM & LABOR ROOM	1,559	0	55	0	110	52.00
54.00 RADIOLOGY-DIAGNOSTIC	11,853	46,670	317	0	3,066	54.00
57.00 CT SCAN	438	0	0	0	267	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	535	0	0	0	144	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	7,950	1,275	143	0	3,274	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	2,355	0	87	0	814	65.00
66.00 PHYSICAL THERAPY	1,105	17,292	562	0	468	66.00
68.00 SPEECH PATHOLOGY	193	0	0	0	1,237	68.00
69.00 ELECTROCARDIOLOGY	0	0	40	0	255	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 CARDIAC REHABILITATION	0	0	0	0	208	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 EMERGENCY	8,789	100,873	344	0	3,188	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00 HOME HEALTH AGENCY	0	0	58	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 INTEREST EXPENSE						113.00
114.00 UTILIZATION REVIEW-SNF						114.00
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	126,971	514,818	4,246	10,688	30,210	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,009	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	11	0	0	192.00
194.00 MCH	0	0	0	0	0	194.00
194.01 RENTAL	0	237	986	0	0	194.01
194.02 CMHS	0	0	0	0	0	194.02
194.03 MCH	0	0	0	0	0	194.03
194.04 WIC	0	0	0	0	0	194.04
194.05 OTHER NONREIMBURSABLE COSTS	0	19,895	0	0	0	194.05
194.06 LI FELINE	0	0	0	0	0	194.06
194.07 PHILLIPS HALL	0	1,905	134	0	0	194.07
194.08 OB DRS	0	10,894	0	0	0	194.08
194.09 THE WATERS	0	105,312	0	0	0	194.09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	5,270,045	549,038	1,189,378	1,241,952	427,468	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	41.178661	0.840715	221.197322	116.200599	14.149884	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	1,422,058	110,316	83,940	236,340	65,717	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	11.111564	0.168921	15.610935	22.112650	2.175339	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150030

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

Worksheet B-1

Date/Time Prepared:  
5/29/2012 8:55 pm

Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
	(DIRECT NRSING HRS)				
	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 EMPLOYEE BENEFITS					4.00
5.00 ADMINISTRATIVE & GENERAL					5.00
7.00 OPERATION OF PLANT					7.00
8.00 LAUNDRY & LINEN SERVICE					8.00
9.00 HOUSEKEEPING					9.00
10.00 DIETARY					10.00
11.00 CAFETERIA					11.00
13.00 NURSING ADMINISTRATION	17,084				13.00
14.00 CENTRAL SERVICES & SUPPLY	0	5,655,941			14.00
15.00 PHARMACY	0	11,922	100		15.00
16.00 MEDICAL RECORDS & LIBRARY	0	2,510	0	3,852	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00 ADULTS & PEDIATRICS	6,297	179,163	0	652	30.00
31.00 INTENSIVE CARE UNIT	1,769	52,370	0	293	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	42.00
43.00 NURSERY	751	0	0	79	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 OPERATING ROOM	3,947	484,846	0	919	50.00
52.00 DELIVERY ROOM & LABOR ROOM	110	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	279,195	0	310	54.00
57.00 CT SCAN	0	54,728	0	96	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	18,102	0	58	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 LABORATORY	0	703,492	0	411	60.00
60.01 BLOOD LABORATORY	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	814	5,984	0	42	65.00
66.00 PHYSICAL THERAPY	0	28,679	0	32	66.00
68.00 SPEECH PATHOLOGY	0	96	0	1	68.00
69.00 ELECTROCARDIOLOGY	0	7,847	0	46	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	132	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	3,658,078	0	106	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	100	0	73.00
76.00 CARDIAC REHABILITATION	208	1,349	0	3	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00 EMERGENCY	3,188	157,539	0	642	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00 HOME HEALTH AGENCY	0	6,836	0	13	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00 INTEREST EXPENSE					113.00
114.00 UTILIZATION REVIEW-SNF					114.00
116.00 HOSPICE	0	3,205	0	17	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	17,084	5,655,941	100	3,852	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 MCH	0	0	0	0	194.00
194.01 RENTAL	0	0	0	0	194.01
194.02 CMHS	0	0	0	0	194.02
194.03 MCH	0	0	0	0	194.03
194.04 WIC	0	0	0	0	194.04
194.05 OTHER NONREIMBURSABLE COSTS	0	0	0	0	194.05
194.06 LIFELINE	0	0	0	0	194.06
194.07 PHILLIPS HALL	0	0	0	0	194.07
194.08 OB DRS	0	0	0	0	194.08
194.09 THE WATERS	0	0	0	0	194.09
200.00 Cross Foot Adjustments					200.00
201.00 Negative Cost Centers					201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	2,829,486	1,409,471	3,260,205	2,167,580	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	165.621985	0.249202	32,602.050000	562.715472	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	136,632	235,889	83,950	190,654	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	7.997659	0.041706	839.500000	49.494808	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/29/2012 8:55 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS		10,718,061	0	10,718,061	30.00
31.00	INTENSIVE CARE UNIT		3,442,924	0	3,442,924	31.00
41.00	SUBPROVIDER - IRF		0	0	0	41.00
42.00	SUBPROVIDER		0	0	0	42.00
43.00	NURSERY		1,255,838	0	1,255,838	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM		6,956,925	0	6,956,925	50.00
52.00	DELIVERY ROOM & LABOR ROOM		261,910	0	261,910	52.00
54.00	RADIOLOGY-DIAGNOSTIC		4,704,932	0	4,704,932	54.00
57.00	CT SCAN		631,666	0	631,666	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)		415,790	0	415,790	58.00
59.00	CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	LABORATORY		5,653,088	9,933	5,663,021	60.00
60.01	BLOOD LABORATORY		0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	1,219,830	0	1,219,830	65.00
66.00	PHYSICAL THERAPY	0	2,193,398	0	2,193,398	66.00
68.00	SPEECH PATHOLOGY	0	136,520	0	136,520	68.00
69.00	ELECTROCARDIOLOGY		297,925	0	297,925	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		1,025,999	0	1,025,999	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT		4,606,298	0	4,606,298	72.00
73.00	DRUGS CHARGED TO PATIENTS		3,260,205	0	3,260,205	73.00
76.00	CARDIAC REHABILITATION		238,835	0	238,835	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	RURAL HEALTH CLINIC		0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
91.00	EMERGENCY		5,358,510	0	5,358,510	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		1,126,315	0	1,126,315	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	HOME HEALTH AGENCY		949,621	0	949,621	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	INTEREST EXPENSE					113.00
114.00	UTILIZATION REVIEW-SNF					114.00
116.00	HOSPICE		867,562		867,562	116.00
200.00	Subtotal (see instructions)		55,322,152	9,933	55,332,085	200.00
201.00	Less Observation Beds		1,126,315		1,126,315	201.00
202.00	Total (see instructions)		54,195,837	9,933	54,205,770	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/29/2012 8:55 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
9.00	10.00					
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS	10,189,831		10,189,831		30.00
31.00	INTENSIVE CARE UNIT	3,564,319		3,564,319		31.00
41.00	SUBPROVIDER - IRF	0		0		41.00
42.00	SUBPROVIDER	0		0		42.00
43.00	NURSERY	645,060		645,060		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	4,621,473	15,130,127	19,751,600	0.352221	50.00
52.00	DELIVERY ROOM & LABOR ROOM	553,917	634,558	1,188,475	0.220375	52.00
54.00	RADIOLOGY-DIAGNOSTIC	1,457,969	16,488,562	17,946,531	0.262164	54.00
57.00	CT SCAN	1,454,897	14,277,166	15,732,063	0.040152	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	179,907	4,894,433	5,074,340	0.081940	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	LABORATORY	4,247,519	15,550,905	19,798,424	0.285532	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	RESPIRATORY THERAPY	2,214,506	1,448,482	3,662,988	0.333015	65.00
66.00	PHYSICAL THERAPY	555,759	2,252,325	2,808,084	0.781101	66.00
68.00	SPEECH PATHOLOGY	17,332	82,839	100,171	1.362869	68.00
69.00	ELECTROCARDIOLOGY	804,232	3,230,654	4,034,886	0.073837	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,439,052	7,090,755	11,529,807	0.088987	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	7,466,995	1,838,969	9,305,964	0.494983	72.00
73.00	DRUGS CHARGED TO PATIENTS	13,711,948	7,161,984	20,873,932	0.156185	73.00
76.00	CARDIAC REHABILITATION	1,323	296,023	297,346	0.803223	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	EMERGENCY	525,000	10,109,773	10,634,773	0.503867	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	456,501	993,883	1,450,384	0.776563	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	HOME HEALTH AGENCY	0	1,145,846	1,145,846		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	INTEREST EXPENSE					113.00
114.00	UTILIZATION REVIEW-SNF					114.00
116.00	HOSPICE	0	1,462,677	1,462,677		116.00
200.00	Subtotal (see instructions)	57,107,540	104,089,961	161,197,501		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	57,107,540	104,089,961	161,197,501		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/29/2012 8:55 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS		30.00
31.00	INTENSIVE CARE UNIT		31.00
41.00	SUBPROVIDER - IRF		41.00
42.00	SUBPROVIDER		42.00
43.00	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	0.352221	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.220375	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.262164	54.00
57.00	CT SCAN	0.040152	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.081940	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	LABORATORY	0.286034	60.00
60.01	BLOOD LABORATORY	0.000000	60.01
65.00	RESPIRATORY THERAPY	0.333015	65.00
66.00	PHYSICAL THERAPY	0.781101	66.00
68.00	SPEECH PATHOLOGY	1.362869	68.00
69.00	ELECTROCARDIOLOGY	0.073837	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.088987	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.494983	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.156185	73.00
76.00	CARDIAC REHABILITATION	0.803223	76.00
OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER		89.00
91.00	EMERGENCY	0.503867	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.776563	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	HOME HEALTH AGENCY		101.00
SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE		113.00
114.00	UTILIZATION REVIEW-SNF		114.00
116.00	HOSPICE		116.00
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/29/2012 8:55 pm
		Title XIX	Hospital	Cost

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS		10,718,061	0	0	30.00
31.00	INTENSIVE CARE UNIT		3,442,924	0	0	31.00
41.00	SUBPROVIDER - IRF		0	0	0	41.00
42.00	SUBPROVIDER		0	0	0	42.00
43.00	NURSERY		1,255,838	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM		6,956,925	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM		261,910	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC		4,704,932	0	0	54.00
57.00	CT SCAN		631,666	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)		415,790	0	0	58.00
59.00	CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	LABORATORY		5,653,088	0	0	60.00
60.01	BLOOD LABORATORY		0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	1,219,830	0	0	65.00
66.00	PHYSICAL THERAPY	0	2,193,398	0	0	66.00
68.00	SPEECH PATHOLOGY	0	136,520	0	0	68.00
69.00	ELECTROCARDIOLOGY		297,925	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		1,025,999	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT		4,606,298	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS		3,260,205	0	0	73.00
76.00	CARDIAC REHABILITATION		238,835	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	RURAL HEALTH CLINIC		0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
91.00	EMERGENCY		5,358,510	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		1,126,315	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	HOME HEALTH AGENCY		949,621			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	INTEREST EXPENSE					113.00
114.00	UTILIZATION REVIEW-SNF					114.00
116.00	HOSPICE		867,562			116.00
200.00	Subtotal (see instructions)	0	55,322,152	0	0	200.00
201.00	Less Observation Beds		1,126,315			201.00
202.00	Total (see instructions)	0	54,195,837	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/29/2012 8:55 pm
		Title XIX	Hospital	Cost

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
9.00	10.00					
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS	10,189,831		10,189,831		30.00
31.00	INTENSIVE CARE UNIT	3,564,319		3,564,319		31.00
41.00	SUBPROVIDER - IRF	0		0		41.00
42.00	SUBPROVIDER	0		0		42.00
43.00	NURSERY	645,060		645,060		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	4,621,473	15,130,127	19,751,600	0.352221	50.00
52.00	DELIVERY ROOM & LABOR ROOM	553,917	634,558	1,188,475	0.220375	52.00
54.00	RADIOLOGY-DIAGNOSTIC	1,457,969	16,488,562	17,946,531	0.262164	54.00
57.00	CT SCAN	1,454,897	14,277,166	15,732,063	0.040152	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	179,907	4,894,433	5,074,340	0.081940	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	LABORATORY	4,247,519	15,550,905	19,798,424	0.285532	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	RESPIRATORY THERAPY	2,214,506	1,448,482	3,662,988	0.333015	65.00
66.00	PHYSICAL THERAPY	555,759	2,252,325	2,808,084	0.781101	66.00
68.00	SPEECH PATHOLOGY	17,332	82,839	100,171	1.362869	68.00
69.00	ELECTROCARDIOLOGY	804,232	3,230,654	4,034,886	0.073837	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,439,052	7,090,755	11,529,807	0.088987	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	7,466,995	1,838,969	9,305,964	0.494983	72.00
73.00	DRUGS CHARGED TO PATIENTS	13,711,948	7,161,984	20,873,932	0.156185	73.00
76.00	CARDIAC REHABILITATION	1,323	296,023	297,346	0.803223	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
91.00	EMERGENCY	525,000	10,109,773	10,634,773	0.503867	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	456,501	993,883	1,450,384	0.776563	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	HOME HEALTH AGENCY	0	1,145,846	1,145,846		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	INTEREST EXPENSE					113.00
114.00	UTILIZATION REVIEW-SNF					114.00
116.00	HOSPICE	0	1,462,677	1,462,677		116.00
200.00	Subtotal (see instructions)	57,107,540	104,089,961	161,197,501		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	57,107,540	104,089,961	161,197,501		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/29/2012 8:55 pm
		Title XIX	Hospital	Cost

Cost Center Description	PPS Inpatient Ratio		
	11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00 ADULTS & PEDIATRICS			30.00
31.00 INTENSIVE CARE UNIT			31.00
41.00 SUBPROVIDER - IRF			41.00
42.00 SUBPROVIDER			42.00
43.00 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 OPERATING ROOM	0.000000		50.00
52.00 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00 CT SCAN	0.000000		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00 CARDIAC CATHETERIZATION	0.000000		59.00
60.00 LABORATORY	0.000000		60.00
60.01 BLOOD LABORATORY	0.000000		60.01
65.00 RESPIRATORY THERAPY	0.000000		65.00
66.00 PHYSICAL THERAPY	0.000000		66.00
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
76.00 CARDIAC REHABILITATION	0.000000		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00 RURAL HEALTH CLINIC	0.000000		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
91.00 EMERGENCY	0.000000		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
101.00 HOME HEALTH AGENCY			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00 INTEREST EXPENSE			113.00
114.00 UTILIZATION REVIEW-SNF			114.00
116.00 HOSPICE			116.00
200.00 Subtotal (see instructions)			200.00
201.00 Less Observation Beds			201.00
202.00 Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150030		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part I Date/Time Prepared: 5/29/2012 8:55 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,331,870	0	1,331,870	10,068	132.29	30.00
31.00	INTENSIVE CARE UNIT	462,033		462,033	1,577	292.98	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	117,580		117,580	816	144.09	43.00
200.00	Total (Lines 30-199)	1,911,483		1,911,483	12,461		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part I Date/Time Prepared: 5/29/2012 8:55 pm
		Title XVIII	Hospital	PPS

Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	5,162	682,881	30.00
31.00	INTENSIVE CARE UNIT	1,158	339,271	31.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	6,320	1,022,152	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part II Date/Time Prepared: 5/29/2012 8:55 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	690,775	19,751,600	0.034973	2,285,603	79,934	50.00
52.00	DELIVERY ROOM & LABOR ROOM	52,046	1,188,475	0.043792	2,606	114	52.00
54.00	RADIOLOGY-DIAGNOSTIC	456,244	17,946,531	0.025422	1,269,110	32,263	54.00
57.00	CT SCAN	27,248	15,732,063	0.001732	1,417,551	2,455	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	24,425	5,074,340	0.004813	129,871	625	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	LABORATORY	359,388	19,798,424	0.018152	3,409,737	61,894	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	95,415	3,662,988	0.026048	1,214,128	31,626	65.00
66.00	PHYSICAL THERAPY	72,310	2,808,084	0.025751	373,305	9,613	66.00
68.00	SPEECH PATHOLOGY	9,979	100,171	0.099620	14,066	1,401	68.00
69.00	ELECTROCARDIOLOGY	6,716	4,034,886	0.001664	786,510	1,309	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,896	11,529,807	0.001465	2,727,766	3,996	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	197,394	9,305,964	0.021212	3,506,726	74,385	72.00
73.00	DRUGS CHARGED TO PATIENTS	83,950	20,873,932	0.004022	9,346,639	37,592	73.00
76.00	CARDIAC REHABILITATION	18,680	297,346	0.062822	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	EMERGENCY	408,958	10,634,773	0.038455	516,504	19,862	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	139,960	1,450,384	0.096499	135,013	13,029	92.00
200.00	Total (lines 50-199)	2,660,384	144,189,768		27,135,135	370,098	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150030		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part III Date/Time Prepared: 5/29/2012 8:55 pm	
Cost Center Description		Title XVIII		Hospital		PPS	
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	0	0	0	0	0	43.00
200.00	Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150030		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part III Date/Time Prepared: 5/29/2012 8:55 pm	
Cost Center Description		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PPS	
		6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	10,068	0.00	5,162	0	30.00	
31.00	INTENSIVE CARE UNIT	1,577	0.00	1,158	0	31.00	
41.00	SUBPROVIDER - IRF	0	0.00	0	0	41.00	
42.00	SUBPROVIDER	0	0.00	0	0	42.00	
43.00	NURSERY	816	0.00	0	0	43.00	
200.00	Total (lines 30-199)	12,461		6,320	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/29/2012 8:55 pm
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Cost Center Description	Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00		5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00 OPERATING ROOM	0	0	0	0	0	0	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	0	54.00
57.00 CT SCAN	0	0	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	0	0	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	0	0	66.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	0	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	0	73.00
76.00 CARDIAC REHABILITATION	0	0	0	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	0	89.00
91.00 EMERGENCY	0	0	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/29/2012 8:55 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	19,751,600	0.000000	0.000000	2,285,603	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	1,188,475	0.000000	0.000000	2,606	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	17,946,531	0.000000	0.000000	1,269,110	54.00
57.00	CT SCAN	0	15,732,063	0.000000	0.000000	1,417,551	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	5,074,340	0.000000	0.000000	129,871	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	LABORATORY	0	19,798,424	0.000000	0.000000	3,409,737	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	RESPIRATORY THERAPY	0	3,662,988	0.000000	0.000000	1,214,128	65.00
66.00	PHYSICAL THERAPY	0	2,808,084	0.000000	0.000000	373,305	66.00
68.00	SPEECH PATHOLOGY	0	100,171	0.000000	0.000000	14,066	68.00
69.00	ELECTROCARDIOLOGY	0	4,034,886	0.000000	0.000000	786,510	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,529,807	0.000000	0.000000	2,727,766	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	9,305,964	0.000000	0.000000	3,506,726	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	20,873,932	0.000000	0.000000	9,346,639	73.00
76.00	CARDIAC REHABILITATION	0	297,346	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	EMERGENCY	0	10,634,773	0.000000	0.000000	516,504	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,450,384	0.000000	0.000000	135,013	92.00
200.00	Total (lines 50-199)	0	144,189,768			27,135,135	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/29/2012 8:55 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0	5,085,823	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	4,917,149	0	54.00
57.00	CT SCAN	0	3,841,119	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	1,241,321	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	LABORATORY	0	468,884	0	60.00
60.01	BLOOD LABORATORY	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	249,145	0	65.00
66.00	PHYSICAL THERAPY	0	1,024	0	66.00
68.00	SPEECH PATHOLOGY	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	2,022,121	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	247,202	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	478,748	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	3,015,295	0	73.00
76.00	CARDIAC REHABILITATION	0	147,840	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00	EMERGENCY	0	1,819,762	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	413,783	0	92.00
200.00	Total (Lines 50-199)	0	23,949,216	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/29/2012 8:55 pm		
		Title XVIII	Hospital	PPS		
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
	1.00	2.00	3.00	4.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	0.352221	5,085,823	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.220375	0	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.262164	4,917,149	0	0	54.00
57.00	CT SCAN	0.040152	3,841,119	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.081940	1,241,321	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	LABORATORY	0.285532	468,884	0	0	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0.333015	249,145	0	0	65.00
66.00	PHYSICAL THERAPY	0.781101	1,024	0	0	66.00
68.00	SPEECH PATHOLOGY	1.362869	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.073837	2,022,121	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.088987	247,202	1,393	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.494983	478,748	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.156185	3,015,295	0	9,178	73.00
76.00	CARDIAC REHABILITATION	0.803223	147,840	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	RURAL HEALTH CLINIC	0.000000				88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
91.00	EMERGENCY	0.503867	1,819,762	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.776563	413,783	0	0	92.00
200.00	Subtotal (see instructions)		23,949,216	1,393	9,178	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		23,949,216	1,393	9,178	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/29/2012 8:55 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 OPERATING ROOM	1,791,334	0	0		50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00 RADIOLOGY-DIAGNOSTIC	1,289,099	0	0		54.00
57.00 CT SCAN	154,229	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	101,714	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00 LABORATORY	133,881	0	0		60.00
60.01 BLOOD LABORATORY	0	0	0		60.01
65.00 RESPIRATORY THERAPY	82,969	0	0		65.00
66.00 PHYSICAL THERAPY	800	0	0		66.00
68.00 SPEECH PATHOLOGY	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	149,307	0	0		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	21,998	124	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	236,972	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	470,944	0	1,433		73.00
76.00 CARDIAC REHABILITATION	118,748	0	0		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 RURAL HEALTH CLINIC	0	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00 EMERGENCY	916,918	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	321,329	0	0		92.00
200.00 Subtotal (see instructions)	5,790,242	124	1,433		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	5,790,242	124	1,433		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/29/2012 8:55 pm
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		10,068	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		10,068	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)		10,068	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		5,162	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		10,718,061	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		10,718,061	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		11,442,849	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		11,442,849	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.936660	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)		1,136.56	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)		10,718,061	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,064.57	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,495,310	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		5,495,310	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150030		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 5/29/2012 8:55 pm	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	3,442,924	1,577	2,183.21	1,158	2,528,157		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					6,757,749		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					14,781,216		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)					1,022,152		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					370,098		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,392,250		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					13,388,966		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					1,058		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,064.57		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,126,315		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150030		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 5/29/2012 8:55 pm	
Title XVIII		Hospital		PPS			
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,331,870	10,718,061	0.124264	1,126,315	139,960	90.00
91.00	Nursing School cost	0	10,718,061	0.000000	1,126,315	0	91.00
92.00	Allied health cost	0	10,718,061	0.000000	1,126,315	0	92.00
93.00	All other Medical Education	0	10,718,061	0.000000	1,126,315	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/29/2012 8:55 pm
Cost Center Description				Cost
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		10,068	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		10,068	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)		10,068	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		472	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		816	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		10,718,061	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		10,718,061	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		11,442,849	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		11,442,849	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.936660	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)		1,136.56	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)		10,718,061	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,064.57	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		502,477	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)		502,477	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/29/2012 8:55 pm	
Cost Center Description			Title XIX	Hospital	Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1,255,838	816	1,539.02	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,442,924	1,577	2,183.21	0	43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				390,793	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				893,270	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0 54.00
55.00	Target amount per discharge				0.00	55.00
56.00	Target amount (line 54 x line 55)					0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00	Bonus payment (see instructions)					0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00	Relief payment (see instructions)					0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)				1,058	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,064.57	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				1,126,315	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150030		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 5/29/2012 8:55 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/29/2012 8:55 pm
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Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS		5,307,950		30.00
31.00	INTENSIVE CARE UNIT		2,320,266		31.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.352221	2,285,603	805,037	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.220375	2,606	574	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.262164	1,269,110	332,715	54.00
57.00	CT SCAN	0.040152	1,417,551	56,918	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.081940	129,871	10,642	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.286034	3,409,737	975,301	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0.333015	1,214,128	404,323	65.00
66.00	PHYSICAL THERAPY	0.781101	373,305	291,589	66.00
68.00	SPEECH PATHOLOGY	1.362869	14,066	19,170	68.00
69.00	ELECTROCARDIOLOGY	0.073837	786,510	58,074	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.088987	2,727,766	242,736	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.494983	3,506,726	1,735,770	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.156185	9,346,639	1,459,805	73.00
76.00	CARDIAC REHABILITATION	0.803223	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	EMERGENCY	0.503867	516,504	260,249	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.776563	135,013	104,846	92.00
200.00	Total (sum of lines 50-94 and 96-98)		27,135,135	6,757,749	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)		27,135,135		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/29/2012 8:55 pm
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS		745,212		30.00
31.00	INTENSIVE CARE UNIT		105,099		31.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY		188,695		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.352221	266,896	94,006	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.220375	148,097	32,637	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.262164	43,986	11,532	54.00
57.00	CT SCAN	0.040152	15,465	621	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.081940	9,785	802	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.285532	272,251	77,736	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0.333015	81,928	27,283	65.00
66.00	PHYSICAL THERAPY	0.781101	9,996	7,808	66.00
68.00	SPEECH PATHOLOGY	1.362869	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.073837	14,488	1,070	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.088987	436,615	38,853	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.494983	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.156185	630,167	98,423	73.00
76.00	CARDIAC REHABILITATION	0.803223	28	22	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
91.00	EMERGENCY	0.503867	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.776563	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,929,702	390,793	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		1,929,702		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part A Date/Time Prepared: 5/29/2012 8:55 pm
		Title VIII	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER PPS</b>				
1.00	DRG Amounts Other than Outlier Payments		8,556,451	1.00
2.00	Outlier payments for discharges. (see instructions)		171,316	2.00
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		87.10	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.96	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		16.79	31.00
32.00	Sum of lines 30 and 31		20.75	32.00
33.00	Allowable disproportionate share percentage (see instructions)		6.33	33.00
34.00	Disproportionate share adjustment (see instructions)		541,623	34.00
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0	46.00
47.00	Subtotal (see instructions)		9,269,390	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		10,943,404	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		10,524,901	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		711,786	50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0	56.00
57.00	Routine service other pass through costs		0	57.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part A Date/Time Prepared: 5/29/2012 8:55 pm
		Title XVIII	Hospital	PPS
				1.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)			0 58.00
59.00	Total (sum of amounts on lines 49 through 58)			11,236,687 59.00
60.00	Primary payer payments			4,669 60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			11,232,018 61.00
62.00	Deductibles billed to program beneficiaries			1,176,608 62.00
63.00	Coinsurance billed to program beneficiaries			9,339 63.00
64.00	Allowable bad debts (see instructions)			228,772 64.00
65.00	Adjusted reimbursable bad debts (see instructions)			160,140 65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			228,772 66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			10,206,211 67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)			0 68.00
69.00	Outlier payments reconciliation			0 69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 70.00
70.95	Recovery of Accelerated Depreciation			0 70.95
70.96	Low Volume Payment-1			0 70.96
70.97	Low Volume Payment-2			0 70.97
70.98	Low Volume Payment-3			0 70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			10,206,211 71.00
72.00	Interim payments			10,231,841 72.00
73.00	Tentative settlement (for contractor use only)			0 73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)			-25,630 74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			150,000 75.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Operating outlier amount from Worksheet E, Part A line 2			0 90.00
91.00	Capital outlier from Worksheet L, Part I, line 2			0 91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0 92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0 93.00
94.00	The rate used to calculate the Time Value of Money			0.00 94.00
95.00	Time Value of Money for operating expenses(see instructions)			0 95.00
96.00	Time Value of Money for capital related expenses (see instructions)			0 96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/29/2012 8:55 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		1,557	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		5,790,242	2.00
3.00	PPS payments		5,771,955	3.00
4.00	Outlier payment (see instructions)		7,273	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.859	5.00
6.00	Line 2 times line 5		4,973,818	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)		1,557	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		10,571	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)		10,571	14.00
<b>Customary charges</b>				
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)		10,571	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		9,014	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)		1,557	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		5,779,228	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		279	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,431,824	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		4,348,682	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		4,348,682	30.00
31.00	Primary payer payments		1,929	31.00
32.00	Subtotal (line 30 minus line 31)		4,346,753	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		285,178	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		199,625	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		285,178	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		4,546,378	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-198	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		4,546,576	40.00
41.00	Interim payments		4,518,722	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)		27,854	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150030

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/29/2012 8:55 pm

Title XVIII

Hospital

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		9,992,315		4,346,170	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	09/07/2011	75,559	09/07/2011	11,055	3.01
3.02		12/31/2011	163,967	12/31/2011	161,497	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		239,526		172,552	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		10,231,841		4,518,722	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		27,854	6.01
6.02	SETTLEMENT TO PROGRAM		25,630		0	6.02
7.00	Total Medicare program liability (see instructions)		10,206,211		4,546,576	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2012 8:55 pm
		Title XIX	Hospital	Cost
				1.00
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>				
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient hospital/SNF/NF services		893,270	1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		893,270	4.00
5.00	Inpatient primary payer payments		0	5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		893,270	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable Charges</b>				
8.00	Routine service charges		1,039,006	8.00
9.00	Ancillary service charges		1,929,702	9.00
10.00	Organ acquisition charges, net of revenue		0	10.00
11.00	Incentive from target amount computation		0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		2,968,708	12.00
<b>CUSTOMARY CHRGES</b>				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		2,968,708	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		2,075,438	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		893,270	21.00
<b>PROSPECTIVE PAYMENT AMOUNT</b>				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		0	23.00
24.00	Program capital payments		0	24.00
25.00	Capital exception payments (see instructions)		0	25.00
26.00	Routine and Ancillary service other pass through costs		0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX enter the sum of lines 27 and 21.		893,270	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		893,270	31.00
32.00	Deductibles		0	32.00
33.00	Coinsurance		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Utilization review		0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		893,270	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		893,270	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		893,270	40.00
41.00	Interim payments		596,839	41.00
42.00	Balance due provider/program (line 40 minus 41)		296,431	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	43.00

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

Provider CCN: 150030

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

Worksheet G

Date/Time Prepared:  
5/29/2012 8:55 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	3,559,388	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	9,221,510	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	2,042,658	0	0	0	9.00
10.00	Due from other funds	15,338,414	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	30,161,970	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	46,000	0	0	0	12.00
13.00	Land improvements	1,643,952	0	0	0	13.00
14.00	Accumulated depreciation	-1,548,406	0	0	0	14.00
15.00	Buildings	38,463,416	0	0	0	15.00
16.00	Accumulated depreciation	-24,439,051	0	0	0	16.00
17.00	Leasehold improvements	1,060,712	0	0	0	17.00
18.00	Accumulated depreciation	-572,159	0	0	0	18.00
19.00	Fixed equipment	15,835,226	0	0	0	19.00
20.00	Accumulated depreciation	-13,343,490	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	25,085,454	0	0	0	23.00
24.00	Accumulated depreciation	-18,265,751	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)	23,965,903	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	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	22,172,029	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	22,172,029	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	76,299,902	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	2,927,207	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,060,929	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	405,689	0	0	0	43.00
44.00	Other current liabilities	2,725,077	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,118,902	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	13,756,035	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	13,756,035	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	23,874,937	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	52,424,965				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)	52,424,965	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	76,299,902	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150030

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

Worksheet G-1

Date/Time Prepared:  
5/29/2012 8:55 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
1.00	Fund balances at beginning of period		49,121,496		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		5,388,489			2.00
3.00	Total (sum of line 1 and line 2)		54,509,985		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)		54,509,985		0	11.00
12.00	RELATED PARTY LOSSES	2,085,020		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)		2,085,020		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		52,424,965		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150030

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

Worksheet G-1

Date/Time Prepared:  
5/29/2012 8:55 pm

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150030

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

Worksheet G-2 Parts  
Date/Time Prepared:  
5/29/2012 8:55 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	12,087,909		12,087,909	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	12,087,909		12,087,909	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,564,319		3,564,319	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)	3,564,319		3,564,319	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	15,652,228		15,652,228	17.00
18.00	Ancillary services	40,576,829	91,527,782	132,104,611	18.00
19.00	Outpatient services	0	10,832,139	10,832,139	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,145,846	1,145,846	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	1,462,677	1,462,677	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	56,229,057	104,968,444	161,197,501	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		58,637,476		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		58,637,476		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150030

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

Worksheet G-3

Date/Time Prepared:  
5/29/2012 8:55 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	161,197,501	1.00
2.00	Less contractual allowances and discounts on patients' accounts	99,625,879	2.00
3.00	Net patient revenues (line 1 minus line 2)	61,571,622	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	58,637,476	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,934,146	5.00
<b>OTHER INCOME</b>			
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	<b>OTHER REVENUE</b>	2,734,545	24.00
24.01	NONOPERATING REVENUE	0	24.01
25.00	Total other income (sum of lines 6-24)	2,734,545	25.00
26.00	Total (line 5 plus line 25)	5,668,691	26.00
27.00	<b>NONOPERATING EXPENSE</b>	280,202	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	280,202	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,388,489	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 150030

Period: From 01/01/2011

Worksheet H

HHA CCN: 157430

To 12/31/2011

Date/Time Prepared:  
5/29/2012 8:55 pm

Home Health Agency I

PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures			0		0	1.00
2.00	Capital Related - Movable Equipment			0		0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	64,528	0	0	0	124,573	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	197,739	0	0	0	0	6.00
7.00	Physical Therapy	125,637	0	0	0	0	7.00
8.00	Occupational Therapy	39,756	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	21,259	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
<b>HHA NONREIMBURSABLE SERVICES</b>							
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)	448,919	0	0	0	124,573	24.00

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

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 150030

Period: From 01/01/2011

Worksheet H

HHA CCN: 157430

To 12/31/2011

Date/Time Prepared: 5/29/2012 8:55 pm

Home Health Agency I

PPS

	Total (sum of col.s. 1 thru 5)	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
	6.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	189,101	-6,010	183,091	0	5.00
<b>HHA REIMBURSABLE SERVICES</b>						
6.00	Skilled Nursing Care	197,739	0	197,739	0	6.00
7.00	Physical Therapy	125,637	0	125,637	0	7.00
8.00	Occupational Therapy	39,756	0	39,756	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	21,259	0	21,259	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>						
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)	573,492	-6,010	567,482	0	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: 150030	Period: From 01/01/2011	Worksheet H-1 Part I Date/Time Prepared: 5/29/2012 8:55 pm
	HHA CCN: 157430	To 12/31/2011	
		Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	
		Bldgs & Fixtures	Movable Equipment			
		1.00	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	Capital Related - Bldg. & Fixtures	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	183,091	0	0	0	5.00
<b>HHA REIMBURSABLE SERVICES</b>						
6.00	Skilled Nursing Care	197,739	0	0	0	6.00
7.00	Physical Therapy	125,637	0	0	0	7.00
8.00	Occupational Therapy	39,756	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	21,259	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>						
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)	567,482	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 150030	Period: From 01/01/2011	Worksheet H-1 Part I Date/Time Prepared: 5/29/2012 8:55 pm
		HHA CCN: 157430	To 12/31/2011	
			Home Health Agency I	PPS

		Subtotal (col s. 0-4)	Administrative & General	Total (col s. 4A + 5)	
		4A.00	5.00	6.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	Capital Related - Bldg. & Fixtures	0			1.00
2.00	Capital Related - Movable Equipment	0			2.00
3.00	Plant Operation & Maintenance	0			3.00
4.00	Transportation				4.00
5.00	Administrative and General	183,091	183,091		5.00
<b>HHA REIMBURSABLE SERVICES</b>					
6.00	Skilled Nursing Care	197,739	94,186	291,925	6.00
7.00	Physical Therapy	125,637	59,843	185,480	7.00
8.00	Occupational Therapy	39,756	18,936	58,692	8.00
9.00	Speech Pathology	0	0	0	9.00
10.00	Medical Social Services	0	0	0	10.00
11.00	Home Health Aide	21,259	10,126	31,385	11.00
12.00	Supplies (see instructions)	0	0	0	12.00
13.00	Drugs	0	0	0	13.00
14.00	DME	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>					
15.00	Home Dialysis Aide Services	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	17.00
18.00	Clinic	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	19.00
20.00	Day Care Program	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	21.00
22.00	Homemaker Service	0	0	0	22.00
23.00	All Others (specify)	0	0	0	23.00
24.00	Total (sum of lines 1-23)	384,391		567,482	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 150030

Period: From 01/01/2011

Worksheet H-1

HHA CCN: 157430

To 12/31/2011

Part II  
Date/Time Prepared:  
5/29/2012 8:55 pm

Home Health Agency I

PPS

		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)				
		1.00	2.00	3.00	4.00	5A.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	-183,091	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
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
<b>HHA NONREIMBURSABLE SERVICES</b>							
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	-183,091	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	0	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		26.00

COST ALLOCATION - HHA STATISTICAL BASIS	Provider CCN: 150030	Period: From 01/01/2011	Worksheet H-1 Part II Date/Time Prepared: 5/29/2012 8:55 pm
	HHA CCN: 157430	To 12/31/2011	
		Home Health Agency I	PPS

		Administrative & General (ACCUM. COST)	
		5.00	
<b>GENERAL SERVICE COST CENTERS</b>			
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	384,391	5.00
<b>HHA REIMBURSABLE SERVICES</b>			
6.00	Skilled Nursing Care	197,739	6.00
7.00	Physical Therapy	125,637	7.00
8.00	Occupational Therapy	39,756	8.00
9.00	Speech Pathology	0	9.00
10.00	Medical Social Services	0	10.00
11.00	Home Health Aide	21,259	11.00
12.00	Supplies (see instructions)	0	12.00
13.00	Drugs	0	13.00
14.00	DME	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>			
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)	384,391	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	183,091	25.00
26.00	Unit Cost Multiplier	0.476314	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150030

Period: From 01/01/2011

Worksheet H-2

HHA CCN: 157430

To 12/31/2011

Part I  
Date/Time Prepared:  
5/29/2012 8:55 pm

Home Health Agency I

PPS

	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		1.00	2.00			
	0			4.00	4A	
1.00 Administrative and General	0	0	0	172,443	172,443	1.00
2.00 Skilled Nursing Care	291,925	0	0	0	291,925	2.00
3.00 Physical Therapy	185,480	0	0	0	185,480	3.00
4.00 Occupational Therapy	58,692	0	0	0	58,692	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	31,385	0	0	0	31,385	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)	567,482	0	0	172,443	739,925	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: 150030

Period:

Worksheet H-2

HHA CCN: 157430

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

Part I  
Date/Time Prepared:  
5/29/2012 8:55 pm

Home Health  
Agency I

PPS

		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	43,779	0	0	12,829	0	1.00
2.00	Skilled Nursing Care	74,112	0	0	0	0	2.00
3.00	Physical Therapy	47,089	0	0	0	0	3.00
4.00	Occupational Therapy	14,900	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	7,968	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)	187,848	0	0	12,829	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: 150030

Period: From 01/01/2011

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HHA CCN: 157430

To 12/31/2011

Part I  
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	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
1.00 Administrative and General	0	0	1,704	0	7,315	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	1,704	0	7,315	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: 150030

Period: From 01/01/2011

Worksheet H-2

HHA CCN: 157430

To 12/31/2011

Part I  
Date/Time Prepared:  
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Home Health Agency I

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		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	238,070	0	238,070			1.00
2.00	Skilled Nursing Care	366,037	0	366,037	122,468	488,505	2.00
3.00	Physical Therapy	232,569	0	232,569	77,813	310,382	3.00
4.00	Occupational Therapy	73,592	0	73,592	24,622	98,214	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	39,353	0	39,353	13,167	52,520	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)	949,621	0	949,621	238,070	949,621	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.				0.334579		21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150030  
HHA CCN: 157430

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

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

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	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
1.00	Administrative and General	0	0	448,919	5A	172,443	1.00
2.00	Skilled Nursing Care	0	0	0	0	291,925	2.00
3.00	Physical Therapy	0	0	0	0	185,480	3.00
4.00	Occupational Therapy	0	0	0	0	58,692	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	31,385	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	448,919		739,925	20.00
21.00	Total cost to be allocated	0	0	172,443		187,848	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.384129		0.253874	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150030  
HHA CCN: 157430

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		PPS	
		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	0	0	58	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	58	0	0	20.00
21.00	Total cost to be allocated	0	0	12,829	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	221.189655	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 150030 HHA CCN: 157430	Period: From 01/01/2011 To 12/31/2011	Worksheet H-2 Part II Date/Time Prepared: 5/29/2012 8:55 pm PPS
		Home Health Agency I	

	NURSING ADMINISTRATION  (DIRECT NRSING HRS) 13.00	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.) 14.00	PHARMACY (COSTED REQUIS.) 15.00	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16.00		
1.00 Administrative and General	0	6,836	0	13		1.00
2.00 Skilled Nursing Care	0	0	0	0		2.00
3.00 Physical Therapy	0	0	0	0		3.00
4.00 Occupational Therapy	0	0	0	0		4.00
5.00 Speech Pathology	0	0	0	0		5.00
6.00 Medical Social Services	0	0	0	0		6.00
7.00 Home Health Aide	0	0	0	0		7.00
8.00 Supplies (see instructions)	0	0	0	0		8.00
9.00 Drugs	0	0	0	0		9.00
10.00 DME	0	0	0	0		10.00
11.00 Home Dialysis Aide Services	0	0	0	0		11.00
12.00 Respiratory Therapy	0	0	0	0		12.00
13.00 Private Duty Nursing	0	0	0	0		13.00
14.00 Clinic	0	0	0	0		14.00
15.00 Health Promotion Activities	0	0	0	0		15.00
16.00 Day Care Program	0	0	0	0		16.00
17.00 Home Delivered Meals Program	0	0	0	0		17.00
18.00 Homemaker Service	0	0	0	0		18.00
19.00 All Others (specify)	0	0	0	0		19.00
20.00 Total (sum of lines 1-19)	0	6,836	0	13		20.00
21.00 Total cost to be allocated	0	1,704	0	7,315		21.00
22.00 Unit cost multiplier	0.000000	0.249269	0.000000	562.692308		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 150030 HHA CCN: 157430		Period: From 01/01/2011 To 12/31/2011		Worksheet H-3 Parts I-II Date/Time Prepared: 5/29/2012 8:55 pm	
		Title XVIII		Home Health Agency I		PPS	
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (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	488,505		488,505	2,220	1.00
2.00	Physical Therapy	3.00	310,382	0	310,382	1,898	2.00
3.00	Occupational Therapy	4.00	98,214	0	98,214	500	3.00
4.00	Speech Pathology	5.00	0	0	0	0	4.00
5.00	Medical Social Services	6.00	0		0	0	5.00
6.00	Home Health Aide	7.00	52,520		52,520	763	6.00
7.00	Total (sum of lines 1-6)		949,621	0	949,621	5,381	7.00
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits		
					Part B		
					Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	
Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	830	459		8.00
9.00	Physical Therapy		99915	780	519		9.00
10.00	Occupational Therapy		99915	207	237		10.00
11.00	Speech Pathology		99915	0	0		11.00
12.00	Medical Social Services		99915	0	0		12.00
13.00	Home Health Aide		99915	145	301		13.00
14.00	Total (sum of lines 8-13)			1,962	1,516		14.00
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	
		0	1.00	2.00	3.00	4.00	
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	4,929	15.00
16.00	Cost of Drugs	9.00	0	0	0	810	16.00
Cost Center Description		From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)		
		0	1.00	2.00	3.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy		66.00	0.781101	0	0	1.00
2.00	Occupational Therapy						2.00
3.00	Speech Pathology		68.00	1.362869	0	0	3.00
4.00	Cost of Medical Supplies		71.00	0.088987	0	0	4.00
5.00	Cost of Drugs		73.00	0.156185	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 150030 HHA CCN: 157430	Period: From 01/01/2011 To 12/31/2011	Worksheet H-3 Parts I-III Date/Time Prepared: 5/29/2012 8:55 pm		
		Title XVIIII	Home Health Agency I	PPS		
Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Part A	Program Visits			
			Not Subject to Deductibles & Coi nsurance	Subject to Deductibles & Coi nsurance		
			Part B			
		5.00	6.00	7.00	8.00	
<b>PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION</b>						
<b>Cost Per Visit Computation</b>						
1.00	Skilled Nursing Care	220.05	830	459	1.00	
2.00	Physical Therapy	163.53	780	519	2.00	
3.00	Occupational Therapy	196.43	207	237	3.00	
4.00	Speech Pathology	0.00	0	0	4.00	
5.00	Medical Social Services	0.00	0	0	5.00	
6.00	Home Health Aide	68.83	145	301	6.00	
7.00	Total (sum of lines 1-6)		1,962	1,516	7.00	
Cost Center Description		5.00	6.00	7.00	8.00	9.00
<b>Limitation Cost Computation</b>						
8.00	Skilled Nursing Care					8.00
9.00	Physical Therapy					9.00
10.00	Occupational Therapy					10.00
11.00	Speech Pathology					11.00
12.00	Medical Social Services					12.00
13.00	Home Health Aide					13.00
14.00	Total (sum of lines 8-13)					14.00
Cost Center Description		Ratio (col. 3 ÷ col. 4)	Part A	Program Covered Charges		
				Part B		
				Not Subject to Deductibles & Coi nsurance	Subject to Deductibles & Coi nsurance	
		5.00	6.00	7.00	8.00	
<b>Supplies and Drugs Cost Computations</b>						
15.00	Cost of Medical Supplies	0.000000	0	4,929	0	15.00
16.00	Cost of Drugs	0.000000	0	810	0	16.00
Cost Center Description		Transfer to Part I as Indicated				
		4.00				
<b>PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS</b>						
1.00	Physical Therapy	col. 2, line 2.00				1.00
2.00	Occupational Therapy					2.00
3.00	Speech Pathology	col. 2, line 4.00				3.00
4.00	Cost of Medical Supplies	col. 2, line 15.00				4.00
5.00	Cost of Drugs	col. 2, line 16.00				5.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 150030 HHA CCN: 157430		Period: From 01/01/2011 To 12/31/2011		Worksheet H-3 Parts I-III Date/Time Prepared: 5/29/2012 8:55 pm	
		Title XVII		Home Health Agency I		PPS	
Cost Center Description	Cost of Services			Total Program Cost (sum of col.s. 9-10)			
	Part A	Part B					
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance				
9.00	10.00	11.00	12.00				
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	182,642	101,003		283,645		1.00
2.00	Physical Therapy	127,553	84,872		212,425		2.00
3.00	Occupational Therapy	40,661	46,554		87,215		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	9,980	20,718		30,698		6.00
7.00	Total (sum of lines 1-6)	360,836	253,147		613,983		7.00
Cost Center Description							
		10.00	11.00	12.00			
Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00
Cost of Services							
Cost Center Description	Part A	Part B					
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance				
	9.00	10.00	11.00				
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0			15.00
16.00	Cost of Drugs	0	0	0			16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 150030 HHA CCN: 157430	Period: From 01/01/2011 To 12/31/2011	Worksheet H-4 Part I-II Date/Time Prepared: 5/29/2012 8:55 pm
		Title XVII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
<b>PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES</b>				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
		Part A Services	Part B Services	
		1.00	2.00	
<b>PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT</b>				
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	328,692	245,133	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	9,213	7,005	13.00
14.00	Total PPS Reimbursement - PEP Episodes	4,918	0	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	810	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)	342,823	252,948	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	342,823	252,948	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)	342,823	252,948	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)	342,823	252,948	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	342,823	252,948	31.00
32.00	Interim payments (see instructions)	342,823	252,948	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: 150030  
HHA CCN: 157430

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

Worksheet H-5  
Date/Time Prepared:  
5/29/2012 8:55 pm  
PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		342,823		252,948	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		342,823		252,948	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		342,823		252,948	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150030

Period: From 01/01/2011

Worksheet K

Hospice CCN: 151564

To 12/31/2011

Date/Time Prepared: 5/29/2012 8:55 pm

		Hospice I					
		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	69,105	0	0	0	280,829	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	32,991	0	0	0	0	9.00
10.00	Nursing Care	164,850	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	20,504	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	16,689	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	304,139	0	0	0	280,829	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150030

Period: From 01/01/2011

Worksheet K

Hospice CCN: 151564

To 12/31/2011

Date/Time Prepared: 5/29/2012 8:55 pm

		Total (col. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Hospice I Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	349,934	-18,159	331,775	0	331,775	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	32,991	0	32,991	0	32,991	9.00
10.00	Nursing Care	164,850	0	164,850	0	164,850	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	20,504	0	20,504	0	20,504	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	16,689	0	16,689	0	16,689	20.00
21.00	Other	0	0	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	584,968	-18,159	566,809	0	566,809	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150030

Period: From 01/01/2011

Worksheet K-1

Hospice CCN: 151564

To 12/31/2011

Date/Time Prepared: 5/29/2012 8:55 pm

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	69,105	0	0	0	0	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	164,850	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	20,504	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	69,105	0	20,504	0	164,850	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150030

Period: From 01/01/2011

Worksheet K-1

Hospice CCN: 151564

To 12/31/2011

Date/Time Prepared: 5/29/2012 8:55 pm

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	0	69,105	6.00
<b>INPATIENT CARE SERVICE</b>						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
<b>VISITING SERVICES</b>						
9.00	Physician Services		0	32,991	32,991	9.00
10.00	Nursing Care		0	0	164,850	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services		0	0	20,504	15.00
16.00	Spiritual Counseling		0	0	0	16.00
17.00	Dietary Counseling		0	0	0	17.00
18.00	Counseling - Other		0	0	0	18.00
19.00	Home Health Aide and Homemaker		0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		16,689	0	16,689	20.00
21.00	Other		0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	16,689	32,991	304,139	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150030

Period: From 01/01/2011

Worksheet K-4

Hospice CCN: 151564

To 12/31/2011

Part I  
Date/Time Prepared:  
5/29/2012 8:55 pm

		CAPITAL RELATED COST				Hospice I	
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
			1.00	2.00			
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	331,775	0	0	0	0	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	32,991	0	0	0	0	9.00
10.00	Nursing Care	164,850	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	20,504	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	16,689	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	566,809	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST		Provider CCN: 150030	Period: From 01/01/2011	Worksheet K-4
		Hospice CCN: 151564	To 12/31/2011	Part I
		Hospice I		Date/Time Prepared: 5/29/2012 8:55 pm

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col . 5A ± col . 6)	
		5.00	5A	6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	Capital Related Costs-Bldg and Fixt.		0			1.00
2.00	Capital Related Costs-Movable Equip.		0			2.00
3.00	Plant Operation and Maintenance		0			3.00
4.00	Transportation - Staff		0			4.00
5.00	Volunteer Service Coordination	0				5.00
6.00	Administrative and General	0	331,775			6.00
<b>INPATIENT CARE SERVICE</b>						
7.00	Inpatient - General Care	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
<b>VISITING SERVICES</b>						
9.00	Physician Services	0	32,991	46,570	79,561	9.00
10.00	Nursing Care	0	164,850	232,703	397,553	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services	0	20,504	28,944	49,448	15.00
16.00	Spiritual Counseling	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	16,689	23,558	40,247	20.00
21.00	Other	0	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	33.00
34.00	Other	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>						
35.00	Bereavement Program Costs	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	235,034	331,775	566,809	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150030

Period: From 01/01/2011

Worksheet K-4

Hospice CCN: 151564

To 12/31/2011

Part II  
Date/Time Prepared:  
5/29/2012 8:55 pm

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

COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 150030	Period: From 01/01/2011	Worksheet K-4 Part II Date/Time Prepared: 5/29/2012 8:55 pm
	Hospice CCN: 151564	To 12/31/2011	

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	Hospice I
		6A	6.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	Capital Related Costs-Bldg and Fixt.	0		1.00
2.00	Capital Related Costs-Movable Equip.	0		2.00
3.00	Plant Operation and Maintenance	0		3.00
4.00	Transportation - Staff	0		4.00
5.00	Volunteer Service Coordination			5.00
6.00	Administrative and General	-331,775	235,034	6.00
<b>INPATIENT CARE SERVICE</b>				
7.00	Inpatient - General Care	0	0	7.00
8.00	Inpatient - Respite Care	0	0	8.00
<b>VISITING SERVICES</b>				
9.00	Physician Services	0	32,991	9.00
10.00	Nursing Care	0	164,850	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	0	12.00
13.00	Occupational Therapy	0	0	13.00
14.00	Speech/ Language Pathology	0	0	14.00
15.00	Medical Social Services	0	20,504	15.00
16.00	Spiritual Counseling	0	0	16.00
17.00	Dietary Counseling	0	0	17.00
18.00	Counseling - Other	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	16,689	20.00
21.00	Other	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>				
22.00	Drugs, Biological and Infusion Therapy	0	0	22.00
23.00	Analgesics	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	24.00
25.00	Other - Specify	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	26.00
27.00	Patient Transportation	0	0	27.00
28.00	Imaging Services	0	0	28.00
29.00	Labs and Diagnostics	0	0	29.00
30.00	Medical Supplies	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	31.00
32.00	Radiation Therapy	0	0	32.00
33.00	Chemotherapy	0	0	33.00
34.00	Other	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>				
35.00	Bereavement Program Costs	0	0	35.00
36.00	Volunteer Program Costs	0	0	36.00
37.00	Fundraising	0	0	37.00
38.00	Other Program Costs	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		331,775	39.00
40.00	Unit Cost Multiplier		1.411604	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150030

Period: From 01/01/2011

Worksheet K-5

Hospice CCN: 151564

To 12/31/2011

Part I  
Date/Time Prepared:  
5/29/2012 8:55 pm

Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		1.00	2.00			
1.00 Administrative and General	0	0	0	116,829	116,829	1.00
2.00 Inpatient - General Care	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	79,561	0	0	0	79,561	4.00
5.00 Nursing Care	397,553	0	0	0	397,553	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	49,448	0	0	0	49,448	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	40,247	0	0	0	40,247	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	566,809	0	0	116,829	683,638	34.00
35.00 Unit Cost Multiplier (see instructions)					0.000000	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150030

Period:

Worksheet K-5

Hospice CCN: 151564

From 01/01/2011

Part I

To 12/31/2011

Date/Time Prepared: 5/29/2012 8:55 pm

Cost Center Description		Hospice I					
		ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
1.00	Administrative and General	29,660	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	20,199	0	0	0	0	4.00
5.00	Nursing Care	100,928	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	12,554	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	10,218	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	173,559	0	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150030

Period: From 01/01/2011

Worksheet K-5

Hospice CCN: 151564

To 12/31/2011

Part I  
Date/Time Prepared:  
5/29/2012 8:55 pm

Cost Center Description		Hospice I					
		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	799	0	9,566	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	799	0	9,566	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150030

Period: From 01/01/2011

Worksheet K-5

Hospice CCN: 151564

To 12/31/2011

Part I  
Date/Time Prepared:  
5/29/2012 8:55 pm

Cost Center Description	Subtotal	Intern &	Subtotal	Allocated	Total Hospice	
	(col.s. 4A-23)	Residents Cost	(col.s. 24 ±	Hospice A&G	Costs (col.s.	
		& Post	25)	(See Part II)	26 ± 27)	
	24.00	Adjustments	25.00	26.00	27.00	28.00
1.00 Administrative and General	156,854					1.00
2.00 Inpatient - General Care	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	99,760	0	99,760	22,017	121,777	4.00
5.00 Nursing Care	498,481	0	498,481	110,015	608,496	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	62,002	0	62,002	13,684	75,686	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	50,465	0	50,465	11,138	61,603	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	867,562	0	867,562		867,562	34.00
35.00 Unit Cost Multiplier (see instructions)				0.220701		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 150030

Hospice CCN: 151564

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

Worksheet K-5  
Part II  
Date/Time Prepared:  
5/29/2012 8:55 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00				
1.00	Administrative and General	0	0	304,139	0	116,829	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	79,561	4.00
5.00	Nursing Care	0	0	0	0	397,553	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	49,448	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	40,247	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	304,139		683,638	34.00
35.00	Total cost to be allocated	0	0	116,829		173,559	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.384130		0.253876	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 150030

Hospice CCN: 151564

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

Worksheet K-5  
Part II  
Date/Time Prepared:  
5/29/2012 8:55 pm

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

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 150030

Hospice CCN: 151564

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

Worksheet K-5  
Part II  
Date/Time Prepared:  
5/29/2012 8:55 pm

Cost Center Description		Hospice I					
		NURSING ADMINISTRATION  (DIRECT NRSING HRS) 13.00	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.) 14.00	PHARMACY (COSTED REQUIS.) 15.00	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16.00		
1.00	Administrative and General	0	3,205	0	17		1.00
2.00	Inpatient - General Care	0	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0	0		3.00
4.00	Physician Services	0	0	0	0		4.00
5.00	Nursing Care	0	0	0	0		5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0		6.00
7.00	Physical Therapy	0	0	0	0		7.00
8.00	Occupational Therapy	0	0	0	0		8.00
9.00	Speech/ Language Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Spiritual Counseling	0	0	0	0		11.00
12.00	Dietary Counseling	0	0	0	0		12.00
13.00	Counseling - Other	0	0	0	0		13.00
14.00	Home Health Aide and Homemaker	0	0	0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00
16.00	Other	0	0	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0		17.00
18.00	Analgesics	0	0	0	0		18.00
19.00	Sedatives / Hypnotics	0	0	0	0		19.00
20.00	Other - Specify	0	0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0		21.00
22.00	Patient Transportation	0	0	0	0		22.00
23.00	Imaging Services	0	0	0	0		23.00
24.00	Labs and Diagnostics	0	0	0	0		24.00
25.00	Medical Supplies	0	0	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0		26.00
27.00	Radiation Therapy	0	0	0	0		27.00
28.00	Chemotherapy	0	0	0	0		28.00
29.00	Other	0	0	0	0		29.00
30.00	Bereavement Program Costs	0	0	0	0		30.00
31.00	Volunteer Program Costs	0	0	0	0		31.00
32.00	Fundraising	0	0	0	0		32.00
33.00	Other Program Costs	0	0	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	3,205	0	17		34.00
35.00	Total cost to be allocated	0	799	0	9,566		35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.249298	0.000000	562.705882		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS		Provider CCN: 150030	Period: From 01/01/2011	Worksheet K-5	
		Hospice CCN: 151564	To 12/31/2011	Part III	
		Hospice I		Date/Time Prepared: 5/29/2012 8:55 pm	
Cost Center Description	Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
	0	1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.781101	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00		0	2.00
3.00	SPEECH PATHOLOGY	68.00	1.362869	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.156185	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00			5.00
6.00	LABORATORY	60.00	0.286034	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.088987	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00			8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00			9.00
10.00	CARDIAC REHABILITATION	76.00	0.803223	0	10.00
11.00	Totals (sum of lines 1-10)				11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 150030

Period: From 01/01/2011

Worksheet K-6

Hospice CCN: 151564

To 12/31/2011

Date/Time Prepared: 5/29/2012 8:55 pm

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				867,562	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				3,428	2.00
3.00	Average cost per diem (line 1 divided by line 2)				253.08	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	3,075				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	778,221				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		89			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		22,524			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	351				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	88,831				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			264		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			66,813		13.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150030	Period: From 01/01/2011 To 12/31/2011	Worksheet L Parts I-III Date/Time Prepared: 5/29/2012 8:55 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		692,421	1.00
2.00	Capital DRG outlier payments		19,365	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		29.01	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		711,786	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00