

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: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet S Parts I-III Date/Time Prepared: 5/31/2012 12:37 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/31/2012	Time: 12:37 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 JASPER COUNTY HOSPITAL for the cost reporting period beginning 01/01/2011 and ending 12/31/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title XVIII			HIT	Title XIX	
	Title V	Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	242,345	477,966	0	450,930	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	81,591	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 WHEATFIELD HEALTH CENTER I	0	0	44	0	0	10.00
10.03 BROOK HEALTH CENTER IV	0	0	9,796	0	0	10.03
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	323,936	487,806	0	450,930	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: 151324		Period: From 01/01/2011 To 12/31/2011		Worksheet S-2 Part I Date/Time Prepared: 5/31/2012 12:03 pm			
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IN		4.00 Zip Code: 47978- County: JASPER			
1.00 Street: 1104 EAST GRACE STREET		2.00 City: RENSSELAER							
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	
3.00 Hospital		JASPER COUNTY HOSPITAL							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		JASPER COUNTY HOSPITAL		152324	99915	12/31/2005	N	O	N
8.00 Swing Beds - NF									7.00
9.00 Hospital-Based SNF									8.00
10.00 Hospital-Based NF									9.00
11.00 Hospital-Based OLTC									10.00
12.00 Hospital-Based HHA		JASPER COUNTY HOSPITAL		157149	99915	05/13/1985	N	P	N
13.00 Separately Certified ASC									11.00
14.00 Hospital-Based Hospice		JASPER COUNTY HOSPITAL		151519	99915	03/12/1993			
15.00 Hospital-Based Health Clinic - RHC		WHEATFIELD CLINIC		153990	99915	10/07/1999	N	O	N
15.03 Hospital-Based Health Clinic - RHC 3		BROOK		158502	99915	01/01/2005	N	O	N
16.00 Hospital-Based Health Clinic - FOHC									12.00
17.00 Hospital-Based (CMHC) 1									13.00
18.00 Renal Dialysis									14.00
19.00 Other									15.00
						From:		To:	
						1.00		2.00	
20.00 Cost Reporting Period (mm/dd/yyyy)						01/01/2011		12/31/2011	
21.00 Type of Control (see instructions)								9	
22.00 Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N		N	
23.00 Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.								0	
		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00 If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.		0	0	0	0	0	0		
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		
		Urban/Rural		Date of Geogr					
		1.00		2.00					
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.						2		26.00	
27.00 For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification (in column 2).						2		27.00	
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0		35.00	
		Beginning:		Ending:					
		1.00		2.00					
36.00 Enter applicable beginning and ending dates of SCH status. Subscriber line 36 for number of periods in excess of one and enter subsequent dates.									

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/31/2012 12:03 pm		
		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.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151324

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

Worksheet S-2
Part I
Date/Time Prepared:
5/31/2012 12:03 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/31/2012 12:03 pm	
			1.00	2.00	3.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.		N		75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.			N	80.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(i)? Enter "Y" for yes and "N" for no.			N	86.00
			V	XIX	
			1.00	2.00	
Title V or XIX Inpatient Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
			Physical	Occupational	Speech
			1.00	2.00	3.00
			Respiratory		4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		Y	N	N
			1.00		2.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.		N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1	118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.		250,000	5,000,000	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00

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		1.00	2.00				
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.						134.00
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		N				140.00
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:			141.00
142.00	Street:	PO Box:		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: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part II Date/Time Prepared: 5/31/2012 12:03 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		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.	Y			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)	N			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)	Y		05/05/2012	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: 151324

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

Worksheet S-2
Part II
Date/Time Prepared:
5/31/2012 12:03 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	N	2.00	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		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.		Y		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		Y		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
Provider-Based Physicians					
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	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		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: 151324

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

Worksheet S-2
Part II
Date/Time Prepared:
5/31/2012 12:03 pm

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		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)	Y	05/05/2012	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: 151324

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

Worksheet S-3
Part I
Date/Time Prepared:
5/31/2012 12:03 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	21	7,665	183,960.00		1.00
2.00 HMO						2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	183,960.00		7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	35,040.00		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00					13.00
14.00 Total (see instructions)		25	9,125	219,000.00		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 WHEATFIELD HEALTH CENTER	88.00					26.00
26.03 BROOK HEALTH CENTER	88.03					26.03
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00					26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days						28.00
28.02 SUBPROVIDER - IRF	41.00					28.02
28.03 SUBPROVIDER	42.00					28.03
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151324

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

Worksheet S-3
Part I
Date/Time Prepared:
5/31/2012 12:03 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	2,218	439	3,342		1.00
2.00 HMO		191	0			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	1,409	0	1,409		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	168		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	3,627	439	4,919		7.00
8.00 INTENSIVE CARE UNIT	0	295	0	389		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	151		13.00
14.00 Total (see instructions)	0	3,922	439	5,459		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	8,894	6,395	17,880		22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE		4,437	100	4,703		24.00
25.00 CMHC - CMHC						25.00
26.00 WHEATFIELD HEALTH CENTER	0	291	1,430	5,490		26.00
26.03 BROOK HEALTH CENTER	0	752	1,037	5,168		26.03
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	1,219		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)			0	0		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151324

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

Worksheet S-3
Part I
Date/Time Prepared:
5/31/2012 12:03 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	623	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	307.02	0.00	0	623	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	26.80	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00	1.73	0.00			24.00
25.00 CMHC - CMHC						25.00
26.00 WHEATFIELD HEALTH CENTER	0.00	4.76	0.00			26.00
26.03 BROOK HEALTH CENTER	0.00	4.89	0.00			26.03
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00 Total (sum of lines 14-26)	0.00	345.20	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: 151324

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

Worksheet S-3
Part I
Date/Time Prepared:
5/31/2012 12:03 pm

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	125	1,032		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)	125	1,032		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 WHEATFIELD HEALTH CENTER				26.00
26.03 BROOK HEALTH CENTER				26.03
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
28.02 SUBPROVIDER - IRF				28.02
28.03 SUBPROVIDER				28.03
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet S-4
		Component CCN: 157149		Date/Time Prepared: 5/31/2012 12:03 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	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	295.00	0.00	0.00	2.00

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

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

HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.				3	19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	23844				20.00
20.01		29140				20.01
20.02		99915				20.02

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

PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	3,030	260	109	45	3,444
22.00	Skilled Nursing Visit Charges	360,366	30,854	13,003	5,499	409,722
23.00	Physical Therapy Visits	2,127	19	26	16	2,188
24.00	Physical Therapy Visit Charges	274,710	2,470	3,383	2,190	282,753
25.00	Occupational Therapy Visits	685	3	4	8	700
26.00	Occupational Therapy Visit Charges	88,598	375	519	1,095	90,587
27.00	Speech Pathology Visits	153	0	0	0	153
28.00	Speech Pathology Visit Charges	20,955	0	0	0	20,955
29.00	Medical Social Service Visits	23	0	0	2	25
30.00	Medical Social Service Visit Charges	4,356	0	0	360	4,716
31.00	Home Health Aide Visits	1,951	414	3	16	2,384
32.00	Home Health Aide Visit Charges	110,670	24,176	173	876	135,895
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	7,969	696	142	87	8,894
34.00	Other Charges	0	0	0	0	0
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	859,655	57,875	17,078	10,020	944,628
36.00	Total Number of Episodes (standard/non outlier)	370		53	6	429
37.00	Total Number of Outlier Episodes		11		0	11
38.00	Total Non-Routine Medical Supply Charges	20,652	3,318	179	77	24,226

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 151324 Component CCN: 153990	Period: From 01/01/2011 To 12/31/2011	Worksheet S-8 Date/Time Prepared: 5/31/2012 12:03 pm
			Rural Health Clinic (RHC) I	Cost
				1.00
1.00	Clinic Address and Identification Street		492 S BIERMA ST	1.00
		City	State	Zip Code
		1.00	2.00	3.00
2.00	City, State, Zip Code, County		WHEATFIELD IN	47978 2.00
				1.00
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0 3.00
			Grant Award	Date
			1.00	2.00
Source of Federal Funds				
4.00	Community Health Center (Section 330(d), PHS Act)			0 4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			0 5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0 6.00
7.00	Appalachian Regional Commission			0 7.00
8.00	Look-Alikes			0 8.00
9.00	OTHER (SPECIFY)			0 9.00
			1.00	2.00
10.00	Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes and "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N	0 10.00
		Sunday	Monday	
		from to	from to	
		1.00 2.00	3.00 4.00	
11.00	Facility hours of operations (1) Clinic		08:00 17:00	11.00
			1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?			N 12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N 0 13.00
			Provider name	CCN number
			1.00	2.00
14.00	Provider name, CCN number			14.00
		Y/N	V	XVIII
		1.00	2.00	3.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes and "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. (see instructions)		0	0 0 15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 151324 Component CCN: 153990	Period: From 01/01/2011 To 12/31/2011	Worksheet S-8 Date/Time Prepared: 5/31/2012 12:03 pm
			Rural Health Clinic (RHC) I	Cost
		County		
		4.00		
2.00	City, State, Zip Code, County	JASPER		2.00
		Tuesday		
		from	to	
		5.00	6.00	
		Wednesday		
		from	to	
		7.00	8.00	
11.00	Facility hours of operations (1) Clinic	08:00	17:00	08:00
				17:00
				11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 151324 Component CCN: 153990	Period: From 01/01/2011 To 12/31/2011	Worksheet S-8 Date/Time Prepared: 5/31/2012 12:03 pm Cost
		Rural Health Clinic (RHC) I	

	Thursday		Friday				
	from	to	from	to			
	9.00	10.00	11.00	12.00			
11.00	Facility hours of operations (1) Clinic		08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 151324 Component CCN: 153990	Period: From 01/01/2011 To 12/31/2011	Worksheet S-8 Date/Time Prepared: 5/31/2012 12:03 pm Cost
		Rural Health Clinic (RHC) I	

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

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 151324 Component CCN: 158502	Period: From 01/01/2011 To 12/31/2011	Worksheet S-8 Date/Time Prepared: 5/31/2012 12:03 pm
			Rural Health Clinic (RHC) IV	Cost
				1.00
1.00	Clinic Address and Identification			1.00
	Street	420 E MAIN ST		1.00
		City	State	Zip Code
		1.00	2.00	3.00
2.00	City, State, Zip Code, County	BROOK	IN	47922
				1.00
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0
				3.00
				Grant Award
				Date
				1.00
				2.00
Source of Federal Funds				
4.00	Community Health Center (Section 330(d), PHS Act)			0
5.00	Migrant Health Center (Section 329(d), PHS Act)			0
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0
7.00	Appalachian Regional Commission			0
8.00	Look-Alikes			0
9.00	OTHER (SPECIFY)			0
				1.00
				2.00
10.00	Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes and "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N
				0
				10.00
Sunday				
Monday				
from		to		
1.00		2.00		
from		to		
3.00		4.00		
11.00	Facility hours of operations (1)			11.00
	Clinic	08:00	17:00	
				1.00
				2.00
12.00	Have you received an approval for an exception to the productivity standard?			N
13.00	Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N
				0
				12.00
				13.00
			Provider name	CCN number
			1.00	2.00
14.00	Provider name, CCN number			14.00
		Y/N	V	XVIII
		1.00	2.00	3.00
				XIX
				4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes and "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. (see instructions)			0
				0
				0
				0
				15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 151324 Component CCN: 158502	Period: From 01/01/2011 To 12/31/2011	Worksheet S-8 Date/Time Prepared: 5/31/2012 12:03 pm												
			Rural Health Clinic (RHC) IV	Cost												
		County 4.00														
2.00	City, State, Zip Code, County	JASPER		2.00												
		<table border="1"> <tr> <th colspan="2">Tuesday</th> <th colspan="2">Wednesday</th> </tr> <tr> <td>from</td> <td>to</td> <td>from</td> <td>to</td> </tr> <tr> <td>5.00</td> <td>6.00</td> <td>7.00</td> <td>8.00</td> </tr> </table>		Tuesday		Wednesday		from	to	from	to	5.00	6.00	7.00	8.00	
Tuesday		Wednesday														
from	to	from	to													
5.00	6.00	7.00	8.00													
11.00	Facility hours of operations (1) Clinic	08:00	17:00	08:00	17:00	11.00										

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 151324 Component CCN: 158502	Period: From 01/01/2011 To 12/31/2011	Worksheet S-8 Date/Time Prepared: 5/31/2012 12:03 pm Cost
		Rural Health Clinic (RHC) IV	

	Thursday		Friday			
	from	to	from	to		
	9.00	10.00	11.00	12.00		
11.00 Facility hours of operations (1) Clinic	08:00	17:00	08:00	17:00		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet S-8
	Component CCN: 158502	Rural Health Clinic (RHC) IV	Date/Time Prepared: 5/31/2012 12:03 pm Cost

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

HOSPITAL IDENTIFICATION DATA	Provider CCN: 151324	Period: From 01/01/2011	Worksheet S-9 Parts I & II Date/Time Prepared: 5/31/2012 12:03 pm
	Component CCN: 151519	To 12/31/2011	

	Unduplicated Days					All Other	
	Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility			
	1.00	2.00	3.00	4.00	5.00		
PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	1.00
2.00	Routine Home Care	4,332	88	1,074	1,153	178	2.00
3.00	Inpatient Respite Care	40	0	0	0	0	3.00
4.00	General Inpatient Care	45	12	0	0	0	4.00
5.00	Total Hospice Days	4,417	100	1,074	1,153	178	5.00
Part II - CENSUS DATA							
6.00	Number of Patients Receiving Hospice Care	65	10	22	13	4	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)	67.95	10.00	48.82	88.69	44.50	8.00
9.00	Unduplicated Census Count	61	10	18	11	4	9.00

HOSPITAL IDENTIFICATION DATA		Provider CCN: 151324 Component CCN: 151519	Period: From 01/01/2011 To 12/31/2011	Worksheet S-9 Parts I & II Date/Time Prepared: 5/31/2012 12:03 pm
		Hospice I		

		Unduplicated Days	
		Total (sum of cols. 1, 2 & 5)	
		6.00	
PART I - ENROLLMENT DAYS			
1.00	Continuous Home Care	0	1.00
2.00	Routine Home Care	4,598	2.00
3.00	Inpatient Respite Care	40	3.00
4.00	General Inpatient Care	57	4.00
5.00	Total Hospice Days	4,695	5.00
Part II - CENSUS DATA			
6.00	Number of Patients Receiving Hospice Care	79	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)	59.43	8.00
9.00	Unduplicated Census Count	75	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet S-10 Date/Time Prepared: 5/31/2012 12:03 pm
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			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)		0.688070	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		0	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		0	6.00
7.00	Medicaid cost (line 1 times line 6)		0	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone SCHIP		0	9.00
10.00	Stand-alone SCHIP charges		0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	0	0	0
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	0	0	0
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	0	0	0
			1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		0	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		326,189	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		-326,189	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		-224,441	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		-224,441	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		-224,441	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 151324		Period: From 01/01/2011 To 12/31/2011		Worksheet A	
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT		1,156,596	1,156,596	39,644	1,196,240	1.00
4.00	EMPLOYEE BENEFITS	0	4,688,556	4,688,556	0	4,688,556	4.00
5.00	ADMINISTRATIVE & GENERAL	2,418,542	2,679,095	5,097,637	8,913	5,106,550	5.00
7.00	OPERATION OF PLANT	265,474	553,553	819,027	0	819,027	7.00
8.00	LAUNDRY & LINEN SERVICE	86,784	35,843	122,627	0	122,627	8.00
9.00	HOUSEKEEPING	453,724	119,710	573,434	0	573,434	9.00
10.00	DIETARY	357,792	308,353	666,145	-378,542	287,603	10.00
11.00	CAFETERIA	0	0	0	378,542	378,542	11.00
13.00	NURSING ADMINISTRATION	323,647	5,570	329,217	0	329,217	13.00
14.00	CENTRAL SERVICES & SUPPLY	20,915	13,118	34,033	0	34,033	14.00
15.00	PHARMACY	404,883	1,750,635	2,155,518	0	2,155,518	15.00
16.00	MEDICAL RECORDS & LIBRARY	357,911	43,394	401,305	0	401,305	16.00
17.00	SOCIAL SERVICE	9,605	91	9,696	0	9,696	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,199,725	168,408	2,368,133	-337,604	2,030,529	30.00
31.00	INTENSIVE CARE UNIT	602,499	53,455	655,954	-10,646	645,308	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	292,247	292,247	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	532,291	1,253,464	1,785,755	-356	1,785,399	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	27,096	27,096	52.00
54.00	RADIOLOGY-DIAGNOSTIC	1,043,931	1,469,671	2,513,602	-49,388	2,464,214	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	795,088	943,338	1,738,426	0	1,738,426	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	127,945	127,945	0	127,945	63.00
65.00	RESPIRATORY THERAPY	819,117	160,214	979,331	-2,091	977,240	65.00
66.00	PHYSICAL THERAPY	1,227,434	269,567	1,497,001	-721,851	775,150	66.00
66.01	KV HEALTH & DEMOTTE PT	31,901	22,580	54,481	551,305	605,786	66.01
67.00	OCCUPATIONAL THERAPY	0	0	0	416,465	416,465	67.00
67.01	KV HEALTH & DEMOTTE OT	0	0	0	127,282	127,282	67.01
68.00	SPEECH PATHOLOGY	0	0	0	130,172	130,172	68.00
68.01	KV HEALTH & DEMOTTE ST	0	0	0	97,609	97,609	68.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	180,222	180,222	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	60,819	60,819	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	WHEATFIELD HEALTH CENTER	260,576	81,419	341,995	0	341,995	88.00
88.03	BROOK HEALTH CENTER	284,346	101,031	385,377	0	385,377	88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	647,493	252,980	900,473	-117,033	783,440	90.00
91.00	EMERGENCY	923,042	1,124,729	2,047,771	-43,266	2,004,505	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	1,370,111	220,037	1,590,148	-203,367	1,386,781	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	HOSPICE	0	287,469	287,469	203,367	490,836	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	15,436,831	17,890,821	33,327,652	649,539	33,977,191	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	ALTERNACARE	518,847	20,778	539,625	0	539,625	194.00
194.01	DME EQUIPMENT	88,096	82,500	170,596	0	170,596	194.01
194.02	KV HEALTH CENTER	856,171	125,251	981,422	-600,982	380,440	194.02
194.04	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	MEALS ON WHEELS	0	0	0	0	0	194.05
194.06	WATER LAB	59,628	22,575	82,203	0	82,203	194.06
194.07	ADVERTISING	116,756	136,458	253,214	-48,557	204,657	194.07
200.00	TOTAL (SUM OF LINES 118-199)	17,076,329	18,278,383	35,354,712	0	35,354,712	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151324

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

Worksheet A
Date/Time Prepared:
5/31/2012 12:03 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	-14,775	1,181,465	1.00
4.00	EMPLOYEE BENEFITS	-28,296	4,660,260	4.00
5.00	ADMINISTRATIVE & GENERAL	-425,463	4,681,087	5.00
7.00	OPERATION OF PLANT	0	819,027	7.00
8.00	LAUNDRY & LINEN SERVICE	0	122,627	8.00
9.00	HOUSEKEEPING	-152	573,282	9.00
10.00	DIETARY	-1,256	286,347	10.00
11.00	CAFETERIA	-83,909	294,633	11.00
13.00	NURSING ADMINISTRATION	0	329,217	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	34,033	14.00
15.00	PHARMACY	-97,502	2,058,016	15.00
16.00	MEDICAL RECORDS & LIBRARY	-14,263	387,042	16.00
17.00	SOCIAL SERVICE	0	9,696	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-19,453	2,011,076	30.00
31.00	INTENSIVE CARE UNIT	-1,975	643,333	31.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	292,247	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	-386,625	1,398,774	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	27,096	52.00
54.00	RADIOLOGY-DIAGNOSTIC	-300	2,463,914	54.00
57.00	CT SCAN	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	0	1,738,426	60.00
60.01	BLOOD LABORATORY	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	127,945	63.00
65.00	RESPIRATORY THERAPY	0	977,240	65.00
66.00	PHYSICAL THERAPY	-4,356	770,794	66.00
66.01	KV HEALTH & DEMOTTE PT	0	605,786	66.01
67.00	OCCUPATIONAL THERAPY	0	416,465	67.00
67.01	KV HEALTH & DEMOTTE OT	0	127,282	67.01
68.00	SPEECH PATHOLOGY	0	130,172	68.00
68.01	KV HEALTH & DEMOTTE ST	0	97,609	68.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	-898	179,324	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	60,819	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	WHEATFIELD HEALTH CENTER	-16,182	325,813	88.00
88.03	BROOK HEALTH CENTER	0	385,377	88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	CLINIC	-5,500	777,940	90.00
91.00	EMERGENCY	-1,013,247	991,258	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	FAMILY PRACTICE	0	0	93.00
OTHER REIMBURSABLE COST CENTERS				
101.00	HOME HEALTH AGENCY	0	1,386,781	101.00
SPECIAL PURPOSE COST CENTERS				
116.00	HOSPICE	0	490,836	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-2,114,152	31,863,039	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	RENSSELAER HEALTH CENTER	0	0	192.01
193.00	NONPAID WORKERS	0	0	193.00
194.00	ALTERNACARE	0	539,625	194.00
194.01	DME EQUIPMENT	0	170,596	194.01
194.02	KV HEALTH CENTER	0	380,440	194.02
194.04	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.04
194.05	MEALS ON WHEELS	0	0	194.05
194.06	WATER LAB	0	82,203	194.06
194.07	ADVERTISING	0	204,657	194.07
200.00	TOTAL (SUM OF LINES 118-199)	-2,114,152	33,240,560	200.00

RECLASSIFICATIONS

Provider CCN: 151324

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

Worksheet A-6

Date/Time Prepared:
5/31/2012 12:03 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - CAFETERIA RECLASS						
1.00	CAFETERIA	11.00	203,318	175,224	1.00	
	TOTALS		203,318	175,224		
B - HOSPICE RECLASS						
1.00	HOSPICE	116.00	78,605	124,762	1.00	
	TOTALS		78,605	124,762		
C - OB RECLASS						
1.00	NURSERY	43.00	273,262	18,985	1.00	
2.00	DELIVERY ROOM & LABOR ROOM	52.00	25,336	1,760	2.00	
	TOTALS		298,598	20,745		
D - CHARGABLE SUPPLIES RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	241,041	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	
	TOTALS		0	241,041		
E - KV CENTER RECLASS						
1.00	KV HEALTH & DEMOTTE PT	66.01	480,946	70,359	1.00	
2.00	KV HEALTH & DEMOTTE OT	67.01	111,038	16,244	2.00	
3.00	KV HEALTH & DEMOTTE ST	68.01	85,152	12,457	3.00	
	TOTALS		677,136	99,060		
F - ADVERTISING RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	22,977	25,580	1.00	
	TOTALS		22,977	25,580		
G - PROPERTY INSURANCE RECLASS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	39,644	1.00	
	TOTALS		0	39,644		
H - REHAB RECLASS						
1.00	OCCUPATIONAL THERAPY	67.00	392,037	24,428	1.00	
2.00	SPEECH PATHOLOGY	68.00	122,537	7,635	2.00	
3.00	KV HEALTH CENTER	194.02	164,937	10,277	3.00	
	TOTALS		679,511	42,340		
I - IMPLANTABLE DEVICES RECLASS						
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	60,819	1.00	
	TOTALS		0	60,819		
500.00	Grand Total: Increases		1,960,145	829,215	500.00	

RECLASSIFICATIONS

Provider CCN: 151324

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

Worksheet A-6

Date/Time Prepared:
5/31/2012 12:03 pm

		Decreases				Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA RECLASS							
1.00	DIETARY	10.00	203,318	175,224	0		1.00
	TOTALS		203,318	175,224			
B - HOSPICE RECLASS							
1.00	HOME HEALTH AGENCY	101.00	78,605	124,762	0		1.00
	TOTALS		78,605	124,762			
C - OB RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	298,598	20,745	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		298,598	20,745			
D - CHARGABLE SUPPLIES RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	0	18,261	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	10,646	0		2.00
3.00	OPERATING ROOM	50.00	0	356	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	49,388	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	2,091	0		5.00
6.00	CLINIC	90.00	0	117,033	0		6.00
7.00	EMERGENCY	91.00	0	43,266	0		7.00
	TOTALS		0	241,041			
E - KV CENTER RECLASS							
1.00	KV HEALTH CENTER	194.02	677,136	99,060	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		677,136	99,060			
F - ADVERTISING RECLASS							
1.00	ADVERTISING	194.07	22,977	25,580	0		1.00
	TOTALS		22,977	25,580			
G - PROPERTY INSURANCE RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	39,644	12		1.00
	TOTALS		0	39,644			
H - REHAB RECLASS							
1.00	PHYSICAL THERAPY	66.00	679,511	42,340	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		679,511	42,340			
I - IMPLANTABLE DEVICES RECLASS							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	60,819	0		1.00
	TOTALS		0	60,819			
500.00	Grand Total: Decreases		1,960,145	829,215			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151324

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/31/2012 12:03 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	53,965	0	0	0	1.00
2.00	Land Improvements	1,844,495	15,245	0	15,245	2.00
3.00	Buildings and Fixtures	14,908,644	16,941,238	0	16,941,238	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	798,894	180,987	0	180,987	5.00
6.00	Movable Equipment	4,493,420	2,324,977	0	2,324,977	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	22,099,418	19,462,447	0	19,462,447	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	22,099,418	19,462,447	0	19,462,447	10.00
SUMMARY OF CAPITAL						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2					
1.00	NEW CAP REL COSTS-BLDG & FIXT	623,692	2,880	530,024	0	1.00
3.00	Total (sum of lines 1-2)	623,692	2,880	530,024	0	3.00
COMPUTATION OF RATIOS						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151324

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/31/2012 12:03 pm

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	53,965	0			1.00
2.00	Land Improvements	1,859,740	0			2.00
3.00	Buildings and Fixtures	20,985,577	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	918,461	0			5.00
6.00	Movable Equipment	5,034,119	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	28,851,862	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	28,851,862	0			10.00
SUMMARY OF CAPITAL						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,156,596			1.00
3.00	Total (sum of lines 1-2)	0	1,156,596			3.00
ALLOCATION OF OTHER CAPITAL						
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	609,317	2,880 1.00
3.00	Total (sum of lines 1-2)	0	0	0	609,317	2,880 3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151324

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/31/2012 12:03 pm

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		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	530,024	39,244	0	0	1,181,465	1.00
3.00	Total (sum of lines 1-2)	530,024	39,244	0	0	1,181,465	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151324

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

Worksheet A-8

Date/Time Prepared:
5/31/2012 12:03 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
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			NEW CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			*** Cost Center Deleted ***	2.00 2.00
3.00 Investment income - other (chapter 2)		0		0.00 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00 7.00
8.00 Television and radio service (chapter 21)		0		0.00 8.00
9.00 Parking lot (chapter 21)		0		0.00 9.00
10.00 Provider-based physician adjustment	A-8-2	-1,010,047		10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0		12.00
13.00 Laundry and linen service		0		0.00 13.00
14.00 Cafeteria-employees and guests		0		0.00 14.00
15.00 Rental of quarters to employee and others		0		0.00 15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00 16.00
17.00 Sale of drugs to other than patients		0		0.00 17.00
18.00 Sale of medical records and abstracts	B	-14,153	MEDICAL RECORDS & LIBRARY	16.00 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00 19.00
20.00 Vending machines		0		0.00 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		ORESPIRATORY THERAPY	65.00 23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY	66.00 24.00
25.00 Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***	114.00 25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			*** Cost Center Deleted ***	2.00 27.00
28.00 Non-physician Anesthetist			*** Cost Center Deleted ***	19.00 28.00
29.00 Physicians' assistant		0		0.00 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY	67.00 30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY	68.00 31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	0		0.00 32.00
33.00 WELLNESS PROGRAM FEE	B	-4,356	PHYSICAL THERAPY	66.00 33.00
34.00 MISCELLANEOUS INCOME INSURANCE	B	-400	NEW CAP REL COSTS-BLDG & FIXT	1.00 34.00
35.00 MISCELLANEOUS INCOME BENEFITS	B	-28,296	EMPLOYEE BENEFITS	4.00 35.00
36.00 MISCELLANEOUS INCOME ADMIN	B	-341	ADMINISTRATIVE & GENERAL	5.00 36.00
37.00 MISCELLANEOUS INCOME ADMIN	B	-409,095	ADMINISTRATIVE & GENERAL	5.00 37.00
38.00 MISCELLANEOUS INCOME HOUSEKEEPING	B	-152	HOUSEKEEPING	9.00 38.00
39.00 MEALS ON WHEELS	B	-1,256	DIETARY	10.00 39.00
40.00 CAFETERIA GUEST	A	-83,909	CAFETERIA	11.00 40.00
41.00 MISCELLANEOUS INCOME PHARMACY	B	-97,502	PHARMACY	15.00 41.00
42.00 MISCELLANEOUS INCOME MEDICAL RECORDS	B	-110	MEDICAL RECORDS & LIBRARY	16.00 42.00
43.00 MISCELLANEOUS INCOME A&P	B	-278	ADULTS & PEDIATRICS	30.00 43.00
44.00 MISCELLANEOUS SUPPLIES	B	-898	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00 44.00
45.00 MISCELLANEOUS INCOME CLINIC	B	-16,182	WHEATFIELD HEALTH CENTER	88.00 45.00
45.01 INTEREST INCOME	A	-13,389	ADMINISTRATIVE & GENERAL	5.00 45.01
45.02 LOBBYING EXPENSE	A	-2,638	ADMINISTRATIVE & GENERAL	5.00 45.02
45.03 GOODWILL AMORTIZATION	A	-14,375	NEW CAP REL COSTS-BLDG & FIXT	1.00 45.03
45.04 ANESTHESIA OFFSET	A	-19,175	ADULTS & PEDIATRICS	30.00 45.04
45.05 ANESTHESIA OFFSET	A	-1,975	INTENSIVE CARE UNIT	31.00 45.05

Provider CCN: 151324

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

Worksheet A-8

Date/Time Prepared:
 5/31/2012 12:03 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center	Line #	
			1.00	2.00	
45.06 ANESTHESIA OFFSET	A	-386,625	OPERATING ROOM	50.00	45.06
45.07 ANESTHESIA OFFSET	A	-300	RADIOLOGY-DIAGNOSTIC	54.00	45.07
45.08 ANESTHESIA OFFSET	A	-5,500	CLINIC	90.00	45.08
45.09 ANESTHESIA OFFSET	A	-3,200	EMERGENCY	91.00	45.09
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,114,152			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151324

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

Worksheet A-8

Date/Time Prepared:
5/31/2012 12:03 pm

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	WELLNESS PROGRAM FEE	0	33.00
34.00	MISCELLANEOUS INCOME INSURANCE	12	34.00
35.00	MISCELLANEOUS INCOME BENEFITS	0	35.00
36.00	MISCELLANEOUS INCOME ADMIN	0	36.00
37.00	MISCELLANEOUS INCOME ADMIN	0	37.00
38.00	MISCELLANEOUS INCOME HOUSEKEEPING	0	38.00
39.00	MEALS ON WHEELS	0	39.00
40.00	CAFETERIA GUEST	0	40.00
41.00	MISCELLANEOUS INCOME PHARMACY	0	41.00
42.00	MISCELLANEOUS INCOME MEDICAL RECORDS	0	42.00
43.00	MISCELLANEOUS INCOME A&P	0	43.00
44.00	MISCELLANEOUS SUPPLIES	0	44.00
45.00	MISCELLANEOUS INCOME CLINIC	0	45.00
45.01	INTEREST INCOME	0	45.01
45.02	LOBBYING EXPENSE	0	45.02
45.03	GOODWILL AMORTIZATION	9	45.03
45.04	ANESTHESIA OFFSET	0	45.04
45.05	ANESTHESIA OFFSET	0	45.05
45.06	ANESTHESIA OFFSET	0	45.06
45.07	ANESTHESIA OFFSET	0	45.07
45.08	ANESTHESIA OFFSET	0	45.08
45.09	ANESTHESIA OFFSET	0	45.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151324

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

Worksheet A-8-2

Date/Time Prepared:
5/31/2012 12:03 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	39,498	0	1.00
2.00	91.00	EMERGENCY	1,010,047	1,010,047	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			1,049,545	1,010,047	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151324

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

Worksheet A-8-2

Date/Time Prepared:
5/31/2012 12:03 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	39,498	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	39,498					200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151324

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

Worksheet A-8-2

Date/Time Prepared:
5/31/2012 12:03 pm

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151324

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

Worksheet A-8-2

Date/Time Prepared:
5/31/2012 12:03 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	0	1.00
2.00	0	1,010,047	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	0	1,010,047	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151324		Period: From 01/01/2011 To 12/31/2011		Worksheet A-8-3 Part	
				Physical Therapy		Date/Time Prepared: 5/31/2012 12:03 pm	
						Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.51	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	2,891.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.44	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.72	36.72	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					212,315	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					212,315	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					212,315	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					212,315	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151324				Period: From 01/01/2011 To 12/31/2011		Worksheet A-8-3 Part	
						Physical Therapy		Date/Time Prepared: 5/31/2012 12:03 pm	
						Cost			
						1.00			
46.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						0		46.00	
		Therapists	Assistants	Aides	Trainees	Total			
		1.00	2.00	3.00	4.00	5.00			
PART V - OVERTIME COMPUTATION									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00		51.00	
DETERMINATION OF OVERTIME ALLOWANCE									
52.00	Adjusted hourly salary equivalency amount (see instructions)	73.44	0.00	0.00	0.00			52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0			53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0			54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0			55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0			56.00	
						1.00			
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT									
57.00	Salary equivalency amount (from line 23)					212,315		57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35)					0		58.00	
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0		59.00	
60.00	Overtime allowance (from column 5, line 56)					0		60.00	
61.00	Equipment cost (see instructions)					0		61.00	
62.00	Supplies (see instructions)					0		62.00	
63.00	Total allowance (sum of lines 57-62)					212,315		63.00	
64.00	Total cost of outside supplier services (from your records)					193,084		64.00	
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0		65.00	
LINE 33 CALCULATION									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0		100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0		100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27					0		100.02	
LINE 34 CALCULATION									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0		101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		101.01	
101.02	Line 34 = sum of lines 27 and 31					0		101.02	
LINE 35 CALCULATION									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		102.00	
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0		102.01	
102.02	Line 35 = sum of lines 31 and 32					0		102.02	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151324

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

Worksheet B
Part I
Date/Time Prepared:
5/31/2012 12:03 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT				
	0	1.00	4.00	4A	5.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT	1,181,465	1,181,465				1.00
4.00 EMPLOYEE BENEFITS	4,660,260	0	4,660,260			4.00
5.00 ADMINISTRATIVE & GENERAL	4,681,087	91,418	666,304	5,438,809	5,438,809	5.00
7.00 OPERATION OF PLANT	819,027	21,884	72,450	913,361	178,679	7.00
8.00 LAUNDRY & LINEN SERVICE	122,627	18,964	23,684	165,275	32,332	8.00
9.00 HOUSEKEEPING	573,282	22,447	123,825	719,554	140,765	9.00
10.00 DIETARY	286,347	22,165	42,157	350,669	68,601	10.00
11.00 CAFETERIA	294,633	22,423	55,487	372,543	72,880	11.00
13.00 NURSING ADMINISTRATION	329,217	4,726	88,326	422,269	82,608	13.00
14.00 CENTRAL SERVICES & SUPPLY	34,033	0	5,708	39,741	7,774	14.00
15.00 PHARMACY	2,058,016	11,822	110,496	2,180,334	426,534	15.00
16.00 MEDICAL RECORDS & LIBRARY	387,042	13,323	97,677	498,042	97,431	16.00
17.00 SOCIAL SERVICE	9,696	0	2,621	12,317	2,410	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,011,076	162,886	518,833	2,692,795	526,786	30.00
31.00 INTENSIVE CARE UNIT	643,333	8,866	164,427	816,626	159,755	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	292,247	2,955	74,575	369,777	72,339	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	1,398,774	115,694	145,266	1,659,734	324,690	50.00
52.00 DELIVERY ROOM & LABOR ROOM	27,096	5,981	6,914	39,991	7,823	52.00
54.00 RADIOLOGY-DIAGNOSTIC	2,463,914	81,649	284,897	2,830,460	553,726	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	1,738,426	28,897	216,986	1,984,309	388,186	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	127,945	2,346	0	130,291	25,489	63.00
65.00 RESPIRATORY THERAPY	977,240	28,721	223,544	1,229,505	240,526	65.00
66.00 PHYSICAL THERAPY	770,794	28,651	149,533	948,978	185,647	66.00
66.01 KV HEALTH & DEMOTTE PT	605,786	97,821	139,960	843,567	165,025	66.01
67.00 OCCUPATIONAL THERAPY	416,465	18,131	106,990	541,586	105,949	67.00
67.01 KV HEALTH & DEMOTTE OT	127,282	22,588	30,303	180,173	35,247	67.01
68.00 SPEECH PATHOLOGY	130,172	5,665	33,441	169,278	33,116	68.00
68.01 KV HEALTH & DEMOTTE ST	97,609	17,322	23,239	138,170	27,030	68.01
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	179,324	15,082	0	194,406	38,031	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	60,819	0	0	60,819	11,898	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 WHEATFIELD HEALTH CENTER	325,813	0	71,113	396,926	77,650	88.00
88.03 BROOK HEALTH CENTER	385,377	31,079	77,600	494,056	96,651	88.03
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	777,940	40,883	176,706	995,529	194,753	90.00
91.00 EMERGENCY	991,258	52,353	251,906	1,295,517	253,439	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	1,386,781	36,192	352,462	1,775,435	347,325	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 HOSPICE	490,836	2,920	21,452	515,208	100,789	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	31,863,039	1,035,854	4,358,882	31,416,050	5,081,884	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,697	0	2,697	528	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 ALTERNACARE	539,625	98,067	141,597	779,289	152,451	194.00
194.01 DME EQUIPMENT	170,596	1,384	24,042	196,022	38,347	194.01
194.02 KV HEALTH CENTER	380,440	33,858	93,873	508,171	99,412	194.02
194.04 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05 MEALS ON WHEELS	0	0	0	0	0	194.05
194.06 WATER LAB	82,203	6,497	16,273	104,973	20,536	194.06
194.07 ADVERTISING	204,657	3,108	25,593	233,358	45,651	194.07
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)	33,240,560	1,181,465	4,660,260	33,240,560	5,438,809	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151324

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT	1,092,040					7.00
8.00	LAUNDRY & LINEN SERVICE	19,388	216,995				8.00
9.00	HOUSEKEEPING	22,949	0	883,268			9.00
10.00	DIETARY	22,661	0	750	442,681		10.00
11.00	CAFETERIA	22,925	0	987	0	469,335	11.00
13.00	NURSING ADMINISTRATION	4,832	0	0	0	10,464	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	12,086	0	3,947	0	14,122	15.00
16.00	MEDICAL RECORDS & LIBRARY	13,621	0	0	0	24,156	16.00
17.00	SOCIAL SERVICE	0	0	0	0	137	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	166,527	75,983	405,478	181,173	94,488	30.00
31.00	INTENSIVE CARE UNIT	9,064	10,900	22,737	18,134	22,907	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	3,021	2,304	3,789	0	9,938	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	118,280	9,465	0	0	20,677	50.00
52.00	DELIVERY ROOM & LABOR ROOM	6,115	213	1,579	0	921	52.00
54.00	RADIOLOGY-DIAGNOSTIC	83,474	11,450	34,105	0	40,899	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	29,543	0	23,684	0	40,412	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	2,398	0	0	0	0	63.00
65.00	RESPIRATORY THERAPY	29,363	1,453	2,842	0	37,558	65.00
66.00	PHYSICAL THERAPY	29,291	26,799	20,353	0	19,835	66.00
66.01	KV HEALTH & DEMOTTE PT	100,008	0	0	0	0	66.01
67.00	OCCUPATIONAL THERAPY	18,536	0	14,566	0	14,192	67.00
67.01	KV HEALTH & DEMOTTE OT	23,093	0	0	0	0	67.01
68.00	SPEECH PATHOLOGY	5,791	0	4,555	0	4,435	68.00
68.01	KV HEALTH & DEMOTTE ST	17,709	0	0	0	0	68.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,419	0	0	0	2,379	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	WHEATFIELD HEALTH CENTER	0	0	0	0	0	88.00
88.03	BROOK HEALTH CENTER	31,773	0	0	0	0	88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	41,797	18,362	0	3,313	25,275	90.00
91.00	EMERGENCY	53,523	18,096	68,211	0	40,093	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	37,001	0	56,842	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	HOSPICE	2,985	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	943,173	175,025	664,425	202,620	422,888	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,758	0	4,579	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	ALTERNACARE	100,260	41,970	194,054	154,361	34,435	194.00
194.01	DME EQUIPMENT	1,415	0	18,947	0	4,361	194.01
194.02	KV HEALTH CENTER	34,615	0	0	0	0	194.02
194.04	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	MEALS ON WHEELS	0	0	0	85,700	0	194.05
194.06	WATER LAB	6,642	0	1,263	0	3,039	194.06
194.07	ADVERTISING	3,177	0	0	0	4,612	194.07
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,092,040	216,995	883,268	442,681	469,335	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151324

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

Worksheet B
Part I
Date/Time Prepared:
5/31/2012 12:03 pm

Cost Center Description	NURSING	CENTRAL	PHARMACY	MEDICAL	SOCIAL SERVICE	
	ADMINISTRATION	SERVICES & SUPPLY		RECORDS & LIBRARY		
	13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT						7.00
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	520,173					13.00
14.00 CENTRAL SERVICES & SUPPLY	0	47,515				14.00
15.00 PHARMACY	0	0	2,637,023			15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	0	633,250		16.00
17.00 SOCIAL SERVICE	0	0	0	0	14,864	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	190,818	0	0	281,934	13,545	30.00
31.00 INTENSIVE CARE UNIT	46,261	0	0	0	1,319	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	20,070	0	0	2,900	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	41,756	0	0	50,537	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	1,860	0	0	267	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	82,594	0	0	79,102	0	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	12,435	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01 KV HEALTH & DEMOTTE PT	0	0	0	0	0	66.01
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01 KV HEALTH & DEMOTTE OT	0	0	0	0	0	67.01
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01 KV HEALTH & DEMOTTE ST	0	0	0	0	0	68.01
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,804	47,515	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	2,637,023	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 WHEATFIELD HEALTH CENTER	0	0	0	0	0	88.00
88.03 BROOK HEALTH CENTER	0	0	0	0	0	88.03
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	51,042	0	0	152,967	0	90.00
91.00 EMERGENCY	80,968	0	0	53,108	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	520,173	47,515	2,637,023	633,250	14,864	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 ALTERNACARE	0	0	0	0	0	194.00
194.01 DME EQUIPMENT	0	0	0	0	0	194.01
194.02 KV HEALTH CENTER	0	0	0	0	0	194.02
194.04 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05 MEALS ON WHEELS	0	0	0	0	0	194.05
194.06 WATER LAB	0	0	0	0	0	194.06
194.07 ADVERTISING	0	0	0	0	0	194.07
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)	520,173	47,515	2,637,023	633,250	14,864	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151324

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

Worksheet B
Part I
Date/Time Prepared:
5/31/2012 12:03 pm

Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00 NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00 EMPLOYEE BENEFITS				4.00
5.00 ADMINISTRATIVE & GENERAL				5.00
7.00 OPERATION OF PLANT				7.00
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
17.00 SOCIAL SERVICE				17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS	4,629,527	0	4,629,527	30.00
31.00 INTENSIVE CARE UNIT	1,107,703	0	1,107,703	31.00
41.00 SUBPROVIDER - IRF	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	42.00
43.00 NURSERY	484,138	0	484,138	43.00
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	2,225,139	0	2,225,139	50.00
52.00 DELIVERY ROOM & LABOR ROOM	58,769	0	58,769	52.00
54.00 RADIOLOGY-DIAGNOSTIC	3,715,810	0	3,715,810	54.00
57.00 CT SCAN	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 LABORATORY	2,478,569	0	2,478,569	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	158,178	0	158,178	63.00
65.00 RESPIRATORY THERAPY	1,541,247	0	1,541,247	65.00
66.00 PHYSICAL THERAPY	1,230,903	0	1,230,903	66.00
66.01 KV HEALTH & DEMOTTE PT	1,108,600	0	1,108,600	66.01
67.00 OCCUPATIONAL THERAPY	694,829	0	694,829	67.00
67.01 KV HEALTH & DEMOTTE OT	238,513	0	238,513	67.01
68.00 SPEECH PATHOLOGY	217,175	0	217,175	68.00
68.01 KV HEALTH & DEMOTTE ST	182,909	0	182,909	68.01
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	302,554	0	302,554	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	72,717	0	72,717	72.00
73.00 DRUGS CHARGED TO PATIENTS	2,637,023	0	2,637,023	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00 WHEATFIELD HEALTH CENTER	474,576	0	474,576	88.00
88.03 BROOK HEALTH CENTER	622,480	0	622,480	88.03
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00 CLINIC	1,483,038	0	1,483,038	90.00
91.00 EMERGENCY	1,862,955	0	1,862,955	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00 FAMILY PRACTICE	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS				
101.00 HOME HEALTH AGENCY	2,216,603	0	2,216,603	101.00
SPECIAL PURPOSE COST CENTERS				
116.00 HOSPICE	618,982	0	618,982	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	30,362,937	0	30,362,937	118.00
NONREIMBURSABLE COST CENTERS				
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,562	0	10,562	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
192.01 RENSSELAER HEALTH CENTER	0	0	0	192.01
193.00 NONPAID WORKERS	0	0	0	193.00
194.00 ALTERNACARE	1,456,820	0	1,456,820	194.00
194.01 DME EQUIPMENT	259,092	0	259,092	194.01
194.02 KV HEALTH CENTER	642,198	0	642,198	194.02
194.04 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.04
194.05 MEALS ON WHEELS	85,700	0	85,700	194.05
194.06 WATER LAB	136,453	0	136,453	194.06
194.07 ADVERTISING	286,798	0	286,798	194.07
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)	33,240,560	0	33,240,560	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151324

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

Worksheet B
Part II
Date/Time Prepared:
5/31/2012 12:03 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00 NEW CAP REL COSTS-BLDG & FIXT							1.00
4.00 EMPLOYEE BENEFITS	0	0	0	0	0		4.00
5.00 ADMINISTRATIVE & GENERAL	0	91,418	91,418	0	0	91,418	5.00
7.00 OPERATION OF PLANT	0	21,884	21,884	0	0	3,003	7.00
8.00 LAUNDRY & LINEN SERVICE	0	18,964	18,964	0	0	543	8.00
9.00 HOUSEKEEPING	0	22,447	22,447	0	0	2,366	9.00
10.00 DIETARY	0	22,165	22,165	0	0	1,153	10.00
11.00 CAFETERIA	0	22,423	22,423	0	0	1,225	11.00
13.00 NURSING ADMINISTRATION	0	4,726	4,726	0	0	1,388	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	131	14.00
15.00 PHARMACY	0	11,822	11,822	0	0	7,169	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	13,323	13,323	0	0	1,638	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	40	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	0	162,886	162,886	0	0	8,854	30.00
31.00 INTENSIVE CARE UNIT	0	8,866	8,866	0	0	2,685	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	0	42.00
43.00 NURSERY	0	2,955	2,955	0	0	1,216	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0	115,694	115,694	0	0	5,457	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	5,981	5,981	0	0	131	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	81,649	81,649	0	0	9,314	54.00
57.00 CT SCAN	0	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00 LABORATORY	0	28,897	28,897	0	0	6,524	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	2,346	2,346	0	0	428	63.00
65.00 RESPIRATORY THERAPY	0	28,721	28,721	0	0	4,043	65.00
66.00 PHYSICAL THERAPY	0	28,651	28,651	0	0	3,120	66.00
66.01 KV HEALTH & DEMOTTE PT	0	97,821	97,821	0	0	2,774	66.01
67.00 OCCUPATIONAL THERAPY	0	18,131	18,131	0	0	1,781	67.00
67.01 KV HEALTH & DEMOTTE OT	0	22,588	22,588	0	0	592	67.01
68.00 SPEECH PATHOLOGY	0	5,665	5,665	0	0	557	68.00
68.01 KV HEALTH & DEMOTTE ST	0	17,322	17,322	0	0	454	68.01
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	15,082	15,082	0	0	639	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	200	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00 WHEATFIELD HEALTH CENTER	0	0	0	0	0	1,305	88.00
88.03 BROOK HEALTH CENTER	0	31,079	31,079	0	0	1,624	88.03
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00 CLINIC	0	40,883	40,883	0	0	3,273	90.00
91.00 EMERGENCY	0	52,353	52,353	0	0	4,260	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
93.00 FAMILY PRACTICE	0	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
101.00 HOME HEALTH AGENCY	0	36,192	36,192	0	0	5,838	101.00
SPECIAL PURPOSE COST CENTERS							
116.00 HOSPICE	0	2,920	2,920	0	0	1,694	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	1,035,854	1,035,854	0	0	85,419	118.00
NONREIMBURSABLE COST CENTERS							
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,697	2,697	0	0	9	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	0	192.00
192.01 RENSSELAER HEALTH CENTER	0	0	0	0	0	0	192.01
193.00 NONPAID WORKERS	0	0	0	0	0	0	193.00
194.00 ALTERNACARE	0	98,067	98,067	0	0	2,562	194.00
194.01 DME EQUIPMENT	0	1,384	1,384	0	0	645	194.01
194.02 KV HEALTH CENTER	0	33,858	33,858	0	0	1,671	194.02
194.04 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	0	194.04
194.05 MEALS ON WHEELS	0	0	0	0	0	0	194.05
194.06 WATER LAB	0	6,497	6,497	0	0	345	194.06
194.07 ADVERTISING	0	3,108	3,108	0	0	767	194.07
200.00 Cross Foot Adjustments							200.00
201.00 Negative Cost Centers		0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	1,181,465	1,181,465	0	0	91,418	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151324		Period: From 01/01/2011 To 12/31/2011		Worksheet B Part II Date/Time Prepared: 5/31/2012 12:03 pm	
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT	24,887					7.00
8.00	LAUNDRY & LINEN SERVICE	442	19,949				8.00
9.00	HOUSEKEEPING	523	0	25,336			9.00
10.00	DIETARY	516	0	22	23,856		10.00
11.00	CAFETERIA	522	0	28	0	24,198	11.00
13.00	NURSING ADMINISTRATION	110	0	0	0	540	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	275	0	113	0	728	15.00
16.00	MEDICAL RECORDS & LIBRARY	310	0	0	0	1,245	16.00
17.00	SOCIAL SERVICE	0	0	0	0	7	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,797	6,984	11,632	9,764	4,871	30.00
31.00	INTENSIVE CARE UNIT	207	1,002	652	977	1,181	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	69	212	109	0	512	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	2,696	870	0	0	1,066	50.00
52.00	DELIVERY ROOM & LABOR ROOM	139	20	45	0	47	52.00
54.00	RADIOLOGY-DIAGNOSTIC	1,902	1,053	978	0	2,109	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	673	0	679	0	2,084	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	55	0	0	0	0	63.00
65.00	RESPIRATORY THERAPY	669	134	82	0	1,936	65.00
66.00	PHYSICAL THERAPY	668	2,464	584	0	1,023	66.00
66.01	KV HEALTH & DEMOTTE PT	2,279	0	0	0	0	66.01
67.00	OCCUPATIONAL THERAPY	422	0	418	0	732	67.00
67.01	KV HEALTH & DEMOTTE OT	526	0	0	0	0	67.01
68.00	SPEECH PATHOLOGY	132	0	131	0	229	68.00
68.01	KV HEALTH & DEMOTTE ST	404	0	0	0	0	68.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	351	0	0	0	123	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	WHEATFIELD HEALTH CENTER	0	0	0	0	0	88.00
88.03	BROOK HEALTH CENTER	724	0	0	0	0	88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	953	1,688	0	179	1,303	90.00
91.00	EMERGENCY	1,220	1,664	1,957	0	2,067	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	843	0	1,630	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	HOSPICE	68	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	21,495	16,091	19,060	10,920	21,803	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	63	0	131	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	ALTERNACARE	2,285	3,858	5,566	8,318	1,775	194.00
194.01	DME EQUIPMENT	32	0	543	0	225	194.01
194.02	KV HEALTH CENTER	789	0	0	0	0	194.02
194.04	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05	MEALS ON WHEELS	0	0	0	4,618	0	194.05
194.06	WATER LAB	151	0	36	0	157	194.06
194.07	ADVERTISING	72	0	0	0	238	194.07
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)	24,887	19,949	25,336	23,856	24,198	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151324

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

Worksheet B
Part II
Date/Time Prepared:
5/31/2012 12:03 pm

Cost Center Description	NURSING	CENTRAL	PHARMACY	MEDICAL	SOCIAL SERVICE	
	ADMINISTRATION	SERVICES & SUPPLY		RECORDS & LIBRARY		
	13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT						7.00
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	6,764					13.00
14.00 CENTRAL SERVICES & SUPPLY	0	131				14.00
15.00 PHARMACY	0	0	20,107			15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	0	16,516		16.00
17.00 SOCIAL SERVICE	0	0	0	0	47	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,481	0	0	7,353	43	30.00
31.00 INTENSIVE CARE UNIT	602	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	261	0	0	76	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	543	0	0	1,318	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	24	0	0	7	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	1,074	0	0	2,063	0	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	324	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01 KV HEALTH & DEMOTTE PT	0	0	0	0	0	66.01
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01 KV HEALTH & DEMOTTE OT	0	0	0	0	0	67.01
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01 KV HEALTH & DEMOTTE ST	0	0	0	0	0	68.01
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	62	131	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	20,107	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 WHEATFIELD HEALTH CENTER	0	0	0	0	0	88.00
88.03 BROOK HEALTH CENTER	0	0	0	0	0	88.03
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	664	0	0	3,990	0	90.00
91.00 EMERGENCY	1,053	0	0	1,385	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	6,764	131	20,107	16,516	47	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 ALTERNACARE	0	0	0	0	0	194.00
194.01 DME EQUIPMENT	0	0	0	0	0	194.01
194.02 KV HEALTH CENTER	0	0	0	0	0	194.02
194.04 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05 MEALS ON WHEELS	0	0	0	0	0	194.05
194.06 WATER LAB	0	0	0	0	0	194.06
194.07 ADVERTISING	0	0	0	0	0	194.07
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)	6,764	131	20,107	16,516	47	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151324

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

Worksheet B
Part II
Date/Time Prepared:
5/31/2012 12:03 pm

Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00 NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00 EMPLOYEE BENEFITS				4.00
5.00 ADMINISTRATIVE & GENERAL				5.00
7.00 OPERATION OF PLANT				7.00
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
17.00 SOCIAL SERVICE				17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS	218,665	0	218,665	30.00
31.00 INTENSIVE CARE UNIT	16,176	0	16,176	31.00
41.00 SUBPROVIDER - IRF	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	42.00
43.00 NURSERY	5,410	0	5,410	43.00
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	127,644	0	127,644	50.00
52.00 DELIVERY ROOM & LABOR ROOM	6,394	0	6,394	52.00
54.00 RADIOLOGY-DIAGNOSTIC	100,142	0	100,142	54.00
57.00 CT SCAN	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 LABORATORY	39,181	0	39,181	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	2,829	0	2,829	63.00
65.00 RESPIRATORY THERAPY	35,585	0	35,585	65.00
66.00 PHYSICAL THERAPY	36,510	0	36,510	66.00
66.01 KV HEALTH & DEMOTTE PT	102,874	0	102,874	66.01
67.00 OCCUPATIONAL THERAPY	21,484	0	21,484	67.00
67.01 KV HEALTH & DEMOTTE OT	23,706	0	23,706	67.01
68.00 SPEECH PATHOLOGY	6,714	0	6,714	68.00
68.01 KV HEALTH & DEMOTTE ST	18,180	0	18,180	68.01
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	16,388	0	16,388	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	200	0	200	72.00
73.00 DRUGS CHARGED TO PATIENTS	20,107	0	20,107	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00 WHEATFIELD HEALTH CENTER	1,305	0	1,305	88.00
88.03 BROOK HEALTH CENTER	33,427	0	33,427	88.03
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00 CLINIC	52,933	0	52,933	90.00
91.00 EMERGENCY	65,959	0	65,959	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00 FAMILY PRACTICE	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS				
101.00 HOME HEALTH AGENCY	44,503	0	44,503	101.00
SPECIAL PURPOSE COST CENTERS				
116.00 HOSPICE	4,682	0	4,682	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1,000,998	0	1,000,998	118.00
NONREIMBURSABLE COST CENTERS				
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,900	0	2,900	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
192.01 RENSSELAER HEALTH CENTER	0	0	0	192.01
193.00 NONPAID WORKERS	0	0	0	193.00
194.00 ALTERNACARE	122,431	0	122,431	194.00
194.01 DME EQUIPMENT	2,829	0	2,829	194.01
194.02 KV HEALTH CENTER	36,318	0	36,318	194.02
194.04 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.04
194.05 MEALS ON WHEELS	4,618	0	4,618	194.05
194.06 WATER LAB	7,186	0	7,186	194.06
194.07 ADVERTISING	4,185	0	4,185	194.07
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)	1,181,465	0	1,181,465	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

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

Worksheet B-1

Date/Time Prepared:
5/31/2012 12:03 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)						
	1.00	4.00					
GENERAL SERVICE COST CENTERS							
1.00 NEW CAP REL COSTS-BLDG & FIXT	100,741						1.00
4.00 EMPLOYEE BENEFITS	0	17,076,329					4.00
5.00 ADMINISTRATIVE & GENERAL	7,795	2,441,519	-5,438,809		27,801,751		5.00
7.00 OPERATION OF PLANT	1,866	265,474	0		913,361	91,080	7.00
8.00 LAUNDRY & LINEN SERVICE	1,617	86,784	0		165,275	1,617	8.00
9.00 HOUSEKEEPING	1,914	453,724	0		719,554	1,914	9.00
10.00 DIETARY	1,890	154,474	0		350,669	1,890	10.00
11.00 CAFETERIA	1,912	203,318	0		372,543	1,912	11.00
13.00 NURSING ADMINISTRATION	403	323,647	0		422,269	403	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	20,915	0		39,741	0	14.00
15.00 PHARMACY	1,008	404,883	0		2,180,334	1,008	15.00
16.00 MEDICAL RECORDS & LIBRARY	1,136	357,911	0		498,042	1,136	16.00
17.00 SOCIAL SERVICE	0	9,605	0		12,317	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	13,889	1,901,127	0		2,692,795	13,889	30.00
31.00 INTENSIVE CARE UNIT	756	602,499	0		816,626	756	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	252	273,262	0		369,777	252	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	9,865	532,291	0		1,659,734	9,865	50.00
52.00 DELIVERY ROOM & LABOR ROOM	510	25,336	0		39,991	510	52.00
54.00 RADIOLOGY-DIAGNOSTIC	6,962	1,043,931	0		2,830,460	6,962	54.00
57.00 CT SCAN	0	0	0		0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0		0	0	59.00
60.00 LABORATORY	2,464	795,088	0		1,984,309	2,464	60.00
60.01 BLOOD LABORATORY	0	0	0		0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	200	0	0		130,291	200	63.00
65.00 RESPIRATORY THERAPY	2,449	819,117	0		1,229,505	2,449	65.00
66.00 PHYSICAL THERAPY	2,443	547,923	0		948,978	2,443	66.00
66.01 KV HEALTH & DEMOTTE PT	8,341	512,847	0		843,567	8,341	66.01
67.00 OCCUPATIONAL THERAPY	1,546	392,037	0		541,586	1,546	67.00
67.01 KV HEALTH & DEMOTTE OT	1,926	111,038	0		180,173	1,926	67.01
68.00 SPEECH PATHOLOGY	483	122,537	0		169,278	483	68.00
68.01 KV HEALTH & DEMOTTE ST	1,477	85,152	0		138,170	1,477	68.01
70.00 ELECTROENCEPHALOGRAPHY	0	0	0		0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,286	0	0		194,406	1,286	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0		60,819	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0		0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00 WHEATFIELD HEALTH CENTER	0	260,576	0		396,926	0	88.00
88.03 BROOK HEALTH CENTER	2,650	284,346	0		494,056	2,650	88.03
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0	0	89.00
90.00 CLINIC	3,486	647,493	0		995,529	3,486	90.00
91.00 EMERGENCY	4,464	923,042	0		1,295,517	4,464	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)							92.00
93.00 FAMILY PRACTICE	0	0	0		0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
101.00 HOME HEALTH AGENCY	3,086	1,291,506	0		1,775,435	3,086	101.00
SPECIAL PURPOSE COST CENTERS							
116.00 HOSPICE	249	78,605	0		515,208	249	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	88,325	15,972,007	-5,438,809		25,977,241	78,664	118.00
NONREIMBURSABLE COST CENTERS							
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	230	0	0		2,697	230	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0		0	0	192.00
192.01 RENSSELAER HEALTH CENTER	0	0	0		0	0	192.01
193.00 NONPAID WORKERS	0	0	0		0	0	193.00
194.00 ALTERNACARE	8,362	518,847	0		779,289	8,362	194.00
194.01 DME EQUIPMENT	118	88,096	0		196,022	118	194.01
194.02 KV HEALTH CENTER	2,887	343,972	0		508,171	2,887	194.02
194.04 OTHER NONREIMBURSABLE COST CENTERS	0	0	0		0	0	194.04
194.05 MEALS ON WHEELS	0	0	0		0	0	194.05
194.06 WATER LAB	554	59,628	0		104,973	554	194.06
194.07 ADVERTISING	265	93,779	0		233,358	265	194.07
200.00 Cross Foot Adjustments							200.00
201.00 Negative Cost Centers							201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	1,181,465	4,660,260			5,438,809	1,092,040	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	11.727747	0.272908			0.195628	11.989899	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

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

Worksheet B-1

Date/Time Prepared:
5/31/2012 12:03 pm

Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)					
	1.00					
204.00 Cost to be allocated (per Wkst. B, Part II)		0	5A	91,418	24,887	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)		0.000000		0.003288	0.273243	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

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

Worksheet B-1

Date/Time Prepared:
5/31/2012 12:03 pm

Cost Center Description	LAUNDRY & LINEN SERVICE (DOLLAR VALUE)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (MAN HOURS)	
	8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE	48,972					8.00
9.00 HOUSEKEEPING	0	111,880				9.00
10.00 DIETARY	0	95	45,699			10.00
11.00 CAFETERIA	0	125	0	401,472		11.00
13.00 NURSING ADMINISTRATION	0	0	0	8,951	220,333	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00 PHARMACY	0	500	0	12,080	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	0	20,663	0	16.00
17.00 SOCIAL SERVICE	0	0	0	117	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	17,148	51,360	18,703	80,826	80,826	30.00
31.00 INTENSIVE CARE UNIT	2,460	2,880	1,872	19,595	19,595	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	520	480	0	8,501	8,501	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	2,136	0	0	17,687	17,687	50.00
52.00 DELIVERY ROOM & LABOR ROOM	48	200	0	788	788	52.00
54.00 RADIOLOGY-DIAGNOSTIC	2,584	4,320	0	34,985	34,985	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	3,000	0	34,569	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00 RESPIRATORY THERAPY	328	360	0	32,127	0	65.00
66.00 PHYSICAL THERAPY	6,048	2,578	0	16,967	0	66.00
66.01 KV HEALTH & DEMOTTE PT	0	0	0	0	0	66.01
67.00 OCCUPATIONAL THERAPY	0	1,845	0	12,140	0	67.00
67.01 KV HEALTH & DEMOTTE OT	0	0	0	0	0	67.01
68.00 SPEECH PATHOLOGY	0	577	0	3,794	0	68.00
68.01 KV HEALTH & DEMOTTE ST	0	0	0	0	0	68.01
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,035	2,035	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 WHEATFIELD HEALTH CENTER	0	0	0	0	0	88.00
88.03 BROOK HEALTH CENTER	0	0	0	0	0	88.03
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	4,144	0	342	21,620	21,620	90.00
91.00 EMERGENCY	4,084	8,640	0	34,296	34,296	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00 FAMILY PRACTICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	0	7,200	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	39,500	84,160	20,917	361,741	220,333	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	580	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 ALTERNACARE	9,472	24,580	15,935	29,456	0	194.00
194.01 DME EQUIPMENT	0	2,400	0	3,730	0	194.01
194.02 KV HEALTH CENTER	0	0	0	0	0	194.02
194.04 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
194.05 MEALS ON WHEELS	0	0	8,847	0	0	194.05
194.06 WATER LAB	0	160	0	2,600	0	194.06
194.07 ADVERTISING	0	0	0	3,945	0	194.07
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)	216,995	883,268	442,681	469,335	520,173	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	4.431001	7.894780	9.686886	1.169035	2.360849	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	19,949	25,336	23,856	24,198	6,764	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

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

Worksheet B-1

Date/Time Prepared:
5/31/2012 12:03 pm

Cost Center Description	LAUNDRY & LINEN SERVICE (DOLLAR VALUE)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (MAN HOURS)	
	8.00	9.00	10.00	11.00	13.00	
205.00 Unit cost multiplier (Wkst. B, Part II)	0.407355	0.226457	0.522025	0.060273	0.030699	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

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

Worksheet B-1

Date/Time Prepared:
5/31/2012 12:03 pm

Cost Center Description	CENTRAL SERVICES & SUPPLY (100% ALLOCATION)	PHARMACY (100% ALLOCATION)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00 EMPLOYEE BENEFITS					4.00
5.00 ADMINISTRATIVE & GENERAL					5.00
7.00 OPERATION OF PLANT					7.00
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	100				14.00
15.00 PHARMACY	0	100			15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	182,316		16.00
17.00 SOCIAL SERVICE	0	0	0	586	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS	0	0	81,170	534	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	52	31.00
41.00 SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	42.00
43.00 NURSERY	0	0	835	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	0	14,550	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	77	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	22,774	0	54.00
57.00 CT SCAN	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 LABORATORY	0	0	3,580	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00 RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	66.00
66.01 KV HEALTH & DEMOTTE PT	0	0	0	0	66.01
67.00 OCCUPATIONAL THERAPY	0	0	0	0	67.00
67.01 KV HEALTH & DEMOTTE OT	0	0	0	0	67.01
68.00 SPEECH PATHOLOGY	0	0	0	0	68.00
68.01 KV HEALTH & DEMOTTE ST	0	0	0	0	68.01
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	100	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	100	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 WHEATFIELD HEALTH CENTER	0	0	0	0	88.00
88.03 BROOK HEALTH CENTER	0	0	0	0	88.03
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 CLINIC	0	0	44,040	0	90.00
91.00 EMERGENCY	0	0	15,290	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00 FAMILY PRACTICE	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
101.00 HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
116.00 HOSPICE	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	100	100	182,316	586	118.00
NONREIMBURSABLE COST CENTERS					
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 RENSSELAER HEALTH CENTER	0	0	0	0	192.01
193.00 NONPAID WORKERS	0	0	0	0	193.00
194.00 ALTERNACARE	0	0	0	0	194.00
194.01 DME EQUIPMENT	0	0	0	0	194.01
194.02 KV HEALTH CENTER	0	0	0	0	194.02
194.04 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.04
194.05 MEALS ON WHEELS	0	0	0	0	194.05
194.06 WATER LAB	0	0	0	0	194.06
194.07 ADVERTISING	0	0	0	0	194.07
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)	47,515	2,637,023	633,250	14,864	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	475.150000	26,370.230000	3.473365	25.365188	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	131	20,107	16,516	47	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

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

Worksheet B-1

Date/Time Prepared:
5/31/2012 12:03 pm

Cost Center Description	CENTRAL SERVICES & SUPPLY (100% ALLOCATION)	PHARMACY (100% ALLOCATION)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)		
205.00 Unit cost multiplier (Wkst. B, Part II)	1.310000	201.070000	0.090590	0.080205		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151324

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

Worksheet C
Part I
Date/Time Prepared:
5/31/2012 12:03 pm

		Title XVIII		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS		4,629,527	0	0	30.00	
31.00	INTENSIVE CARE UNIT		1,107,703	0	0	31.00	
41.00	SUBPROVIDER - IRF		0	0	0	41.00	
42.00	SUBPROVIDER		0	0	0	42.00	
43.00	NURSERY		484,138	0	0	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM		2,225,139	0	0	50.00	
52.00	DELIVERY ROOM & LABOR ROOM		58,769	0	0	52.00	
54.00	RADIOLOGY-DIAGNOSTIC		3,715,810	0	0	54.00	
57.00	CT SCAN		0	0	0	57.00	
58.00	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00	
59.00	CARDIAC CATHETERIZATION		0	0	0	59.00	
60.00	LABORATORY		2,478,569	0	0	60.00	
60.01	BLOOD LABORATORY		0	0	0	60.01	
63.00	BLOOD STORING, PROCESSING & TRANS.		158,178	0	0	63.00	
65.00	RESPIRATORY THERAPY	0	1,541,247	0	0	65.00	
66.00	PHYSICAL THERAPY	0	1,230,903	0	0	66.00	
66.01	KV HEALTH & DEMOTTE PT	0	1,108,600	0	0	66.01	
67.00	OCCUPATIONAL THERAPY	0	694,829	0	0	67.00	
67.01	KV HEALTH & DEMOTTE OT	0	238,513	0	0	67.01	
68.00	SPEECH PATHOLOGY	0	217,175	0	0	68.00	
68.01	KV HEALTH & DEMOTTE ST	0	182,909	0	0	68.01	
70.00	ELECTROENCEPHALOGRAPHY		0	0	0	70.00	
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		302,554	0	0	71.00	
72.00	IMPL. DEV. CHARGED TO PATIENT		72,717	0	0	72.00	
73.00	DRUGS CHARGED TO PATIENTS		2,637,023	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS							
88.00	WHEATFIELD HEALTH CENTER		474,576	0	0	88.00	
88.03	BROOK HEALTH CENTER		622,480	0	0	88.03	
89.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00	
90.00	CLINIC		1,483,038	0	0	90.00	
91.00	EMERGENCY		1,862,955	0	0	91.00	
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		940,324	0	0	92.00	
93.00	FAMILY PRACTICE		0	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY		2,216,603			101.00	
SPECIAL PURPOSE COST CENTERS							
116.00	HOSPICE		618,982			116.00	
200.00	Subtotal (see instructions)		31,303,261	0	0	200.00	
201.00	Less Observation Beds		940,324			201.00	
202.00	Total (see instructions)		30,362,937	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/31/2012 12:03 pm
			Title XVIII	Hospital	Cost
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
	Inpatient	Outpatient	Total (col. 6 + col. 7)		
	6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS	3,351,705		3,351,705		30.00
31.00 INTENSIVE CARE UNIT	515,705		515,705		31.00
41.00 SUBPROVIDER - IRF	0		0		41.00
42.00 SUBPROVIDER	0		0		42.00
43.00 NURSERY	88,095		88,095		43.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	1,017,726	3,233,273	4,250,999	0.523439	50.00
52.00 DELIVERY ROOM & LABOR ROOM	124,766	37,113	161,879	0.363043	52.00
54.00 RADIOLOGY-DIAGNOSTIC	724,727	6,340,237	7,064,964	0.525949	54.00
57.00 CT SCAN	0	0	0	0.000000	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00 LABORATORY	1,203,526	5,838,165	7,041,691	0.351985	60.00
60.01 BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	135,940	135,616	271,556	0.582488	63.00
65.00 RESPIRATORY THERAPY	1,032,554	1,356,530	2,389,084	0.645120	65.00
66.00 PHYSICAL THERAPY	302,133	1,470,125	1,772,258	0.694539	66.00
66.01 KV HEALTH & DEMOTTE PT	0	1,181,564	1,181,564	0.938248	66.01
67.00 OCCUPATIONAL THERAPY	205,707	381,621	587,328	1.183034	67.00
67.01 KV HEALTH & DEMOTTE OT	0	177,841	177,841	1.341159	67.01
68.00 SPEECH PATHOLOGY	32,785	128,571	161,356	1.345937	68.00
68.01 KV HEALTH & DEMOTTE ST	0	97,457	97,457	1.876817	68.01
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	167,704	617,375	785,079	0.385380	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	64,277	118,181	182,458	0.398541	72.00
73.00 DRUGS CHARGED TO PATIENTS	2,130,780	4,290,948	6,421,728	0.410641	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 WHEATFIELD HEALTH CENTER	0	365,700	365,700		88.00
88.03 BROOK HEALTH CENTER	0	339,827	339,827		88.03
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00 CLINIC	143,364	2,429,264	2,572,628	0.576468	90.00
91.00 EMERGENCY	21,314	1,606,843	1,628,157	1.144211	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	263,687	1,454,396	1,718,083	0.547310	92.00
93.00 FAMILY PRACTICE	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS					
101.00 HOME HEALTH AGENCY	0	2,367,168	2,367,168		101.00
SPECIAL PURPOSE COST CENTERS					
116.00 HOSPICE	0	0	0		116.00
200.00 Subtotal (see instructions)	11,526,495	33,967,815	45,494,310		200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)	11,526,495	33,967,815	45,494,310		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/31/2012 12:03 pm
		Title XVIII	Hospital	Cost

Cost Center Description	PPS Inpatient Ratio		
	11.00		
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS			30.00
31.00 INTENSIVE CARE UNIT			31.00
41.00 SUBPROVIDER - IRF			41.00
42.00 SUBPROVIDER			42.00
43.00 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	0.000000		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
63.00 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00 RESPIRATORY THERAPY	0.000000		65.00
66.00 PHYSICAL THERAPY	0.000000		66.00
66.01 KV HEALTH & DEMOTTE PT	0.000000		66.01
67.00 OCCUPATIONAL THERAPY	0.000000		67.00
67.01 KV HEALTH & DEMOTTE OT	0.000000		67.01
68.00 SPEECH PATHOLOGY	0.000000		68.00
68.01 KV HEALTH & DEMOTTE ST	0.000000		68.01
70.00 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS			
88.00 WHEATFIELD HEALTH CENTER			88.00
88.03 BROOK HEALTH CENTER			88.03
89.00 FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00 CLINIC	0.000000		90.00
91.00 EMERGENCY	0.000000		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00 FAMILY PRACTICE	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS			
101.00 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS			
116.00 HOSPICE			116.00
200.00 Subtotal (see instructions)			200.00
201.00 Less Observation Beds			201.00
202.00 Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151324

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

Worksheet C
Part I
Date/Time Prepared:
5/31/2012 12:03 pm

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS		4,629,527	0	0	30.00	
31.00	INTENSIVE CARE UNIT		1,107,703	0	0	31.00	
41.00	SUBPROVIDER - IRF		0	0	0	41.00	
42.00	SUBPROVIDER		0	0	0	42.00	
43.00	NURSERY		484,138	0	0	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM		2,225,139	0	0	50.00	
52.00	DELIVERY ROOM & LABOR ROOM		58,769	0	0	52.00	
54.00	RADIOLOGY-DIAGNOSTIC		3,715,810	0	0	54.00	
57.00	CT SCAN		0	0	0	57.00	
58.00	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00	
59.00	CARDIAC CATHETERIZATION		0	0	0	59.00	
60.00	LABORATORY		2,478,569	0	0	60.00	
60.01	BLOOD LABORATORY		0	0	0	60.01	
63.00	BLOOD STORING, PROCESSING & TRANS.		158,178	0	0	63.00	
65.00	RESPIRATORY THERAPY	0	1,541,247	0	0	65.00	
66.00	PHYSICAL THERAPY	0	1,230,903	0	0	66.00	
66.01	KV HEALTH & DEMOTTE PT	0	1,108,600	0	0	66.01	
67.00	OCCUPATIONAL THERAPY	0	694,829	0	0	67.00	
67.01	KV HEALTH & DEMOTTE OT	0	238,513	0	0	67.01	
68.00	SPEECH PATHOLOGY	0	217,175	0	0	68.00	
68.01	KV HEALTH & DEMOTTE ST	0	182,909	0	0	68.01	
70.00	ELECTROENCEPHALOGRAPHY		0	0	0	70.00	
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		302,554	0	0	71.00	
72.00	IMPL. DEV. CHARGED TO PATIENT		72,717	0	0	72.00	
73.00	DRUGS CHARGED TO PATIENTS		2,637,023	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS							
88.00	WHEATFIELD HEALTH CENTER		474,576	0	0	88.00	
88.03	BROOK HEALTH CENTER		622,480	0	0	88.03	
89.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00	
90.00	CLINIC		1,483,038	0	0	90.00	
91.00	EMERGENCY		1,862,955	0	0	91.00	
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		940,324	0	0	92.00	
93.00	FAMILY PRACTICE		0	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY		2,216,603			101.00	
SPECIAL PURPOSE COST CENTERS							
116.00	HOSPICE		618,982			116.00	
200.00	Subtotal (see instructions)		31,303,261	0	0	200.00	
201.00	Less Observation Beds		940,324			201.00	
202.00	Total (see instructions)		30,362,937	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151324

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

Worksheet C
Part I
Date/Time Prepared:
5/31/2012 12:03 pm

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
Title XIX Hospital Cost						
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	3,351,705		3,351,705			30.00
31.00 INTENSIVE CARE UNIT	515,705		515,705			31.00
41.00 SUBPROVIDER - IRF	0		0			41.00
42.00 SUBPROVIDER	0		0			42.00
43.00 NURSERY	88,095		88,095			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	1,017,726	3,233,273	4,250,999	0.523439	0.000000	50.00
52.00 DELIVERY ROOM & LABOR ROOM	124,766	37,113	161,879	0.363043	0.000000	52.00
54.00 RADIOLOGY-DIAGNOSTIC	724,727	6,340,237	7,064,964	0.525949	0.000000	54.00
57.00 CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00 LABORATORY	1,203,526	5,838,165	7,041,691	0.351985	0.000000	60.00
60.01 BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	135,940	135,616	271,556	0.582488	0.000000	63.00
65.00 RESPIRATORY THERAPY	1,032,554	1,356,530	2,389,084	0.645120	0.000000	65.00
66.00 PHYSICAL THERAPY	302,133	1,470,125	1,772,258	0.694539	0.000000	66.00
66.01 KV HEALTH & DEMOTTE PT	0	1,181,564	1,181,564	0.938248	0.000000	66.01
67.00 OCCUPATIONAL THERAPY	205,707	381,621	587,328	1.183034	0.000000	67.00
67.01 KV HEALTH & DEMOTTE OT	0	177,841	177,841	1.341159	0.000000	67.01
68.00 SPEECH PATHOLOGY	32,785	128,571	161,356	1.345937	0.000000	68.00
68.01 KV HEALTH & DEMOTTE ST	0	97,457	97,457	1.876817	0.000000	68.01
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	167,704	617,375	785,079	0.385380	0.000000	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	64,277	118,181	182,458	0.398541	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	2,130,780	4,290,948	6,421,728	0.410641	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 WHEATFIELD HEALTH CENTER	0	365,700	365,700	1.297719	0.000000	88.00
88.03 BROOK HEALTH CENTER	0	339,827	339,827	1.831756	0.000000	88.03
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00 CLINIC	143,364	2,429,264	2,572,628	0.576468	0.000000	90.00
91.00 EMERGENCY	21,314	1,606,843	1,628,157	1.144211	0.000000	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	263,687	1,454,396	1,718,083	0.547310	0.000000	92.00
93.00 FAMILY PRACTICE	0	0	0	0.000000	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	0	2,367,168	2,367,168			101.00
SPECIAL PURPOSE COST CENTERS						
116.00 HOSPICE	0	0	0			116.00
200.00 Subtotal (see instructions)	11,526,495	33,967,815	45,494,310			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	11,526,495	33,967,815	45,494,310			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/31/2012 12:03 pm
		Title XIX	Hospital	Cost

Cost Center Description	PPS Inpatient Ratio		
	11.00		
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS			30.00
31.00 INTENSIVE CARE UNIT			31.00
41.00 SUBPROVIDER - IRF			41.00
42.00 SUBPROVIDER			42.00
43.00 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	0.000000		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
63.00 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00 RESPIRATORY THERAPY	0.000000		65.00
66.00 PHYSICAL THERAPY	0.000000		66.00
66.01 KV HEALTH & DEMOTTE PT	0.000000		66.01
67.00 OCCUPATIONAL THERAPY	0.000000		67.00
67.01 KV HEALTH & DEMOTTE OT	0.000000		67.01
68.00 SPEECH PATHOLOGY	0.000000		68.00
68.01 KV HEALTH & DEMOTTE ST	0.000000		68.01
70.00 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS			
88.00 WHEATFIELD HEALTH CENTER	0.000000		88.00
88.03 BROOK HEALTH CENTER	0.000000		88.03
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00 CLINIC	0.000000		90.00
91.00 EMERGENCY	0.000000		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00 FAMILY PRACTICE	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS			
101.00 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS			
116.00 HOSPICE			116.00
200.00 Subtotal (see instructions)			200.00
201.00 Less Observation Beds			201.00
202.00 Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part II Date/Time Prepared: 5/31/2012 12:03 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	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	127,644	4,250,999	0.030027	465,482	13,977	50.00
52.00	DELIVERY ROOM & LABOR ROOM	6,394	161,879	0.039499	3,182	126	52.00
54.00	RADIOLOGY-DIAGNOSTIC	100,142	7,064,964	0.014174	524,259	7,431	54.00
57.00	CT SCAN	0	0	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	LABORATORY	39,181	7,041,691	0.005564	748,917	4,167	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	2,829	271,556	0.010418	87,785	915	63.00
65.00	RESPIRATORY THERAPY	35,585	2,389,084	0.014895	720,858	10,737	65.00
66.00	PHYSICAL THERAPY	36,510	1,772,258	0.020601	118,045	2,432	66.00
66.01	KV HEALTH & DEMOTTE PT	102,874	1,181,564	0.087066	0	0	66.01
67.00	OCCUPATIONAL THERAPY	21,484	587,328	0.036579	66,500	2,433	67.00
67.01	KV HEALTH & DEMOTTE OT	23,706	177,841	0.133299	0	0	67.01
68.00	SPEECH PATHOLOGY	6,714	161,356	0.041610	20,470	852	68.00
68.01	KV HEALTH & DEMOTTE ST	18,180	97,457	0.186544	0	0	68.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,388	785,079	0.020874	76,370	1,594	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	200	182,458	0.001096	42,533	47	72.00
73.00	DRUGS CHARGED TO PATIENTS	20,107	6,421,728	0.003131	1,151,851	3,606	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	WHEATFIELD HEALTH CENTER	1,305	365,700	0.003568	0	0	88.00
88.03	BROOK HEALTH CENTER	33,427	339,827	0.098365	0	0	88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	CLINIC	52,933	2,572,628	0.020575	92,296	1,899	90.00
91.00	EMERGENCY	65,959	1,628,157	0.040511	4,405	178	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,718,083	0.000000	0	0	92.00
93.00	FAMILY PRACTICE	0	0	0.000000	0	0	93.00
200.00	Total (lines 50-199)	711,562	39,171,637		4,122,953	50,394	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151324

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

Worksheet D
Part IV
Date/Time Prepared:
5/31/2012 12:03 pm

Cost Center Description		Title XVIII				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	KV HEALTH & DEMOTTE PT	0	0	0	0	0	66.01
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
67.01	KV HEALTH & DEMOTTE OT	0	0	0	0	0	67.01
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	KV HEALTH & DEMOTTE ST	0	0	0	0	0	68.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	WHEATFIELD HEALTH CENTER	0	0	0	0	0	88.00
88.03	BROOK HEALTH CENTER	0	0	0	0	0	88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
200.00	Total (Lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part IV Date/Time Prepared: 5/31/2012 12:03 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)	Hospital Cost		
				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	4,250,999	0.000000	0.000000	465,482	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	161,879	0.000000	0.000000	3,182	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	7,064,964	0.000000	0.000000	524,259	54.00
57.00 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00 LABORATORY	0	7,041,691	0.000000	0.000000	748,917	60.00
60.01 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	271,556	0.000000	0.000000	87,785	63.00
65.00 RESPIRATORY THERAPY	0	2,389,084	0.000000	0.000000	720,858	65.00
66.00 PHYSICAL THERAPY	0	1,772,258	0.000000	0.000000	118,045	66.00
66.01 KV HEALTH & DEMOTTE PT	0	1,181,564	0.000000	0.000000	0	66.01
67.00 OCCUPATIONAL THERAPY	0	587,328	0.000000	0.000000	66,500	67.00
67.01 KV HEALTH & DEMOTTE OT	0	177,841	0.000000	0.000000	0	67.01
68.00 SPEECH PATHOLOGY	0	161,356	0.000000	0.000000	20,470	68.00
68.01 KV HEALTH & DEMOTTE ST	0	97,457	0.000000	0.000000	0	68.01
70.00 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	785,079	0.000000	0.000000	76,370	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	182,458	0.000000	0.000000	42,533	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	6,421,728	0.000000	0.000000	1,151,851	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 WHEATFIELD HEALTH CENTER	0	365,700	0.000000	0.000000	0	88.00
88.03 BROOK HEALTH CENTER	0	339,827	0.000000	0.000000	0	88.03
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00 CLINIC	0	2,572,628	0.000000	0.000000	92,296	90.00
91.00 EMERGENCY	0	1,628,157	0.000000	0.000000	4,405	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,718,083	0.000000	0.000000	0	92.00
93.00 FAMILY PRACTICE	0	0	0.000000	0.000000	0	93.00
200.00 Total (Lines 50-199)	0	39,171,637			4,122,953	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151324

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

Worksheet D
Part IV
Date/Time Prepared:
5/31/2012 12:03 pm

Cost Center Description		Title XVIII			Hospital	Cost
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0		50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	CT SCAN	0	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	LABORATORY	0	0	0		60.00
60.01	BLOOD LABORATORY	0	0	0		60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	RESPIRATORY THERAPY	0	0	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
66.01	KV HEALTH & DEMOTTE PT	0	0	0		66.01
67.00	OCCUPATIONAL THERAPY	0	0	0		67.00
67.01	KV HEALTH & DEMOTTE OT	0	0	0		67.01
68.00	SPEECH PATHOLOGY	0	0	0		68.00
68.01	KV HEALTH & DEMOTTE ST	0	0	0		68.01
70.00	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	WHEATFIELD HEALTH CENTER	0	0	0		88.00
88.03	BROOK HEALTH CENTER	0	0	0		88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	CLINIC	0	0	0		90.00
91.00	EMERGENCY	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	FAMILY PRACTICE	0	0	0		93.00
200.00	Total (Lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/31/2012 12:03 pm
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		Title XVIII			Hospital	Cost
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)		Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	
			1.00	2.00		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.523439	0	908,259	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.363043	0	714	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.525949	0	1,969,418	0	54.00
57.00	CT SCAN	0.000000	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	LABORATORY	0.351985	0	2,043,763	0	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0.582488	0	71,132	0	63.00
65.00	RESPIRATORY THERAPY	0.645120	0	492,032	0	65.00
66.00	PHYSICAL THERAPY	0.694539	0	444,149	0	66.00
66.01	KV HEALTH & DEMOTTE PT	0.938248	0	334,453	0	66.01
67.00	OCCUPATIONAL THERAPY	1.183034	0	76,597	0	67.00
67.01	KV HEALTH & DEMOTTE OT	1.341159	0	21,873	0	67.01
68.00	SPEECH PATHOLOGY	1.345937	0	33,138	0	68.00
68.01	KV HEALTH & DEMOTTE ST	1.876817	0	1,512	0	68.01
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.385380	0	82,134	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.398541	0	52,163	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.410641	0	1,966,488	40	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	WHEATFIELD HEALTH CENTER	0.000000				88.00
88.03	BROOK HEALTH CENTER	0.000000				88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00	CLINIC	0.576468	0	1,065,648	120	90.00
91.00	EMERGENCY	1.144211	0	436,159	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.547310	0	666,389	0	92.00
93.00	FAMILY PRACTICE	0.000000	0	0	0	93.00
200.00	Subtotal (see instructions)		0	10,666,021	160	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	10,666,021	160	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/31/2012 12:03 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)	
	5.00	6.00	7.00	
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	475,418	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	259	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	1,035,813	0	54.00
57.00 CT SCAN	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 LABORATORY	0	719,374	0	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	41,434	0	63.00
65.00 RESPIRATORY THERAPY	0	317,420	0	65.00
66.00 PHYSICAL THERAPY	0	308,479	0	66.00
66.01 KV HEALTH & DEMOTTE PT	0	313,800	0	66.01
67.00 OCCUPATIONAL THERAPY	0	90,617	0	67.00
67.01 KV HEALTH & DEMOTTE OT	0	29,335	0	67.01
68.00 SPEECH PATHOLOGY	0	44,602	0	68.00
68.01 KV HEALTH & DEMOTTE ST	0	2,838	0	68.01
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	31,653	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	20,789	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	807,521	16	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00 WHEATFIELD HEALTH CENTER	0	0	0	88.00
88.03 BROOK HEALTH CENTER	0	0	0	88.03
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00 CLINIC	0	614,312	69	90.00
91.00 EMERGENCY	0	499,058	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	364,721	0	92.00
93.00 FAMILY PRACTICE	0	0	0	93.00
200.00 Subtotal (see instructions)	0	5,717,443	85	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	5,717,443	85	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151324 Component CCN: 15Z324	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/31/2012 12:03 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	
	1.00	2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.523439	0	0	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0.363043	0	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0.525949	0	0	0	54.00
57.00 CT SCAN	0.000000	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00 LABORATORY	0.351985	0	0	0	60.00
60.01 BLOOD LABORATORY	0.000000	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0.582488	0	0	0	63.00
65.00 RESPIRATORY THERAPY	0.645120	0	0	0	65.00
66.00 PHYSICAL THERAPY	0.694539	0	0	0	66.00
66.01 KV HEALTH & DEMOTTE PT	0.938248	0	0	0	66.01
67.00 OCCUPATIONAL THERAPY	1.183034	0	0	0	67.00
67.01 KV HEALTH & DEMOTTE OT	1.341159	0	0	0	67.01
68.00 SPEECH PATHOLOGY	1.345937	0	0	0	68.00
68.01 KV HEALTH & DEMOTTE ST	1.876817	0	0	0	68.01
70.00 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.385380	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.398541	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.410641	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 WHEATFIELD HEALTH CENTER	0.000000				88.00
88.03 BROOK HEALTH CENTER	0.000000				88.03
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00 CLINIC	0.576468	0	0	0	90.00
91.00 EMERGENCY	1.144211	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.547310	0	0	0	92.00
93.00 FAMILY PRACTICE	0.000000	0	0	0	93.00
200.00 Subtotal (see instructions)		0	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151324 Component CCN: 15Z324	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/31/2012 12:03 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	0	0		50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00 CT SCAN	0	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00 LABORATORY	0	0	0		60.00
60.01 BLOOD LABORATORY	0	0	0		60.01
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00 RESPIRATORY THERAPY	0	0	0		65.00
66.00 PHYSICAL THERAPY	0	0	0		66.00
66.01 KV HEALTH & DEMOTTE PT	0	0	0		66.01
67.00 OCCUPATIONAL THERAPY	0	0	0		67.00
67.01 KV HEALTH & DEMOTTE OT	0	0	0		67.01
68.00 SPEECH PATHOLOGY	0	0	0		68.00
68.01 KV HEALTH & DEMOTTE ST	0	0	0		68.01
70.00 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 WHEATFIELD HEALTH CENTER	0	0	0		88.00
88.03 BROOK HEALTH CENTER	0	0	0		88.03
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00 CLINIC	0	0	0		90.00
91.00 EMERGENCY	0	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00 FAMILY PRACTICE	0	0	0		93.00
200.00 Subtotal (see instructions)	0	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/31/2012 12:03 pm
Cost Center Description		Cost		
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,138	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,561	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,561	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		1,409	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		168	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,218	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)		1,409	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		145.00	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)		4,629,527	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)		24,360	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)		1,111,234	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,518,293	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,666,179	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,666,179	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.319601	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)		584.56	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)		3,518,293	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		771.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,710,921	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,710,921	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151324		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1	
Title XVIII		Hospital		Cost		Date/Time Prepared: 5/31/2012 12:03 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)	1.00	2.00	3.00	4.00	5.00	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	1,107,703	389	2,847.57	295	840,033		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,066,156		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,617,110		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)					1,086,874		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)					1,086,874		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)						1,219	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						771.39	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						940,324	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151324		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 5/31/2012 12:03 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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/31/2012 12:03 pm
Cost Center Description		Cost		
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,138	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,561	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,561	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		1,409	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		168	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)		439	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)		151	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,629,527	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)		1,092,637	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,536,890	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		3,187,505	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		3,187,505	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.109611	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)		698.86	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,536,890	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		775.47	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		340,431	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)		340,431	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/31/2012 12:03 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)	484,138	151	3,206.21	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,107,703	389	2,847.57	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)				360,735	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				701,166	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)				1,219	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				775.46	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				945,286	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151324		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 5/31/2012 12:03 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: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/31/2012 12:03 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		1,652,803		30.00
31.00	INTENSIVE CARE UNIT		383,500		31.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.523439	465,482	243,651	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.363043	3,182	1,155	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.525949	524,259	275,733	54.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.351985	748,917	263,608	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0.582488	87,785	51,134	63.00
65.00	RESPIRATORY THERAPY	0.645120	720,858	465,040	65.00
66.00	PHYSICAL THERAPY	0.694539	118,045	81,987	66.00
66.01	KV HEALTH & DEMOTTE PT	0.938248	0	0	66.01
67.00	OCCUPATIONAL THERAPY	1.183034	66,500	78,672	67.00
67.01	KV HEALTH & DEMOTTE OT	1.341159	0	0	67.01
68.00	SPEECH PATHOLOGY	1.345937	20,470	27,551	68.00
68.01	KV HEALTH & DEMOTTE ST	1.876817	0	0	68.01
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.385380	76,370	29,431	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.398541	42,533	16,951	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.410641	1,151,851	472,997	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	WHEATFIELD HEALTH CENTER	0.000000		0	88.00
88.03	BROOK HEALTH CENTER	0.000000		0	88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	0.576468	92,296	53,206	90.00
91.00	EMERGENCY	1.144211	4,405	5,040	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.547310	0	0	92.00
93.00	FAMILY PRACTICE	0.000000	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		4,122,953	2,066,156	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)		4,122,953		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3	
		Component CCN: 15Z324	Date/Time Prepared: 5/31/2012 12:03 pm		
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		9		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.523439	6,000	3,141	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.363043	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.525949	37,487	19,716	54.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.351985	115,417	40,625	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0.582488	6,055	3,527	63.00
65.00	RESPIRATORY THERAPY	0.645120	220,254	142,090	65.00
66.00	PHYSICAL THERAPY	0.694539	142,499	98,971	66.00
66.01	KV HEALTH & DEMOTTE PT	0.938248	0	0	66.01
67.00	OCCUPATIONAL THERAPY	1.183034	112,492	133,082	67.00
67.01	KV HEALTH & DEMOTTE OT	1.341159	0	0	67.01
68.00	SPEECH PATHOLOGY	1.345937	9,920	13,352	68.00
68.01	KV HEALTH & DEMOTTE ST	1.876817	0	0	68.01
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.385380	2,973	1,146	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.398541	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.410641	351,797	144,462	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	WHEATFIELD HEALTH CENTER	0.000000		0	88.00
88.03	BROOK HEALTH CENTER	0.000000		0	88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	0.576468	2,253	1,299	90.00
91.00	EMERGENCY	1.144211	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.547310	0	0	92.00
93.00	FAMILY PRACTICE	0.000000	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		1,007,147	601,411	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)		1,007,147		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/31/2012 12:03 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		222,541		30.00
31.00	INTENSIVE CARE UNIT		31,200		31.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY		600		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.523439	133,465	69,861	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.363043	83,335	30,254	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.525949	52,172	27,440	54.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.351985	105,244	37,044	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	0.582488	12,654	7,371	63.00
65.00	RESPIRATORY THERAPY	0.645120	60,428	38,983	65.00
66.00	PHYSICAL THERAPY	0.694539	6,435	4,469	66.00
66.01	KV HEALTH & DEMOTTE PT	0.938248	0	0	66.01
67.00	OCCUPATIONAL THERAPY	1.183034	0	0	67.00
67.01	KV HEALTH & DEMOTTE OT	1.341159	0	0	67.01
68.00	SPEECH PATHOLOGY	1.345937	0	0	68.00
68.01	KV HEALTH & DEMOTTE ST	1.876817	0	0	68.01
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.385380	20,414	7,867	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.398541	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.410641	159,632	65,551	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	WHEATFIELD HEALTH CENTER	1.297719	0	0	88.00
88.03	BROOK HEALTH CENTER	1.831756	0	0	88.03
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	CLINIC	0.576468	10,740	6,191	90.00
91.00	EMERGENCY	1.144211	16,473	18,849	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.547310	85,609	46,855	92.00
93.00	FAMILY PRACTICE	0.000000	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		746,601	360,735	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)		746,601		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/31/2012 12:03 pm
		Title VIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			5,717,528 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5,717,528 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			5,774,703 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			41,212 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,705,935 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)			4,027,556 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)			4,027,556 30.00
31.00	Primary payer payments			1,027 31.00
32.00	Subtotal (line 30 minus line 31)			4,026,529 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			248,930 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			248,930 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			238,921 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			4,275,459 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			4,275,459 40.00
41.00	Interim payments			3,797,493 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)			477,966 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151324

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

Worksheet E-1
Part I
Date/Time Prepared:
5/31/2012 12:03 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		3,704,700		3,652,121	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	09/11/2011	45,442	09/11/2011	133,490		3.01
3.02		11/11/2011	240,461	11/11/2011	11,882		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)		285,903		145,372		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,990,603		3,797,493		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		242,345		477,966		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		4,232,948		4,275,459		7.00
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151324

Period: From 01/01/2011

Worksheet E-1

Component CCN: 15Z324

To 12/31/2011

Part I
Date/Time Prepared:
5/31/2012 12:03 pm

Title XVIII

Swing Beds - SNF

Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,539,994		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	09/11/2011	72,278		0	3.01
3.02		11/11/2011	6,777		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		79,055		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,619,049		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		81,591		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,700,640		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151324

Period:

Worksheet E-2

Component CCN: 15Z324

From 01/01/2011

Date/Time Prepared:

To 12/31/2011

5/31/2012 12:03 pm

		Title XVIII		Swing Beds - SNF		Cost	
		Part A	Part B				
		1.00	2.00				
COMPUTATION OF NET COST OF COVERED SERVICES							
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,097,743	0				1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)						2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	607,425	0				3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00				4.00
5.00	Program days	1,409	0				5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0				6.00
7.00	Utilization review - physician compensation - SNF optional method only	0					7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,705,168	0				8.00
9.00	Primary payer payments (see instructions)	0	0				9.00
10.00	Subtotal (line 8 minus line 9)	1,705,168	0				10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0				11.00
12.00	Subtotal (line 10 minus line 11)	1,705,168	0				12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	4,528	0				13.00
14.00	80% of Part B costs (line 12 x 80%)		0				14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,700,640	0				15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0				16.00
17.00	Reimbursable bad debts (see instructions)	0	0				17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0				18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	1,700,640	0				19.00
20.00	Interim payments	1,619,049	0				20.00
21.00	Tentative settlement (for contractor use only)	0	0				21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	81,591	0				22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2	0	0				23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part V Date/Time Prepared: 5/31/2012 12:03 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services			4,617,110 1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 thru 3)			4,617,110 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5) . For CAH (see instructions)			4,663,281 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			4,663,281 19.00
20.00	Deductibles (exclude professional component)			507,026 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			4,156,255 22.00
23.00	Coinsurance			566 23.00
24.00	Subtotal (line 22 minus line 23)			4,155,689 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			77,259 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			77,259 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			70,247 27.00
28.00	Subtotal (sum of lines 24 and 25 or 26)			4,232,948 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (line 28, plus or minus lines 29)			4,232,948 30.00
31.00	Interim payments			3,990,603 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)			242,345 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part VII Date/Time Prepared: 5/31/2012 12:03 pm
		Title XIX	Hospital	Cost
				1.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		701,166	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)		701,166	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)		701,166	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		254,341	8.00
9.00	Ancillary service charges		746,601	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)		1,000,942	12.00
CUSTOMARY CHRGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		1,000,942	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		299,776	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)		701,166	21.00
PROSPECTIVE PAYMENT AMOUNT				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		0	23.00
24.00	Program capital payments		0	24.00
25.00	Capital exception payments (see instructions)		0	25.00
26.00	Routine and Ancillary service other pass through costs		0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX enter the sum of lines 27 and 21.		701,166	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		701,166	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)		701,166	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		701,166	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)		701,166	40.00
41.00	Interim payments		250,236	41.00
42.00	Balance due provider/program (line 40 minus 41)		450,930	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: 151324

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

Worksheet G
Date/Time Prepared:
5/31/2012 12:03 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	2,014,295	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	5,812,518	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	3,767,594	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	11,594,407	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	19,182,077	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	19,182,077	0	0	0	30.00
OTHER ASSETS						
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	366,562	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	366,562	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	31,143,046	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,482,827	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,159,439	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,642,266	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	13,135,216	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	13,135,216	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,777,482	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	13,365,564				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)	13,365,564	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	31,143,046	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151324

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

Worksheet G-1

Date/Time Prepared:
5/31/2012 12:03 pm

		General Fund		Special Purpose Fund			
		1.00	2.00	3.00	4.00		
		1.00	Fund balances at beginning of period		14,805,827		
2.00	Net income (loss) (From Wkst. G-3, line 29)		-1,408,543			2.00	
3.00	Total (sum of line 1 and line 2)		13,397,284		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)		13,397,284		0	11.00	
12.00	MISC ADJ	31,720		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)		31,720		0	18.00	
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		13,365,564		0	19.00	

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151324

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

Worksheet G-1

Date/Time Prepared:
5/31/2012 12:03 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: 151324

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

Worksheet G-2 Parts
Date/Time Prepared:
5/31/2012 12:03 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,666,179		2,666,179	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	768,000		768,000	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)	3,434,179		3,434,179	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	515,705		515,705	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)	515,705		515,705	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,949,884		3,949,884	17.00
18.00	Ancillary services	8,406,839	29,534,245	37,941,084	18.00
19.00	Outpatient services	0	3,490,809	3,490,809	19.00
20.00	WHEATFIELD HEALTH CENTER	0	365,700	365,700	20.00
20.03	BROOK HEALTH CENTER	0	339,531	339,531	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,697,551	2,697,551	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	0	0	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)	12,356,723	36,427,836	48,784,559	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		35,354,712		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)		35,354,712		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151324

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

Worksheet G-3

Date/Time Prepared:
5/31/2012 12:03 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	48,784,559	1.00
2.00	Less contractual allowances and discounts on patients' accounts	20,664,282	2.00
3.00	Net patient revenues (line 1 minus line 2)	28,120,277	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	35,354,712	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-7,234,435	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	5,704,807	24.00
24.01	INVESTMENT INCOME	14,681	24.01
24.02	GAIN ON SALE	1,614	24.02
24.03	GRANT AND CONTRIBUTIONS	148,413	24.03
25.00	Total other income (sum of lines 6-24)	5,869,515	25.00
26.00	Total (line 5 plus line 25)	-1,364,920	26.00
27.00	OTHER EXPENSES	43,623	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	43,623	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,408,543	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151324

Period: From 01/01/2011

Worksheet H

HHA CCN: 157149

To 12/31/2011

Date/Time Prepared: 5/31/2012 12:03 pm

Home Health Agency I

PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	1.00
2.00	Capital Related - Movable Equipment			0		0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	345,487	0	0	0	374,816	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	592,153	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	5,078	0	0	0	0	10.00
11.00	Home Health Aide	272,614	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,215,332	0	0	0	374,816	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: 151324

Period: From 01/01/2011

Worksheet H

HHA CCN: 157149

To 12/31/2011

Date/Time Prepared: 5/31/2012 12:03 pm

Home Health Agency I

PPS

	Total (sum of col. 1 thru 5)	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
	6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00 Capital Related - Bldg. & Fixtures	0	0	0	0	0	1.00
2.00 Capital Related - Movable Equipment	0	0	0	0	0	2.00
3.00 Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00 Transportation	0	0	0	0	0	4.00
5.00 Administrative and General	720,303	-203,367	516,936	0	516,936	5.00
HHA REIMBURSABLE SERVICES						
6.00 Skilled Nursing Care	592,153	0	592,153	0	592,153	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	5,078	0	5,078	0	5,078	10.00
11.00 Home Health Aide	272,614	0	272,614	0	272,614	11.00
12.00 Supplies (see instructions)	0	0	0	0	0	12.00
13.00 Drugs	0	0	0	0	0	13.00
14.00 DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES						
15.00 Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00 Respiratory Therapy	0	0	0	0	0	16.00
17.00 Private Duty Nursing	0	0	0	0	0	17.00
18.00 Clinic	0	0	0	0	0	18.00
19.00 Health Promotion Activities	0	0	0	0	0	19.00
20.00 Day Care Program	0	0	0	0	0	20.00
21.00 Home Delivered Meals Program	0	0	0	0	0	21.00
22.00 Homemaker Service	0	0	0	0	0	22.00
23.00 All Others (specify)	0	0	0	0	0	23.00
24.00 Total (sum of lines 1-23)	1,590,148	-203,367	1,386,781	0	1,386,781	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: 151324	Period: From 01/01/2011	Worksheet H-1 Part I Date/Time Prepared: 5/31/2012 12:03 pm
	HHA CCN: 157149	To 12/31/2011	

	Home Health Agency I	PPS
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	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	
		Bldgs & Fixtures	Movable Equipment			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	516,936	0	0	0	5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	592,153	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	9.00
10.00	Medical Social Services	5,078	0	0	0	10.00
11.00	Home Health Aide	272,614	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,386,781	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 151324	Period: From 01/01/2011	Worksheet H-1 Part I Date/Time Prepared: 5/31/2012 12:03 pm
		HHA CCN: 157149	To 12/31/2011	
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		Subtotal (col s. 0-4)	Administrative & General	Total (col s. 4A + 5)	
		4A.00	5.00	6.00	
GENERAL SERVICE COST CENTERS					
1.00	Capital Related - Bldg. & Fixtures	0			1.00
2.00	Capital Related - Movable Equipment	0			2.00
3.00	Plant Operation & Maintenance	0			3.00
4.00	Transportation				4.00
5.00	Administrative and General	516,936	516,936		5.00
HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	592,153	351,908	944,061	6.00
7.00	Physical Therapy	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	8.00
9.00	Speech Pathology	0	0	0	9.00
10.00	Medical Social Services	5,078	3,018	8,096	10.00
11.00	Home Health Aide	272,614	162,010	434,624	11.00
12.00	Supplies (see instructions)	0	0	0	12.00
13.00	Drugs	0	0	0	13.00
14.00	DME	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	17.00
18.00	Clinic	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	19.00
20.00	Day Care Program	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	21.00
22.00	Homemaker Service	0	0	0	22.00
23.00	All Others (specify)	0	0	0	23.00
24.00	Total (sum of lines 1-23)	869,845		1,386,781	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 151324

Period: From 01/01/2011

Worksheet H-1

HHA CCN: 157149

To 12/31/2011

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		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)				
		1.00	2.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation (see instructions)	0	0	0	0	0	4.00
5.00	Administrative and General	0	0	0	0	-516,936	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-516,936	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	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: 151324	Period: From 01/01/2011	Worksheet H-1 Part II Date/Time Prepared: 5/31/2012 12:03 pm
	HHA CCN: 157149	To 12/31/2011	
		Home Health Agency I	PPS

		Administrative & General (ACCUM. COST)	
		5.00	
GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures		1.00
2.00	Capital Related - Movable Equipment		2.00
3.00	Plant Operation & Maintenance		3.00
4.00	Transportation (see instructions)		4.00
5.00	Administrative and General	869,845	5.00
HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	592,153	6.00
7.00	Physical Therapy	0	7.00
8.00	Occupational Therapy	0	8.00
9.00	Speech Pathology	0	9.00
10.00	Medical Social Services	5,078	10.00
11.00	Home Health Aide	272,614	11.00
12.00	Supplies (see instructions)	0	12.00
13.00	Drugs	0	13.00
14.00	DME	0	14.00
HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	15.00
16.00	Respiratory Therapy	0	16.00
17.00	Private Duty Nursing	0	17.00
18.00	Clinic	0	18.00
19.00	Health Promotion Activities	0	19.00
20.00	Day Care Program	0	20.00
21.00	Home Delivered Meals Program	0	21.00
22.00	Homemaker Service	0	22.00
23.00	All Others (specify)	0	23.00
24.00	Total (sum of lines 1-23)	869,845	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	516,936	25.00
26.00	Unit Cost Multiplier	0.594285	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151324

Period: From 01/01/2011

Worksheet H-2

HHA CCN: 157149

To 12/31/2011

Part I
Date/Time Prepared:
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	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00	4.00		4A	5.00	
1.00 Administrative and General	0	36,192	352,462	388,654	76,032	1.00	
2.00 Skilled Nursing Care	944,061	0	0	944,061	184,684	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	8,096	0	0	8,096	1,584	6.00	
7.00 Home Health Aide	434,624	0	0	434,624	85,025	7.00	
8.00 Supplies (see instructions)	0	0	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19) (2)	1,386,781	36,192	352,462	1,775,435	347,325	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: 151324	Period: From 01/01/2011	Worksheet H-2
		HHA CCN: 157149	To 12/31/2011	Part I
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		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	37,001	0	56,842	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	37,001	0	56,842	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151324

Period:

Worksheet H-2

HHA CCN: 157149

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

Part I
Date/Time Prepared:
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	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	13.00	14.00	15.00	16.00	17.00	
1.00 Administrative and General	0	0	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	0	0	0	0	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 151324 HHA CCN: 157149		Period: From 01/01/2011 To 12/31/2011		Worksheet H-2 Part I Date/Time Prepared: 5/31/2012 12:03 pm PPS	
		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	558,529	0	558,529			1.00
2.00	Skilled Nursing Care	1,128,745	0	1,128,745	380,222	1,508,967	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	9,680	0	9,680	3,261	12,941	6.00
7.00	Home Health Aide	519,649	0	519,649	175,046	694,695	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)	2,216,603	0	2,216,603	558,529	2,216,603	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.				0.336854		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: 151324

Period: From 01/01/2011

Worksheet H-2

HHA CCN: 157149

To 12/31/2011

Part II
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	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)						
	1.00	4.00					
1.00	Administrative and General	3,086	1,291,506	5A	388,654	3,086	1.00
2.00	Skilled Nursing Care	0	0		944,061	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		8,096	0	6.00
7.00	Home Health Aide	0	0		434,624	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)	3,086	1,291,506		1,775,435	3,086	20.00
21.00	Total cost to be allocated	36,192	352,462		347,325	37,001	21.00
22.00	Unit cost multiplier	11.727803	0.272908		0.195628	11.989955	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151324
HHA CCN: 157149

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

Worksheet H-2
Part II
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		LAUNDRY & LINEN SERVICE (DOLLAR VALUE)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (MAN HOURS)	
		8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	7,200	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	7,200	0	0	0	20.00
21.00	Total cost to be allocated	0	56,842	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	7.894722	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151324

HHA CCN: 157149

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

Worksheet H-2 Part II
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		CENTRAL SERVICES & SUPPLY (100% ALLOCATION)	PHARMACY (100% ALLOCATION)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	HOME HEALTH AGENCY I SOCIAL SERVICE (TIME SPENT)	
		14.00	15.00	16.00	17.00	
1.00	Administrative and General	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	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	0	0	0	20.00
21.00	Total cost to be allocated	0	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS	Provider CCN: 151324 HHA CCN: 157149	Period: From 01/01/2011 To 12/31/2011	Worksheet H-3 Parts I-III Date/Time Prepared: 5/31/2012 12:03 pm
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	Title XVIII	Home Health Agency I	PPS
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Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	
	0	1.00	2.00	3.00	4.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
Cost Per Visit Computation						
1.00	Skilled Nursing Care	2.00	1,508,967	1,508,967	5,781	1.00
2.00	Physical Therapy	3.00	0	298,641	2,986	2.00
3.00	Occupational Therapy	4.00	0	161,158	946	3.00
4.00	Speech Pathology	5.00	0	52,990	254	4.00
5.00	Medical Social Services	6.00	12,941	12,941	28	5.00
6.00	Home Health Aide	7.00	694,695	694,695	7,885	6.00
7.00	Total (sum of lines 1-6)		2,216,603	512,789	2,729,392	17,880

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

Limitation Cost Computation						
8.00	Skilled Nursing Care		23844	1,881	1,395	8.00
8.01	Skilled Nursing Care		29140	18	0	8.01
8.02	Skilled Nursing Care		99915	24	126	8.02
9.00	Physical Therapy		23844	1,244	799	9.00
9.01	Physical Therapy		29140	39	0	9.01
9.02	Physical Therapy		99915	53	53	9.02
10.00	Occupational Therapy		23844	439	194	10.00
10.01	Occupational Therapy		29140	26	0	10.01
10.02	Occupational Therapy		99915	18	23	10.02
11.00	Speech Pathology		23844	110	42	11.00
11.01	Speech Pathology		29140	0	0	11.01
11.02	Speech Pathology		99915	0	1	11.02
12.00	Medical Social Services		23844	19	6	12.00
12.01	Medical Social Services		29140	0	0	12.01
12.02	Medical Social Services		99915	0	0	12.02
13.00	Home Health Aide		23844	801	1,534	13.00
13.01	Home Health Aide		29140	8	0	13.01
13.02	Home Health Aide		99915	6	35	13.02
14.00	Total (sum of lines 8-13)			4,686	4,208	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	9,336	9,336	15.00
16.00	Cost of Drugs	9.00	0	0	0	16.00

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	
	0	1.00	2.00	3.00	

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy		66.00	0.694539	429,984	1.00
1.01	Physical Therapy 1		66.01	0.938248	0	1.01
2.00	Occupational Therapy		67.00	1.183034	136,224	2.00
2.01	Occupational Therapy 1		67.01	1.341159	0	2.01
3.00	Speech Pathology		68.00	1.345937	39,370	3.00
3.01	Speech Pathology 1		68.01	1.876817	0	3.01
4.00	Cost of Medical Supplies		71.00	0.385380	24,226	4.00
5.00	Cost of Drugs		73.00	0.410641	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet H-3 Parts I-III Date/Time Prepared: 5/31/2012 12:03 pm
		HHA CCN: 157149	Title XVIII	Home Health Agency I PPS

Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Part A	Program Visits		
			Part B		
			Not Subject to Deductibles & Coi nsurance	Subject to Deductibles & Coi nsurance	
	5.00	6.00	7.00	8.00	

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION

Cost Per Visit Computation					
Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Part A	Not Subject to Deductibles & Coi nsurance	Subject to Deductibles & Coi nsurance	
1.00 Skilled Nursing Care	261.02	1,923	1,521		1.00
2.00 Physical Therapy	100.01	1,336	852		2.00
3.00 Occupational Therapy	170.36	483	217		3.00
4.00 Speech Pathology	208.62	110	43		4.00
5.00 Medical Social Services	462.18	19	6		5.00
6.00 Home Health Aide	88.10	815	1,569		6.00
7.00 Total (sum of lines 1-6)		4,686	4,208		7.00
Cost Center Description	5.00	6.00	7.00	8.00	9.00

Limitation Cost Computation

8.00 Skilled Nursing Care					8.00
8.01 Skilled Nursing Care					8.01
8.02 Skilled Nursing Care					8.02
9.00 Physical Therapy					9.00
9.01 Physical Therapy					9.01
9.02 Physical Therapy					9.02
10.00 Occupational Therapy					10.00
10.01 Occupational Therapy					10.01
10.02 Occupational Therapy					10.02
11.00 Speech Pathology					11.00
11.01 Speech Pathology					11.01
11.02 Speech Pathology					11.02
12.00 Medical Social Services					12.00
12.01 Medical Social Services					12.01
12.02 Medical Social Services					12.02
13.00 Home Health Aide					13.00
13.01 Home Health Aide					13.01
13.02 Home Health Aide					13.02
14.00 Total (sum of lines 8-13)					14.00

Program Covered Charges

Cost Center Description	Ratio (col. 3 ÷ col. 4)	Part A	Part B		
			Not Subject to Deductibles & Coi nsurance	Subject to Deductibles & Coi nsurance	
			5.00	6.00	

Supplies and Drugs Cost Computations

15.00 Cost of Medical Supplies	0.385371	0	24,226	0	15.00
16.00 Cost of Drugs	0.000000	0	0	0	16.00
Cost Center Description		Transfer to Part I as Indicated			
		4.00			

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

1.00 Physical Therapy		col. 2, line 2.00		1.00
1.01 Physical Therapy 1		col. 2, line 2.01		1.01
2.00 Occupational Therapy		col. 2, line 3.00		2.00
2.01 Occupational Therapy 1		col. 2, line 3.01		2.01
3.00 Speech Pathology		col. 2, line 4.00		3.00
3.01 Speech Pathology 1		col. 2, line 4.01		3.01
4.00 Cost of Medical Supplies		col. 2, line 15.00		4.00
5.00 Cost of Drugs		col. 2, line 16.00		5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151324

Period: From 01/01/2011

Worksheet H-3

HHA CCN: 157149

To 12/31/2011

Parts I-III
Date/Time Prepared:
5/31/2012 12:03 pm

Title XVIII

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	501,941	397,011	898,952	1.00
2.00	Physical Therapy	133,613	85,209	218,822	2.00
3.00	Occupational Therapy	82,284	36,968	119,252	3.00
4.00	Speech Pathology	22,948	8,971	31,919	4.00
5.00	Medical Social Services	8,781	2,773	11,554	5.00
6.00	Home Health Aide	71,802	138,229	210,031	6.00
7.00	Total (sum of lines 1-6)	821,369	669,161	1,490,530	7.00
Cost Center Description					
		10.00	11.00	12.00	
Limitation Cost Computation					
8.00	Skilled Nursing Care				8.00
8.01	Skilled Nursing Care				8.01
8.02	Skilled Nursing Care				8.02
9.00	Physical Therapy				9.00
9.01	Physical Therapy				9.01
9.02	Physical Therapy				9.02
10.00	Occupational Therapy				10.00
10.01	Occupational Therapy				10.01
10.02	Occupational Therapy				10.02
11.00	Speech Pathology				11.00
11.01	Speech Pathology				11.01
11.02	Speech Pathology				11.02
12.00	Medical Social Services				12.00
12.01	Medical Social Services				12.01
12.02	Medical Social Services				12.02
13.00	Home Health Aide				13.00
13.01	Home Health Aide				13.01
13.02	Home Health Aide				13.02
14.00	Total (sum of lines 8-13)				14.00
Cost of Services					
Cost Center Description	Part A	Part B			
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	9.00	10.00	11.00		
Supplies and Drugs Cost Computations					
15.00	Cost of Medical Supplies	0	9,336	0	15.00
16.00	Cost of Drugs	0	0	0	16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 151324 HHA CCN: 157149	Period: From 01/01/2011 To 12/31/2011	Worksheet H-4 Part I-II Date/Time Prepared: 5/31/2012 12:03 pm
		Title XVII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	2.00
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	8.00
9.00	Primary payer amounts	0	0	9.00
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		641,491	446,777
12.00	Total PPS Reimbursement - Full Episodes with Outliers		6,310	18,912
13.00	Total PPS Reimbursement - LUPA Episodes		10,145	7,257
14.00	Total PPS Reimbursement - PEP Episodes		2,427	4,741
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		920	5,922
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		661,293	483,609
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		661,293	483,609
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		661,293	483,609
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		661,293	483,609
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		661,293	483,609
32.00	Interim payments (see instructions)		661,293	483,609
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 32 and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	0

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet H-5
	HHA CCN: 157149	Home Health Agency I	Date/Time Prepared: 5/31/2012 12:03 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		661,293		483,609	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		661,293		483,609	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)		661,293		483,609	7.00
			0	Contractor Number	Date (Mo/Day/Yr)	
				1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151324

Period: From 01/01/2011

Worksheet K

Hospice CCN: 151519

To 12/31/2011

Date/Time Prepared: 5/31/2012 12:03 pm

		Hospice I					
		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	17,039	0	132,689	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	35,690	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	96,487	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	5,564	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	154,780	0	132,689	0	0	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151324

Period: From 01/01/2011

Worksheet K

Hospice CCN: 151519

To 12/31/2011

Date/Time Prepared: 5/31/2012 12:03 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	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	149,728	203,367	353,095	0	353,095	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	35,690	0	35,690	0	35,690	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	96,487	0	96,487	0	96,487	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	5,564	0	5,564	0	5,564	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	287,469	203,367	490,836	0	490,836	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151324

Period: From 01/01/2011

Worksheet K-1

Hospice CCN: 151519

To 12/31/2011

Date/Time Prepared: 5/31/2012 12:03 pm

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	17,039	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	35,690	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	96,487	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	52,729	0	96,487	0	0	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151324

Period: From 01/01/2011

Worksheet K-1

Hospice CCN: 151519

To 12/31/2011

Date/Time Prepared: 5/31/2012 12:03 pm

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	0	17,039	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services		0	0	0	9.00
10.00	Nursing Care		0	0	35,690	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	96,487	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		5,564	0	5,564	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	5,564	0	154,780	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151324

Period: From 01/01/2011

Worksheet K-4

Hospice CCN: 151519

To 12/31/2011

Part I
Date/Time Prepared:
5/31/2012 12:03 pm

		CAPITAL RELATED COST				Hospice I	
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
			1.00	2.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	353,095	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	35,690	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	96,487	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	5,564	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	490,836	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST		Provider CCN: 151324	Period: From 01/01/2011	Worksheet K-4 Part I Date/Time Prepared: 5/31/2012 12:03 pm
		Hospice CCN: 151519	To 12/31/2011	

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	Hospice I	TOTAL (col . 5A ± col . 6)	
		5.00	5A	6.00		7.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.		0				1.00
2.00	Capital Related Costs-Movable Equip.		0				2.00
3.00	Plant Operation and Maintenance		0				3.00
4.00	Transportation - Staff		0				4.00
5.00	Volunteer Service Coordination	0					5.00
6.00	Administrative and General	0	353,095				6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	35,690	91,490		127,180	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	96,487	247,342		343,829	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	5,564	14,263		19,827	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0		0	20.00
21.00	Other	0	0	0		0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0		0	22.00
23.00	Analgesics	0	0	0		0	23.00
24.00	Sedatives / Hypnotics	0	0	0		0	24.00
25.00	Other - Specify	0	0	0		0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0		0	26.00
27.00	Patient Transportation	0	0	0		0	27.00
28.00	Imaging Services	0	0	0		0	28.00
29.00	Labs and Diagnostics	0	0	0		0	29.00
30.00	Medical Supplies	0	0	0		0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0		0	31.00
32.00	Radiation Therapy	0	0	0		0	32.00
33.00	Chemotherapy	0	0	0		0	33.00
34.00	Other	0	0	0		0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0		0	35.00
36.00	Volunteer Program Costs	0	0	0		0	36.00
37.00	Fundraising	0	0	0		0	37.00
38.00	Other Program Costs	0	0	0		0	38.00
39.00	Total (sum of lines 1 thru 38)	0	137,741	353,095		490,836	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

Period: From 01/01/2011

Worksheet K-4

Hospice CCN: 151519

To 12/31/2011

Part II
Date/Time Prepared:
5/31/2012 12:03 pm

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

COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 151324	Period: From 01/01/2011	Worksheet K-4 Part II Date/Time Prepared: 5/31/2012 12:03 pm
	Hospice CCN: 151519	To 12/31/2011	

	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	Hospice I
	6A	6.00	
GENERAL SERVICE COST CENTERS			
1.00 Capital Related Costs-Bldg and Fixt.	0		1.00
2.00 Capital Related Costs-Movable Equip.	0		2.00
3.00 Plant Operation and Maintenance	0		3.00
4.00 Transportation - Staff	0		4.00
5.00 Volunteer Service Coordination			5.00
6.00 Administrative and General	-353,095	137,741	6.00
INPATIENT CARE SERVICE			
7.00 Inpatient - General Care	0	0	7.00
8.00 Inpatient - Respite Care	0	0	8.00
VISITING SERVICES			
9.00 Physician Services	0	0	9.00
10.00 Nursing Care	0	35,690	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	96,487	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	5,564	19.00
20.00 HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00 Other	0	0	21.00
OTHER HOSPICE SERVICE COSTS			
22.00 Drugs, Biological and Infusion Therapy	0	0	22.00
23.00 Analgesics	0	0	23.00
24.00 Sedatives / Hypnotics	0	0	24.00
25.00 Other - Specify	0	0	25.00
26.00 Durable Medical Equipment/Oxygen	0	0	26.00
27.00 Patient Transportation	0	0	27.00
28.00 Imaging Services	0	0	28.00
29.00 Labs and Diagnostics	0	0	29.00
30.00 Medical Supplies	0	0	30.00
31.00 Outpatient Services (including E/R Dept.)	0	0	31.00
32.00 Radiation Therapy	0	0	32.00
33.00 Chemotherapy	0	0	33.00
34.00 Other	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE			
35.00 Bereavement Program Costs	0	0	35.00
36.00 Volunteer Program Costs	0	0	36.00
37.00 Fundraising	0	0	37.00
38.00 Other Program Costs	0	0	38.00
39.00 Cost to be Allocated (per Wkst. K-4, Part I)		353,095	39.00
40.00 Unit Cost Multiplier		2.563471	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151324

Period: From 01/01/2011

Worksheet K-5

Hospice CCN: 151519

To 12/31/2011

Part I
Date/Time Prepared:
5/31/2012 12:03 pm

Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal 4A	ADMINISTRATIVE & GENERAL 5.00	
		NEW BLDG & FIXT					
		1.00	4.00				
1.00 Administrative and General	0	2,920	21,452	24,372	4,768	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	127,180	0	0	127,180	24,880	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	343,829	0	0	343,829	67,262	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	19,827	0	0	19,827	3,879	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)	490,836	2,920	21,452	515,208	100,789	34.00	
35.00 Unit Cost Multiplier (see instructions)				0.000000		35.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151324

Period:

Worksheet K-5

Hospice CCN: 151519

From 01/01/2011

Part I

To 12/31/2011

Date/Time Prepared:

5/31/2012 12:03 pm

Cost Center Description		Hospice I					
		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	2,985	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	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)	2,985	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: 151324

Period: From 01/01/2011

Worksheet K-5

Hospice CCN: 151519

To 12/31/2011

Part I
Date/Time Prepared:
5/31/2012 12:03 pm

Cost Center Description		Hospice I					
		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
1.00	Administrative and General	0	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	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	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: 151324

Period: From 01/01/2011

Worksheet K-5

Hospice CCN: 151519

To 12/31/2011

Part I
Date/Time Prepared:
5/31/2012 12:03 pm

Cost Center Description		Hospice I					
		Subtotal (cols. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 ± 27)	
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	32,125					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	152,060	0	152,060	8,324	160,384	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	411,091	0	411,091	22,503	433,594	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	23,706	0	23,706	1,298	25,004	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)	618,982	0	618,982		618,982	34.00
35.00	Unit Cost Multiplier (see instructions)				0.054741		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151324

Period:

Worksheet K-5

Hospice CCN: 151519

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

Part II
Date/Time Prepared:
5/31/2012 12:03 pm

Cost Center Description		CAPITAL RELATED COSTS		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)				
		1.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	249	154,779	0	24,372	249	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	127,180	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	343,829	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	19,827	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	249	154,779		515,208	249	34.00
35.00	Total cost to be allocated	2,920	21,452		100,789	2,985	35.00
36.00	Unit Cost Multiplier (see instructions)	11.726908	0.138598		0.195628	11.987952	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151324

Hospice CCN: 151519

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

Worksheet K-5
Part II
Date/Time Prepared:
5/31/2012 12:03 pm

Cost Center Description		Hospice I					
		LAUNDRY & LINEN SERVICE (DOLLAR VALUE)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (MAN HOURS)	
		8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	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	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	0	0	0	34.00
35.00	Total cost to be allocated	0	0	0	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	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: 151324
Hospice CCN: 151519

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

Worksheet K-5
Part II
Date/Time Prepared:
5/31/2012 12:03 pm

Cost Center Description		Hospice I					
		CENTRAL SERVICES & SUPPLY (100% ALLOCATION)	PHARMACY (100% ALLOCATION)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)		
		14.00	15.00	16.00	17.00		
1.00	Administrative and General	0	0	0	0		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	0	0	0		34.00
35.00	Total cost to be allocated	0	0	0	0		35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.000000		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS		Provider CCN: 151324	Period: From 01/01/2011	Worksheet K-5 Part III Date/Time Prepared: 5/31/2012 12:03 pm
		Hospice CCN: 151519	To 12/31/2011	

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	
ANCI LLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.694539	0	0	1.00
1.01	KV HEALTH & DEMOTTE PT	66.01	0.938248	0	0	1.01
2.00	OCCUPATIONAL THERAPY	67.00	1.183034	0	0	2.00
2.01	KV HEALTH & DEMOTTE OT	67.01	1.341159	0	0	2.01
3.00	SPEECH PATHOLOGY	68.00	1.345937	0	0	3.00
3.01	KV HEALTH & DEMOTTE ST	68.01	1.876817	0	0	3.01
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.410641	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.351985	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	6.01
7.00	MEDI CAL SUPPLIES CHARGED TO PATIENTS	71.00	0.385380	0	0	7.00
8.00	FAMI LY PRACTICE	93.00	0.000000	0	0	8.00
9.00	RADI OLOGY-THERAPEUTIC	55.00				9.00
10.00	OTHER ANCI LLARY SERVICE COST CENTERS	76.00				10.00
11.00	Totals (sum of lines 1-10)					0 11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 151324

Period: From 01/01/2011

Worksheet K-6

Hospice CCN: 151519

To 12/31/2011

Date/Time Prepared: 5/31/2012 12:03 pm

		Hospice I			Total	
		Title XVIII	Title XIX	Other	4.00	
		1.00	2.00	3.00		
1.00	Total cost (see instructions)				618,982	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				4,695	2.00
3.00	Average cost per diem (line 1 divided by line 2)				131.84	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	4,417				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	582,337				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		100			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		13,184			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	1,074				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	141,596				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		1,153			10.00
11.00	Aggregate NF cost (line 3 times line 10)		152,012			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			178		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			23,468		13.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 151324

Period: From 01/01/2011

Worksheet M-1

Component CCN: 153990

To 12/31/2011

Date/Time Prepared: 5/31/2012 12:03 pm

		Title XVIII			Rural Health Clinic (RHC) I	Cost
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	2.00
3.00	Nurse Practitioner	118,953	0	118,953	0	3.00
4.00	Visiting Nurse	0	0	0	0	4.00
5.00	Other Nurse	45,769	0	45,769	0	5.00
6.00	Clinical Psychologist	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	164,722	0	164,722	0	10.00
11.00	Physician Services Under Agreement	0	25,389	25,389	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	25,389	25,389	0	14.00
15.00	Medical Supplies	0	13,551	13,551	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	13,551	13,551	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	164,722	38,940	203,662	0	22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	23.00
24.00	Dental	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	29.00
30.00	Administrative Costs	95,854	42,479	138,333	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	95,854	42,479	138,333	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	260,576	81,419	341,995	0	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 151324 Component CCN: 153990	Period: From 01/01/2011 To 12/31/2011	Worksheet M-1 Date/Time Prepared: 5/31/2012 12:03 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	0
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	118,953
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	45,769
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	0
10.00	Subtotal (sum of lines 1-9)	0	164,722
11.00	Physician Services Under Agreement	0	25,389
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11-13)	0	25,389
15.00	Medical Supplies	0	13,551
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15-20)	0	13,551
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	203,662
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	0
30.00	Administrative Costs	-16,182	122,151
31.00	Total Facility Overhead (sum of lines 29 and 30)	-16,182	122,151
32.00	Total facility costs (sum of lines 22, 28 and 31)	-16,182	325,813

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 151324

Period: From 01/01/2011

Worksheet M-1

Component CCN: 158502

To 12/31/2011

Date/Time Prepared: 5/31/2012 12:03 pm

		Title XVIII		Rural Health Clinic (RHC) IV	Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	2.00
3.00	Nurse Practitioner	142,064	0	142,064	0	3.00
4.00	Visiting Nurse	0	0	0	0	4.00
5.00	Other Nurse	72,371	0	72,371	0	5.00
6.00	Clinical Psychologist	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	214,435	0	214,435	0	10.00
11.00	Physician Services Under Agreement	0	50,440	50,440	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	50,440	50,440	0	14.00
15.00	Medical Supplies	0	16,993	16,993	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	16,993	16,993	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	214,435	67,433	281,868	0	22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	23.00
24.00	Dental	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	29.00
30.00	Administrative Costs	69,911	33,598	103,509	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	69,911	33,598	103,509	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	284,346	101,031	385,377	0	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 151324 Component CCN: 158502	Period: From 01/01/2011 To 12/31/2011	Worksheet M-1 Date/Time Prepared: 5/31/2012 12:03 pm
	Title XVIII	Rural Health Clinic (RHC) IV	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	0
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	142,064
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	72,371
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	0
10.00	Subtotal (sum of lines 1-9)	0	214,435
11.00	Physician Services Under Agreement	0	50,440
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11-13)	0	50,440
15.00	Medical Supplies	0	16,993
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15-20)	0	16,993
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	281,868
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0
FACILITY OVERHEAD			
29.00	Facility Costs	0	0
30.00	Administrative Costs	0	103,509
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	103,509
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	385,377

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet M-2
		Component CCN: 153990		Date/Time Prepared: 5/31/2012 12:03 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.00	0	4,200	0	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	1.50	5,388	2,100	3,150	3.00
4.00	Subtotal (sum of lines 1-3)	1.50	5,388		3,150	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	1.50	5,388			8.00
9.00	Physician Services Under Agreements		102			9.00
					1.00	

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)				203,662	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				203,662	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)				122,151	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				148,763	15.00
16.00	Total overhead (sum of lines 14 and 15)				270,914	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				270,914	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				270,914	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				474,576	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet M-2		
		Component CCN: 158502		Date/Time Prepared: 5/31/2012 12:03 pm		
		Title XVIII	Rural Health Clinic (RHC) IV	Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.00	0	4,200	0	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	1.50	5,027	2,100	3,150	3.00
4.00	Subtotal (sum of lines 1-3)	1.50	5,027		3,150	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	1.50	5,027		5,027	8.00
9.00	Physician Services Under Agreements		141		141	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)				281,868	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				281,868	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)				103,509	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				237,103	15.00
16.00	Total overhead (sum of lines 14 and 15)				340,612	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				340,612	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				340,612	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				622,480	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet M-3
		Component CCN: 153990		Date/Time Prepared: 5/31/2012 12:03 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		474,576	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		6,462	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		468,114	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		5,388	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		102	5.00
6.00	Total adjusted visits (line 4 plus line 5)		5,490	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		85.27	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27, Sec. 505 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	85.27	85.27	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	291	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	24,814	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)	0	0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	24,814	16.00
16.01	Total program charges (see instructions)(from contractor's records)		21,807	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		180	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		205	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		14,878	16.04
16.05	Total program cost (see instructions)		15,083	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		6,011	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		15,083	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,444	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		16,527	22.00
23.00	Reimbursable bad debts (see instructions)		0	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		16,527	26.00
27.00	Interim payments		16,483	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		44	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet M-3
		Component CCN: 158502		Date/Time Prepared: 5/31/2012 12:03 pm
		Title XVIII	Rural Health Clinic (RHC) IV	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		622,480	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		7,727	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		614,753	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		5,027	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		141	5.00
6.00	Total adjusted visits (line 4 plus line 5)		5,168	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		118.95	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 27, Sec. 505 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	118.95	118.95	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	752	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	89,450	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)	0	0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	89,450	16.00
16.01	Total program charges (see instructions)(from contractor's records)		51,850	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,020	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,760	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		59,837	16.04
16.05	Total program cost (see instructions)		61,597	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		12,894	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		61,597	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		3,909	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		65,506	22.00
23.00	Reimbursable bad debts (see instructions)		0	23.00
24.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)		65,506	26.00
27.00	Interim payments		55,710	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 27 and 28)		9,796	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 151324 Component CCN: 153990	Period: From 01/01/2011 To 12/31/2011	Worksheet M-4 Date/Time Prepared: 5/31/2012 12:03 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	164,722	164,722	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000131	0.005900	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	22	972	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	159	1,620	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	181	2,592	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	203,662	203,662	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	270,914	270,914	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000889	0.012727	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	241	3,448	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	422	6,040	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	3	135	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	140.67	44.74	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	2	26	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	281	1,163	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		6,462	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		1,444	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 151324	Period: From 01/01/2011 To 12/31/2011	Worksheet M-4
		Component CCN: 158502		Date/Time Prepared: 5/31/2012 12:03 pm
		Title XVIII	Rural Health Clinic (RHC) IV	Cost
		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	214,435	214,435	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000401	0.005609	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	86	1,203	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	530	1,680	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	616	2,883	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	281,868	281,868	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	340,612	340,612	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002185	0.010228	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	744	3,484	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,360	6,367	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	10	140	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	136.00	45.48	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	6	68	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	816	3,093	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		7,727	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		3,909	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 151324 Component CCN: 153990	Period: From 01/01/2011 To 12/31/2011	Worksheet M-5 Date/Time Prepared: 5/31/2012 12:03 pm
	Title VIII	Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		16,483	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		16,483	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		44	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		16,527	7.00
		Contractor Number	Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 151324 Component CCN: 158502	Period: From 01/01/2011 To 12/31/2011	Worksheet M-5 Date/Time Prepared: 5/31/2012 12:03 pm
	Title XVIII	Rural Health Clinic (RHC) IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		55,710	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		55,710	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		9,796	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		65,506	7.00
		Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00