

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: 151329	Period: From 01/01/2011 To 12/31/2011	Worksheet S Parts I-III Date/Time Prepared: 5/30/2012 3:29 pm
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PART I - COST REPORT STATUS

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

Date: 5/30/2012 Time: 3:29 pm

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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

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

 Title

 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	573,250	-247,006	0	182,865	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	1	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	573,251	-247,006	0	182,865	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: 151329		Period: From 01/01/2011 To 12/31/2011		Worksheet S-2 Part I Date/Time Prepared: 5/30/2012 3:28 pm				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 321 MITCHELL		PO Box:							
2.00	City: BATESVILLE		State: IN		Zip Code: 47006-		County: RIPLEY			
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		MARGARET MARY COMMUNITY HOSPITAL	151329	99915	1	01/07/1966	N	O	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF						N	N	N	
8.00	Swing Beds - NF						N		N	
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA		MARGARET MARY COMMUNITY HOSPITAL	157143	99915		03/01/1985	N	P	N
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice		MARGARET MARY COMMUNITY HOSPITAL	151551	99915		12/31/2003			
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) 1									
18.00	Renal Dialysis									
19.00	Other									
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2011		12/31/2011		20.00
21.00	Type of Control (see instructions)							2		21.00
Inpatient PPS Information										
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N				22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.							0		23.00
		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.		0	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.		0	0	0	0	0	0	0	25.00
						Urban/Rural S	Date of Geogr			
						1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.							2		26.00
27.00	For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification (in column 2).							2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							0		35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151329	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/30/2012 3:28 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00	61.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00	
		Program Name 1.00	Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151329

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

Worksheet S-2
Part I
Date/Time Prepared:
5/30/2012 3:28 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		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010								
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00	
						1.00	2.00	3.00
Inpatient Psychiatric Facility PPS								
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N		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: 151329	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part I Date/Time Prepared: 5/30/2012 3:28 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	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
				1.00	2.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.		N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			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.		Y	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00

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				1.00			2.00			
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							126.00		
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							127.00		
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							128.00		
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							129.00		
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							130.00		
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							131.00		
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							132.00		
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							133.00		
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.							134.00		
All Providers										
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)			N				140.00		
				1.00	2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name:			Contractor's Name:		Contractor's Number:			141.00	
142.00	Street:			PO Box:					142.00	
143.00	City:			State:		Zip Code:			143.00	
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?			Y				144.00		
145.00	If costs for renal services are claimed on Worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.			N				145.00		
								1.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.			N				146.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N				147.00		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N				148.00		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N				149.00		
								Part A	Part B	
								1.00	2.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital			N		N		155.00		
156.00	Subprovider - IPF			N		N		156.00		
157.00	Subprovider - IRF			N		N		157.00		
158.00	SUBPROVIDER			N		N		158.00		
159.00	SNF			N		N		159.00		
160.00	HOME HEALTH AGENCY			N		N		160.00		
161.00	CMHC			N		N		161.00		
								1.00		
Multi campus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N				165.00		
								0.00		
Name										
County										
State										
Zip Code										
CBSA										
FTE/Campus										
				1.00	2.00		3.00		4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5							0.00	166.00	
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.			N				167.00		
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							0	168.00	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151329	Period: From 01/01/2011 To 12/31/2011	Worksheet S-2 Part II Date/Time Prepared: 5/30/2012 3:28 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.				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?				6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.				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.				8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.				9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.				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.				11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A			
		Description	Y/N	Date	
		0	1.00	2.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	02/22/2012		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 151329

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

Worksheet S-2
Part II
Date/Time Prepared:
5/30/2012 3:28 pm

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

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	02/22/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			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: 151329

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2012 3:28 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	18	6,570	111,576.00		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)		18	6,570	111,576.00		7.00
8.00 INTENSIVE CARE UNIT	31.00	7	2,555	0.00		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00					13.00
14.00 Total (see instructions)		25	9,125	111,576.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151329

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2012 3:28 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	2,250	191	4,646		1.00
2.00 HMO		481	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	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,250	191	4,646		7.00
8.00 INTENSIVE CARE UNIT	0	264	15	469		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	769		13.00
14.00 Total (see instructions)	0	2,514	206	5,884		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	5,151	1,344	9,429		22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE		0	0	0		24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	734		28.00
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				0		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			0	0		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151329

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2012 3:28 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	726	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	420.03	0.00	0	726	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00	0.00	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00	0.00	0.00			24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	420.03	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151329

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

Worksheet S-3
Part I
Date/Time Prepared:
5/30/2012 3:28 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)	77	2,056		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)	77	2,056		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 151329		Period: From 01/01/2011 To 12/31/2011		Worksheet S-4	
		Component CCN: 157143		Home Health Agency I		Date/Time Prepared: 5/30/2012 3:28 pm	
						PPS	
						1.00	
0.00	County					0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	334.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	0.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			0.00	0.00	0.00	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99915			20.00
20.01				17140			20.01
		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	2,762	124	162	72	3,120	21.00
22.00	Skilled Nursing Visit Charges	442,076	19,840	25,933	11,520	499,369	22.00
23.00	Physical Therapy Visits	1,175	0	24	19	1,218	23.00
24.00	Physical Therapy Visit Charges	224,438	0	4,608	3,648	232,694	24.00
25.00	Occupational Therapy Visits	376	0	1	9	386	25.00
26.00	Occupational Therapy Visit Charges	77,201	0	206	1,854	79,261	26.00
27.00	Speech Pathology Visits	42	0	1	0	43	27.00
28.00	Speech Pathology Visit Charges	8,646	0	208	0	8,854	28.00
29.00	Medical Social Service Visits	13	0	0	1	14	29.00
30.00	Medical Social Service Visit Charges	3,965	0	0	305	4,270	30.00
31.00	Home Health Aide Visits	362	0	2	6	370	31.00
32.00	Home Health Aide Visit Charges	33,832	0	188	564	34,584	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,730	124	190	107	5,151	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	790,158	19,840	31,143	17,891	859,032	35.00
36.00	Total Number of Episodes (standard/non outlier)	359		74	12	445	36.00
37.00	Total Number of Outlier Episodes		3		0	3	37.00
38.00	Total Non-Routine Medical Supply Charges	17,194	2,792	3,066	343	23,395	38.00

HOSPITAL IDENTIFICATION DATA

Provider CCN: 151329

Period:

Worksheet S-9

Component CCN: 151551

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

Parts I & II
Date/Time Prepared:
5/30/2012 3:28 pm

Hospice I

	Unduplicated Days					
	Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	
	1.00	2.00	3.00	4.00	5.00	
PART I - ENROLLMENT DAYS						
1.00	Continuous Home Care	0	0	0	0	0
2.00	Routine Home Care	4,700	169	4,417	32	577
3.00	Inpatient Respite Care	0	0	0	0	0
4.00	General Inpatient Care	0	0	0	0	0
5.00	Total Hospice Days	4,700	169	4,417	32	577
Part II - CENSUS DATA						
6.00	Number of Patients Receiving Hospice Care	85	2	59	3	13
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	74.00		0.00		
8.00	Average Length of Stay (line 5/line 6)	55.29	84.50	74.86	10.67	44.38
9.00	Unduplicated Census Count	83	5	57	3	13

HOSPITAL IDENTIFICATION DATA		Provider CCN: 151329	Period: From 01/01/2011 To 12/31/2011	Worksheet S-9 Parts I & II Date/Time Prepared: 5/30/2012 3:28 pm
		Component CCN: 151551	Hospice I	

		Unduplicated Days	
		Total (sum of cols. 1, 2 & 5)	
		6.00	
PART I - ENROLLMENT DAYS			
1.00	Continuous Home Care	0	1.00
2.00	Routine Home Care	5,446	2.00
3.00	Inpatient Respite Care	0	3.00
4.00	General Inpatient Care	0	4.00
5.00	Total Hospice Days	5,446	5.00
Part II - CENSUS DATA			
6.00	Number of Patients Receiving Hospice Care	100	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare		7.00
8.00	Average Length of Stay (line 5/line 6)	54.46	8.00
9.00	Unduplicated Census Count	101	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151329	Period: From 01/01/2011 To 12/31/2011	Worksheet S-10 Date/Time Prepared: 5/30/2012 3:28 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)		0.431406	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		1,340,802	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		8,289,681	6.00	
7.00	Medicaid cost (line 1 times line 6)		3,576,218	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)		2,235,416	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)		2,235,416	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	1,855,734	0	1,855,734	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	800,575	0	800,575	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	800,575	0	800,575	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		6,324,882	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		807,702	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		5,517,180	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		2,380,145	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		3,180,720	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		5,416,136	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151329

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

Worksheet A
Date/Time Prepared:
5/30/2012 3:28 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT		3,573,492	3,573,492	-54,096	3,519,396	1.00
1.01 NEW CAP REL COSTS-OFFSITE BLDG		221,992	221,992	54,096	276,088	1.01
2.00 NEW CAP REL COSTS-MVBLE EQUIP		2,647,100	2,647,100	-69,231	2,577,869	2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT		0	0	69,231	69,231	2.01
4.00 EMPLOYEE BENEFITS	169,833	8,338,316	8,508,149	0	8,508,149	4.00
5.00 ADMINISTRATIVE & GENERAL	3,419,589	2,947,744	6,367,333	248,618	6,615,951	5.00
7.00 OPERATION OF PLANT	0	1,401,020	1,401,020	0	1,401,020	7.00
7.01 OPERATION OF PLANT -OFFSITE	0	61,129	61,129	0	61,129	7.01
7.02 OPERATION OF PLANT - HOSPITAL & OFFS	545,022	11,407	556,429	0	556,429	7.02
8.00 LAUNDRY & LINEN SERVICE	74,789	68,428	143,217	0	143,217	8.00
9.00 HOUSEKEEPING	546,128	108,180	654,308	0	654,308	9.00
10.00 DIETARY	713,658	445,997	1,159,655	-894,958	264,697	10.00
11.00 CAFETERIA	0	0	0	894,958	894,958	11.00
13.00 NURSING ADMINISTRATION	623,845	18,776	642,621	0	642,621	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	529,276	529,276	0	529,276	14.00
15.00 PHARMACY	490,480	1,270,229	1,760,709	0	1,760,709	15.00
16.00 MEDICAL RECORDS & LIBRARY	776,009	207,136	983,145	0	983,145	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1,540,077	122,820	1,662,897	456,068	2,118,965	30.00
31.00 INTENSIVE CARE UNIT	373,160	18,434	391,594	0	391,594	31.00
43.00 NURSERY	0	20,004	20,004	497,930	517,934	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	1,173,617	2,247,690	3,421,307	-740,687	2,680,620	50.00
52.00 DELIVERY ROOM & LABOR ROOM	899,818	163,655	1,063,473	-953,998	109,475	52.00
54.00 RADIOLOGY-DIAGNOSTIC	1,872,153	4,119,801	5,991,954	0	5,991,954	54.00
60.00 LABORATORY	1,104,229	1,610,837	2,715,066	0	2,715,066	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	826,650	78,642	905,292	-491,071	414,221	65.00
66.00 PHYSICAL THERAPY	680,066	176,001	856,067	0	856,067	66.00
67.00 OCCUPATIONAL THERAPY	446,529	60,047	506,576	0	506,576	67.00
68.00 SPEECH PATHOLOGY	153,999	5,990	159,989	-27,774	132,215	68.00
69.00 ELECTROCARDIOLOGY	0	263,960	263,960	491,071	755,031	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	765,695	765,695	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	790,839	226,720	1,017,559	0	1,017,559	90.00
90.01 WOUND CLINIC	175,479	260,303	435,782	0	435,782	90.01
91.00 EMERGENCY	1,455,728	1,704,204	3,159,932	0	3,159,932	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	1,080,976	206,017	1,286,993	0	1,286,993	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE		0	0	0	0	113.00
116.00 HOSPICE	498,864	244,630	743,494	0	743,494	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	20,431,537	33,379,977	53,811,514	245,852	54,057,366	118.00
NONREIMBURSABLE COST CENTERS						
192.00 PHYSICIANS' PRIVATE OFFICES	4,388,080	1,071,614	5,459,694	0	5,459,694	192.00
192.01 PRIVATE DUTY	1,038	898	1,936	0	1,936	192.01
194.00 COMMUNITY RELATIONS	182,290	439,909	622,199	-273,626	348,573	194.00
194.01 COMMUNITY BENEFITS	332,388	249,943	582,331	0	582,331	194.01
194.02 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	27,774	27,774	194.02
194.03 EMS	17,405	48,397	65,802	0	65,802	194.03
200.00 TOTAL (SUM OF LINES 118-199)	25,352,738	35,190,738	60,543,476	0	60,543,476	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151329

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

Worksheet A
Date/Time Prepared:
5/30/2012 3:28 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	-1,341,249	2,178,147	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	276,088	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2,577,869	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	69,231	2.01
4.00	EMPLOYEE BENEFITS	0	8,508,149	4.00
5.00	ADMINISTRATIVE & GENERAL	-241,985	6,373,966	5.00
7.00	OPERATION OF PLANT	0	1,401,020	7.00
7.01	OPERATION OF PLANT -OFFSITE	0	61,129	7.01
7.02	OPERATION OF PLANT - HOSPITAL & OFFS	0	556,429	7.02
8.00	LAUNDRY & LINEN SERVICE	-817	142,400	8.00
9.00	HOUSEKEEPING	0	654,308	9.00
10.00	DIETARY	-35,021	229,676	10.00
11.00	CAFETERIA	-197,825	697,133	11.00
13.00	NURSING ADMINISTRATION	0	642,621	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	529,276	14.00
15.00	PHARMACY	0	1,760,709	15.00
16.00	MEDICAL RECORDS & LIBRARY	-11,771	971,374	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	2,118,965	30.00
31.00	INTENSIVE CARE UNIT	0	391,594	31.00
43.00	NURSERY	0	517,934	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	2,680,620	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	109,475	52.00
54.00	RADIOLOGY-DIAGNOSTIC	-361,772	5,630,182	54.00
60.00	LABORATORY	0	2,715,066	60.00
60.01	BLOOD LABORATORY	0	0	60.01
65.00	RESPIRATORY THERAPY	0	414,221	65.00
66.00	PHYSICAL THERAPY	0	856,067	66.00
67.00	OCCUPATIONAL THERAPY	0	506,576	67.00
68.00	SPEECH PATHOLOGY	0	132,215	68.00
69.00	ELECTROCARDIOLOGY	-157,616	597,415	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	765,695	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0	1,017,559	90.00
90.01	WOUND CLINIC	0	435,782	90.01
91.00	EMERGENCY	-1,438,878	1,721,054	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	HOME HEALTH AGENCY	0	1,286,993	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	0	0	113.00
116.00	HOSPICE	0	743,494	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-3,786,934	50,270,432	118.00
NONREIMBURSABLE COST CENTERS				
192.00	PHYSICIANS' PRIVATE OFFICES	0	5,459,694	192.00
192.01	PRIVATE DUTY	0	1,936	192.01
194.00	COMMUNITY RELATIONS	0	348,573	194.00
194.01	COMMUNITY BENEFITS	0	582,331	194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS	0	27,774	194.02
194.03	EMS	0	65,802	194.03
200.00	TOTAL (SUM OF LINES 118-199)	-3,786,934	56,756,542	200.00

RECLASSIFICATIONS

Provider CCN: 151329

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

Worksheet A-6

Date/Time Prepared:
5/30/2012 3:28 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - CAFETERIA						
1.00	CAFETERIA	11.00	550,762	344,196	1.00	
	TOTALS		550,762	344,196		
B - OB RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	385,885	70,183	1.00	
2.00	NURSERY	43.00	421,305	76,625	2.00	
	TOTALS		807,190	146,808		
C - COMMUNITY RELATIONS						
1.00	ADMINISTRATIVE & GENERAL	5.00	78,131	195,495	1.00	
	TOTALS		78,131	195,495		
D - DEPRECIATION						
1.00	NEW CAP REL COSTS-OFFSITE BLDG	1.01	0	54,096	1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP OFFSITE	2.01	0	69,231	2.00	
	TOTALS		0	123,327		
E - IMPLANT						
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	765,695	1.00	
	TOTALS		0	765,695		
F - RT RECLASS						
1.00	ELECTROCARDIOLOGY	69.00	491,071	0	1.00	
	TOTALS		491,071	0		
G - SPEECH THERAPY RECLASS						
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.02	26,734	1,040	1.00	
	TOTALS		26,734	1,040		
H - ANESTHESIA MED DIRECTOR						
1.00	OPERATING ROOM	50.00	0	25,008	1.00	
	TOTALS		0	25,008		
500.00	Grand Total: Increases		1,953,888	1,601,569	500.00	

RECLASSIFICATIONS

Provider CCN: 151329

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

Worksheet A-6
Date/Time Prepared:
5/30/2012 3:28 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA							
1.00	DIETARY	10.00	550,762	344,196	0		1.00
	TOTALS		550,762	344,196			
B - OB RECLASS							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	807,190	146,808	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		807,190	146,808			
C - COMMUNITY RELATIONS							
1.00	COMMUNITY RELATIONS	194.00	78,131	195,495	0		1.00
	TOTALS		78,131	195,495			
D - DEPRECIATION							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	54,096	9		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	69,231	9		2.00
	TOTALS		0	123,327			
E - IMPLANT							
1.00	OPERATING ROOM	50.00	0	765,695	0		1.00
	TOTALS		0	765,695			
F - RT RECLASS							
1.00	RESPIRATORY THERAPY	65.00	491,071	0	0		1.00
	TOTALS		491,071	0			
G - SPEECH THERAPY RECLASS							
1.00	SPEECH PATHOLOGY	68.00	26,734	1,040	0		1.00
	TOTALS		26,734	1,040			
H - ANESTHESIA MED DIRECTOR							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	25,008	0		1.00
	TOTALS		0	25,008			
500.00	Grand Total: Decreases		1,953,888	1,601,569			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151329

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/30/2012 3:28 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,371,158	0	0	0	1.00
2.00	Land Improvements	372,269	0	0	0	2.00
3.00	Buildings and Fixtures	60,304,142	274,896	0	274,896	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	6,136,642	201,216	0	201,216	5.00
6.00	Movable Equipment	29,099,763	2,526,060	0	2,526,060	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	98,283,974	3,002,172	0	3,002,172	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	98,283,974	3,002,172	0	3,002,172	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	1,959,716	0	1,613,776	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	221,992	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,647,100	0	0	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	4,828,808	0	1,613,776	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
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	0	0	0.000000	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0.000000	2.01
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151329

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/30/2012 3:28 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,371,158	0		1.00		
2.00	Land Improvements	372,269	0		2.00		
3.00	Buildings and Fixtures	60,579,038	0		3.00		
4.00	Building Improvements	0	0		4.00		
5.00	Fixed Equipment	6,337,858	0		5.00		
6.00	Movable Equipment	31,586,193	0		6.00		
7.00	HIT designated Assets	0	0		7.00		
8.00	Subtotal (sum of lines 1-7)	101,246,516	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	101,246,516	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	3,573,492		1.00		
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	221,992		1.01		
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2,647,100		2.00		
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0		2.01		
3.00	Total (sum of lines 1-2)	0	6,442,584		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	1,905,620	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	0	0	276,088	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	2,577,869	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	69,231	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	4,828,808	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151329

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
5/30/2012 3:28 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	272,527	0	0	0	2,178,147	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	0	0	0	276,088	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,577,869	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0	69,231	2.01
3.00	Total (sum of lines 1-2)	272,527	0	0	0	5,101,335	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151329

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

Worksheet A-8
Date/Time Prepared:
5/30/2012 3:28 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center		Line #
			1.00	2.00	3.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0NEW CAP REL COSTS-BLDG & FIXT		1.00 1.00
1.01 Investment income - NEW CAP REL COSTS-OFFSITE BLDG (chapter 2)			0NEW CAP REL COSTS-OFFSITE BLDG		1.01 1.01
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0NEW CAP REL COSTS-MVBLE EQUIP		2.00 2.00
2.01 Investment income - NEW CAP REL COSTS-MVBLE EQUIP OFFSIT (chapter 2)			0NEW CAP REL COSTS-MVBLE EQUIP OFFSIT		2.01 2.01
3.00 Investment income - other (chapter 2)		0			0.00 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		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	-1,949,367			10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0			12.00
13.00 Laundry and linen service		0			0.00 13.00
14.00 Cafeteria-employees and guests		0			0.00 14.00
15.00 Rental of quarters to employee and others		0			0.00 15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00 16.00
17.00 Sale of drugs to other than patients		0			0.00 17.00
18.00 Sale of medical records and abstracts		0			0.00 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00 19.00
20.00 Vending machines		0			0.00 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY		65.00 23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY		66.00 24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***		114.00 25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0NEW CAP REL COSTS-BLDG & FIXT		1.00 26.00
26.01 Depreciation - NEW CAP REL COSTS-OFFSITE BLDG			0NEW CAP REL COSTS-OFFSITE BLDG		1.01 26.01
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0NEW CAP REL COSTS-MVBLE EQUIP		2.00 27.00
27.01 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP OFFSIT			0NEW CAP REL COSTS-MVBLE EQUIP OFFSIT		2.01 27.01
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***		19.00 28.00
29.00 Physicians' assistant			0		0.00 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0OCCUPATIONAL THERAPY		67.00 30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY		68.00 31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A		0		0.00 32.00
33.00 OTHEROPERATING OTHOP - VENDING SALES	B	-4,456	0DIETARY		10.00 33.00
34.00 OTHEROPERATING GIRLS ON THE RUN REVE	B	-31,243	0ADMINISTRATIVE & GENERAL		5.00 34.00
35.00 OTHEROPERATING OTHOP - INTERNAL SALE	B	212	0ADMINISTRATIVE & GENERAL		5.00 35.00
36.00 OTHEROPERATING 24 HOUR FLOWER	B	-325	0ADMINISTRATIVE & GENERAL		5.00 36.00
37.00 MMCH OTHER OPERATING COMMBENEFITS SC	B	-1,315	0ADMINISTRATIVE & GENERAL		5.00 37.00
38.00 OTHEROPERATING DIABETES PROGRAM	B	-13,030	0ADMINISTRATIVE & GENERAL		5.00 38.00
39.00 OTHEROPERATING OTHOP - MEDRED TRANSC	B	-11,771	0MEDICAL RECORDS & LIBRARY		16.00 39.00
40.00 OTHEROPERATING OTHOP - DIET SUPP/INS	B	-30,565	0DIETARY		10.00 40.00
41.00 OTHEROPERATING OTHOP-COMMUNITY CLASS	B	-10,095	0ADMINISTRATIVE & GENERAL		5.00 41.00
42.00 OTHEROPERATING OTHOP - EMS EDUCATION	B	-8,995	0EMERGENCY		91.00 42.00
43.00 OTHEROPERATING OTHOP - LAUNDRY SERVI	B	-817	0LAUNDRY & LINEN SERVICE		8.00 43.00
44.00 OTHEROPERATING OTHOP - MISC REVENUE	B	-790	0ADMINISTRATIVE & GENERAL		5.00 44.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151329

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

Worksheet A-8

Date/Time Prepared:
5/30/2012 3:28 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	
45.00 CAFETERIA OFFSET	A	-197,825	CAFETERIA	11.00	45.00
45.01 TELEPHONE & TV OFFSET	A	-2,834	ADMINISTRATIVE & GENERAL	5.00	45.01
45.02 LOBBYING EXPENSE	A	-4,678	ADMINISTRATIVE & GENERAL	5.00	45.02
45.03 MEDICAL STAFF PLACEMENT FEE	A	-5,577	ADMINISTRATIVE & GENERAL	5.00	45.03
45.04 INTEREST OFFSET	A	-1,341,249	NEW CAP REL COSTS-BLDG & FIXT	1.00	45.04
45.05 MEDICAL STAFF RETENTION COST	A	-172,214	ADMINISTRATIVE & GENERAL	5.00	45.05
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,786,934			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151329

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

Worksheet A-8
Date/Time Prepared:
5/30/2012 3:28 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
1.01	Investment income - NEW CAP REL COSTS-OFFSITE BLDG (chapter 2)	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
2.01	Investment income - NEW CAP REL COSTS-MVBLE EQUIP OFFSIT (chapter 2)	0	2.01
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-OFFSITE BLDG	0	26.01
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	0	27.00
27.01	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	27.01
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	OTHEROPERATING OTHOP - VENDING SALES	0	33.00
34.00	OTHEROPERATING GIRLS ON THE RUN REVE	0	34.00
35.00	OTHEROPERATING OTHOP - INTERNAL SALE	0	35.00
36.00	OTHEROPERATING 24 HOUR FLOWER	0	36.00
37.00	MMCH OTHER OPERATING COMMBENEFITS SC	0	37.00
38.00	OTHEROPERATING DIABETES PROGRAM	0	38.00
39.00	OTHEROPERATING OTHOP - MEDRED TRANSC	0	39.00
40.00	OTHEROPERATING OTHOP - DIET SUPP/INS	0	40.00
41.00	OTHEROPERATING OTHOP-COMMUNITY CLASS	0	41.00
42.00	OTHEROPERATING OTHOP - EMS EDUCATION	0	42.00
43.00	OTHEROPERATING OTHOP - LAUNDRY SERVI	0	43.00
44.00	OTHEROPERATING OTHOP - MISC REVENUE	0	44.00
45.00	CAFETERIA OFFSET	0	45.00
45.01	TELEPHONE & TV OFFSET	0	45.01
45.02	LOBBYING EXPENSE	0	45.02
45.03	MEDICAL STAFF PLACEMENT FEE	0	45.03
45.04	INTEREST OFFSET	11	45.04
45.05	MEDICAL STAFF RETENTION COST	0	45.05
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: 151329

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

Worksheet A-8-2

Date/Time Prepared:
5/30/2012 3:28 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	12,096	96	1.00
2.00	43.00	NURSERY	20,004	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	453,772	361,772	3.00
4.00	60.00	LABORATORY	72,855	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	195,608	157,616	5.00
6.00	91.00	EMERGENCY	1,732,070	1,429,883	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			2,486,405	1,949,367	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151329

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

Worksheet A-8-2

Date/Time Prepared:
5/30/2012 3:28 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	12,000	0	0	0	0	1.00
2.00	20,004	0	0	0	0	2.00
3.00	92,000	0	0	0	0	3.00
4.00	72,855	0	0	0	0	4.00
5.00	37,992	0	0	0	0	5.00
6.00	302,187	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	537,038		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151329

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

Worksheet A-8-2

Date/Time Prepared:
5/30/2012 3:28 pm

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151329

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

Worksheet A-8-2

Date/Time Prepared:
5/30/2012 3:28 pm

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	96	1.00
2.00	0	0	2.00
3.00	0	361,772	3.00
4.00	0	0	4.00
5.00	0	157,616	5.00
6.00	0	1,429,883	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	1,949,367	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151329

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2012 3:28 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSIT	
		1.00	1.01	2.00	2.01	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT	2,178,147	2,178,147				1.00
1.01 NEW CAP REL COSTS-OFFSITE BLDG	276,088	0	276,088			1.01
2.00 NEW CAP REL COSTS-MVBLE EQUIP	2,577,869			2,577,869		2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	69,231			0	69,231	2.01
4.00 EMPLOYEE BENEFITS	8,508,149	22,407	0	26,519	0	4.00
5.00 ADMINISTRATIVE & GENERAL	6,373,966	348,810	0	412,819	0	5.00
7.00 OPERATION OF PLANT	1,401,020	348,636	0	412,616	0	7.00
7.01 OPERATION OF PLANT -OFFSITE	61,129	0	0	0	0	7.01
7.02 OPERATION OF PLANT - HOSPITAL & OFFS	556,429	0	0	0	0	7.02
8.00 LAUNDRY & LINEN SERVICE	142,400	27,466	0	32,507	0	8.00
9.00 HOUSEKEEPING	654,308	27,900	0	33,020	0	9.00
10.00 DIETARY	229,676	18,359	0	21,728	0	10.00
11.00 CAFETERIA	697,133	62,060	0	73,449	0	11.00
13.00 NURSING ADMINISTRATION	642,621	0	0	0	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	529,276	20,802	0	24,620	0	14.00
15.00 PHARMACY	1,760,709	14,745	0	17,451	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	971,374	31,890	0	37,742	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,118,965	163,122	0	193,057	0	30.00
31.00 INTENSIVE CARE UNIT	391,594	32,584	0	38,563	0	31.00
43.00 NURSERY	517,934	10,163	0	12,028	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	2,680,620	43,079	0	50,985	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	109,475	58,619	0	69,377	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	5,630,182	287,964	0	340,810	0	54.00
60.00 LABORATORY	2,715,066	71,601	0	84,740	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 RESPIRATORY THERAPY	414,221	14,687	0	17,383	0	65.00
66.00 PHYSICAL THERAPY	856,067	44,799	0	53,021	0	66.00
67.00 OCCUPATIONAL THERAPY	506,576	15,757	0	18,649	0	67.00
68.00 SPEECH PATHOLOGY	132,215	7,156	0	8,469	0	68.00
69.00 ELECTROCARDIOLOGY	597,415	58,879	0	69,685	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	765,695	22,262	0	26,348	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	1,017,559	133,718	0	158,257	0	90.00
90.01 WOUND CLINIC	435,782	8,934	0	10,573	0	90.01
91.00 EMERGENCY	1,721,054	121,546	0	143,852	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	1,286,993	0	25,338	0	6,354	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
116.00 HOSPICE	743,494	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	50,270,432	2,017,945	25,338	2,388,268	6,354	118.00
NONREIMBURSABLE COST CENTERS						
192.00 PHYSICIANS' PRIVATE OFFICES	5,459,694	128,471	250,750	152,047	62,877	192.00
192.01 PRIVATE DUTY	1,936	0	0	0	0	192.01
194.00 COMMUNITY RELATIONS	348,573	6,057	0	7,169	0	194.00
194.01 COMMUNITY BENEFITS	582,331	25,674	0	30,385	0	194.01
194.02 OTHER NONREIMBURSABLE COST CENTERS	27,774	0	0	0	0	194.02
194.03 EMS	65,802	0	0	0	0	194.03
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	56,756,542	2,178,147	276,088	2,577,869	69,231	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 151329		Period: From 01/01/2011 To 12/31/2011		Worksheet B Part I Date/Time Prepared: 5/30/2012 3:28 pm	
Cost Center Description	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE		
	4.00	4A	5.00	7.00	7.01		
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	EMPLOYEE BENEFITS	8,557,075					4.00
5.00	ADMINISTRATIVE & GENERAL	1,188,515	8,324,110	8,324,110			5.00
7.00	OPERATION OF PLANT	0	2,162,272	371,632	2,533,904		7.00
7.01	OPERATION OF PLANT -OFFSITE	0	61,129	10,506	0	71,635	7.01
7.02	OPERATION OF PLANT - HOSPITAL & OFFS	185,197	741,626	127,464	0	0	7.02
8.00	LAUNDRY & LINEN SERVICE	25,413	227,786	39,150	47,725	0	8.00
9.00	HOUSEKEEPING	185,573	900,801	154,822	48,479	0	9.00
10.00	DIETARY	55,352	325,115	55,878	31,900	0	10.00
11.00	CAFETERIA	187,147	1,019,789	175,272	107,834	0	11.00
13.00	NURSING ADMINISTRATION	211,981	854,602	146,881	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	574,698	98,774	36,146	0	14.00
15.00	PHARMACY	166,664	1,959,569	336,793	25,621	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	263,686	1,304,692	224,239	55,411	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	654,436	3,129,580	537,884	283,437	0	30.00
31.00	INTENSIVE CARE UNIT	126,799	589,540	101,325	56,617	0	31.00
43.00	NURSERY	143,158	683,283	117,437	17,658	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	398,792	3,173,476	545,428	74,853	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	31,475	268,946	46,224	101,856	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	636,152	6,895,108	1,185,069	500,362	0	54.00
60.00	LABORATORY	375,214	3,246,621	558,000	124,412	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	114,029	560,320	96,303	25,520	0	65.00
66.00	PHYSICAL THERAPY	231,084	1,184,971	203,662	77,842	0	66.00
67.00	OCCUPATIONAL THERAPY	151,729	692,711	119,057	27,379	0	67.00
68.00	SPEECH PATHOLOGY	43,244	191,084	32,842	12,434	0	68.00
69.00	ELECTROCARDIOLOGY	166,864	892,843	153,454	102,308	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	814,305	139,955	38,682	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	268,725	1,578,259	271,257	232,346	0	90.00
90.01	WOUND CLINIC	59,627	514,916	88,499	15,523	0	90.01
91.00	EMERGENCY	494,652	2,481,104	426,430	211,196	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	367,312	1,685,997	289,774	0	6,574	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	169,512	913,006	156,919	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	6,902,332	47,952,259	6,810,930	2,255,541	6,574	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	1,491,055	7,544,894	1,296,727	223,228	65,061	192.00
192.01	PRIVATE DUTY	353	2,289	393	0	0	192.01
194.00	COMMUNITY RELATIONS	35,393	397,192	68,266	10,525	0	194.00
194.01	COMMUNITY BENEFITS	112,944	751,334	129,133	44,610	0	194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS	9,084	36,858	6,335	0	0	194.02
194.03	EMS	5,914	71,716	12,326	0	0	194.03
200.00	Cross Foot Adjustments		0				200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	8,557,075	56,756,542	8,324,110	2,533,904	71,635	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 151329		Period: From 01/01/2011 To 12/31/2011		Worksheet B Part I Date/Time Prepared: 5/30/2012 3:28 pm	
Cost Center Description		OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.02	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
7.01	OPERATION OF PLANT -OFFSITE						7.01
7.02	OPERATION OF PLANT - HOSPITAL & OFFS	869,090					7.02
8.00	LAUNDRY & LINEN SERVICE	11,958	326,619				8.00
9.00	HOUSEKEEPING	12,147	11,729	1,127,978			9.00
10.00	DIETARY	7,993	367		13,020	434,273	10.00
11.00	CAFETERIA	27,019	1,239	44,011	0	1,375,164	11.00
13.00	NURSING ADMINISTRATION	0	0	0	0	36,632	13.00
14.00	CENTRAL SERVICES & SUPPLY	9,057	4,602	14,752	0	0	14.00
15.00	PHARMACY	6,420	0	10,457	0	28,780	15.00
16.00	MEDICAL RECORDS & LIBRARY	13,884	0	22,616	0	71,675	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	71,019	85,587	115,682	406,312	177,688	30.00
31.00	INTENSIVE CARE UNIT	14,186	5,813	23,108	27,961	28,224	31.00
43.00	NURSERY	4,424	12,061	7,207	0	34,134	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	18,755	40,741	30,550	0	91,498	50.00
52.00	DELIVERY ROOM & LABOR ROOM	25,521	1,678	41,571	0	7,506	52.00
54.00	RADIOLOGY-DIAGNOSTIC	125,371	25,754	204,216	0	144,986	54.00
60.00	LABORATORY	31,173	0	50,777	0	106,532	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	6,394	1,484	10,416	0	0	65.00
66.00	PHYSICAL THERAPY	19,504	23,345	31,770	0	0	66.00
67.00	OCCUPATIONAL THERAPY	6,860	0	11,174	0	0	67.00
68.00	SPEECH PATHOLOGY	3,115	0	5,075	0	0	68.00
69.00	ELECTROCARDIOLOGY	25,634	2,336	41,756	0	40,832	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	9,692	11,627	15,788	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	58,217	29,725	94,829	0	66,258	90.00
90.01	WOUND CLINIC	3,890	0	6,336	0	14,743	90.01
91.00	EMERGENCY	52,918	68,531	86,197	0	114,419	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	21,493	0	0	0	80,043	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	0	0	0	0	46,865	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	586,644	326,619	881,308	434,273	1,090,815	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	268,631	0	224,167	0	244,757	192.00
192.01	PRIVATE DUTY	0	0	0	0	125	192.01
194.00	COMMUNITY RELATIONS	2,637	0	4,296	0	9,958	194.00
194.01	COMMUNITY BENEFITS	11,178	0	18,207	0	27,269	194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	EMS	0	0	0	0	2,240	194.03
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)	869,090	326,619	1,127,978	434,273	1,375,164	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151329

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2012 3:28 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
7.01	OPERATION OF PLANT -OFFSITE						7.01
7.02	OPERATION OF PLANT - HOSPITAL & OFFS						7.02
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	1,038,115					13.00
14.00	CENTRAL SERVICES & SUPPLY	0	738,029				14.00
15.00	PHARMACY	0	109,342	2,476,982			15.00
16.00	MEDICAL RECORDS & LIBRARY	0	161	0	1,692,678		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	562,659	5,213	0	1,027,213	6,402,274	30.00
31.00	INTENSIVE CARE UNIT	89,373	1,114	0	0	937,261	31.00
43.00	NURSERY	0	0	0	0	876,204	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	200,519	0	137,349	4,313,169	50.00
52.00	DELIVERY ROOM & LABOR ROOM	23,769	7,834	0	0	524,905	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	242,613	0	292,108	9,615,587	54.00
60.00	LABORATORY	0	89,071	0	0	4,206,586	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	6,994	0	0	707,431	65.00
66.00	PHYSICAL THERAPY	0	1,357	0	0	1,542,451	66.00
67.00	OCCUPATIONAL THERAPY	0	4,792	0	0	861,973	67.00
68.00	SPEECH PATHOLOGY	0	164	0	0	244,714	68.00
69.00	ELECTROCARDIOLOGY	0	1,480	0	19,345	1,279,988	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,030,049	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	2,476,982	0	2,476,982	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	0	12,911	0	141,218	2,485,020	90.00
90.01	WOUND CLINIC	0	23,971	0	0	667,878	90.01
91.00	EMERGENCY	362,314	7,215	0	65,773	3,876,097	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	0	1,793	0	0	2,085,674	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	0	7,626	0	0	1,124,416	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,038,115	724,170	2,476,982	1,683,006	45,258,659	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	0	13,297	0	9,672	9,890,434	192.00
192.01	PRIVATE DUTY	0	0	0	0	2,807	192.01
194.00	COMMUNITY RELATIONS	0	0	0	0	492,874	194.00
194.01	COMMUNITY BENEFITS	0	562	0	0	982,293	194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	43,193	194.02
194.03	EMS	0	0	0	0	86,282	194.03
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,038,115	738,029	2,476,982	1,692,678	56,756,542	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151329

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

Worksheet B
Part I
Date/Time Prepared:
5/30/2012 3:28 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT			1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG			1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP			2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT			2.01
4.00	EMPLOYEE BENEFITS			4.00
5.00	ADMINISTRATIVE & GENERAL			5.00
7.00	OPERATION OF PLANT			7.00
7.01	OPERATION OF PLANT -OFFSITE			7.01
7.02	OPERATION OF PLANT - HOSPITAL & OFFS			7.02
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
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	6,402,274	30.00
31.00	INTENSIVE CARE UNIT	0	937,261	31.00
43.00	NURSERY	0	876,204	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	4,313,169	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	524,905	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	9,615,587	54.00
60.00	LABORATORY	0	4,206,586	60.00
60.01	BLOOD LABORATORY	0	0	60.01
65.00	RESPIRATORY THERAPY	0	707,431	65.00
66.00	PHYSICAL THERAPY	0	1,542,451	66.00
67.00	OCCUPATIONAL THERAPY	0	861,973	67.00
68.00	SPEECH PATHOLOGY	0	244,714	68.00
69.00	ELECTROCARDIOLOGY	0	1,279,988	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	1,030,049	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	2,476,982	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0	2,485,020	90.00
90.01	WOUND CLINIC	0	667,878	90.01
91.00	EMERGENCY	0	3,876,097	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	HOME HEALTH AGENCY	0	2,085,674	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE			113.00
116.00	HOSPICE	0	1,124,416	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	45,258,659	118.00
NONREIMBURSABLE COST CENTERS				
192.00	PHYSICIANS' PRIVATE OFFICES	0	9,890,434	192.00
192.01	PRIVATE DUTY	0	2,807	192.01
194.00	COMMUNITY RELATIONS	0	492,874	194.00
194.01	COMMUNITY BENEFITS	0	982,293	194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS	0	43,193	194.02
194.03	EMS	0	86,282	194.03
200.00	Cross Foot Adjustments	0	0	200.00
201.00	Negative Cost Centers	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	56,756,542	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151329

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

Worksheet B
Part II
Date/Time Prepared:
5/30/2012 3:28 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSIT		
		0	1.00	1.01	2.00		2.01
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00	
1.01	NEW CAP REL COSTS-OFFSITE BLDG					1.01	
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00	
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT					2.01	
4.00	EMPLOYEE BENEFITS	0	22,407	0	26,519	0	4.00
5.00	ADMINISTRATIVE & GENERAL	0	348,810	0	412,819	0	5.00
7.00	OPERATION OF PLANT	0	348,636	0	412,616	0	7.00
7.01	OPERATION OF PLANT -OFFSITE	0	0	0	0	0	7.01
7.02	OPERATION OF PLANT - HOSPITAL & OFFS	0	0	0	0	0	7.02
8.00	LAUNDRY & LINEN SERVICE	0	27,466	0	32,507	0	8.00
9.00	HOUSEKEEPING	0	27,900	0	33,020	0	9.00
10.00	DIETARY	0	18,359	0	21,728	0	10.00
11.00	CAFETERIA	0	62,060	0	73,449	0	11.00
13.00	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	20,802	0	24,620	0	14.00
15.00	PHARMACY	0	14,745	0	17,451	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	31,890	0	37,742	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	163,122	0	193,057	0	30.00
31.00	INTENSIVE CARE UNIT	0	32,584	0	38,563	0	31.00
43.00	NURSERY	0	10,163	0	12,028	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	43,079	0	50,985	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	58,619	0	69,377	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	287,964	0	340,810	0	54.00
60.00	LABORATORY	0	71,601	0	84,740	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	14,687	0	17,383	0	65.00
66.00	PHYSICAL THERAPY	0	44,799	0	53,021	0	66.00
67.00	OCCUPATIONAL THERAPY	0	15,757	0	18,649	0	67.00
68.00	SPEECH PATHOLOGY	0	7,156	0	8,469	0	68.00
69.00	ELECTROCARDIOLOGY	0	58,879	0	69,685	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	22,262	0	26,348	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	0	133,718	0	158,257	0	90.00
90.01	WOUND CLINIC	0	8,934	0	10,573	0	90.01
91.00	EMERGENCY	0	121,546	0	143,852	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	0	0	25,338	0	6,354	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,017,945	25,338	2,388,268	6,354	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	0	128,471	250,750	152,047	62,877	192.00
192.01	PRIVATE DUTY	0	0	0	0	0	192.01
194.00	COMMUNITY RELATIONS	0	6,057	0	7,169	0	194.00
194.01	COMMUNITY BENEFITS	0	25,674	0	30,385	0	194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	EMS	0	0	0	0	0	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	2,178,147	276,088	2,577,869	69,231	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151329		Period: From 01/01/2011 To 12/31/2011		Worksheet B Part II Date/Time Prepared: 5/30/2012 3:28 pm	
Cost Center	Description	Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	
		2A	4.00	5.00	7.00	7.01	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	EMPLOYEE BENEFITS	48,926	48,926				4.00
5.00	ADMINISTRATIVE & GENERAL	761,629	6,796	768,425			5.00
7.00	OPERATION OF PLANT	761,252	0	34,307	795,559		7.00
7.01	OPERATION OF PLANT -OFFSITE	0	0	970	0	970	7.01
7.02	OPERATION OF PLANT - HOSPITAL & OFFS	0	1,059	11,767	0	0	7.02
8.00	LAUNDRY & LINEN SERVICE	59,973	145	3,614	14,984		8.00
9.00	HOUSEKEEPING	60,920	1,061	14,292	15,221	0	9.00
10.00	DIETARY	40,087	317	5,158	10,016	0	10.00
11.00	CAFETERIA	135,509	1,070	16,180	33,856	0	11.00
13.00	NURSING ADMINISTRATION	0	1,212	13,559	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	45,422	0	9,118	11,348	0	14.00
15.00	PHARMACY	32,196	953	31,091	8,044	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	69,632	1,508	20,700	17,397	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	356,179	3,742	49,654	88,990	0	30.00
31.00	INTENSIVE CARE UNIT	71,147	725	9,354	17,776	0	31.00
43.00	NURSERY	22,191	819	10,841	5,544	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	94,064	2,280	50,350	23,501	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	127,996	180	4,267	31,979	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	628,774	3,638	109,398	157,096	0	54.00
60.00	LABORATORY	156,341	2,146	51,511	39,061	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	32,070	652	8,890	8,013	0	65.00
66.00	PHYSICAL THERAPY	97,820	1,321	18,801	24,440	0	66.00
67.00	OCCUPATIONAL THERAPY	34,406	868	10,991	8,596	0	67.00
68.00	SPEECH PATHOLOGY	15,625	247	3,032	3,904	0	68.00
69.00	ELECTROCARDIOLOGY	128,564	954	14,166	32,121	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	48,610	0	12,920	12,145	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	291,975	1,537	25,041	72,949	0	90.00
90.01	WOUND CLINIC	19,507	341	8,170	4,874	0	90.01
91.00	EMERGENCY	265,398	2,828	39,365	66,308	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	31,692	2,100	26,750	0	89	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	0	969	14,486	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	4,437,905	39,468	628,743	708,163	89	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	594,145	8,522	119,700	70,086	881	192.00
192.01	PRIVATE DUTY	0	2	36	0	0	192.01
194.00	COMMUNITY RELATIONS	13,226	202	6,302	3,304	0	194.00
194.01	COMMUNITY BENEFITS	56,059	646	11,921	14,006	0	194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS	0	52	585	0	0	194.02
194.03	EMS	0	34	1,138	0	0	194.03
200.00	Cross Foot Adjustments	0					200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	5,101,335	48,926	768,425	795,559	970	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151329		Period: From 01/01/2011 To 12/31/2011		Worksheet B Part II Date/Time Prepared: 5/30/2012 3:28 pm	
Cost Center Description		OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.02	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
7.01	OPERATION OF PLANT -OFFSITE						7.01
7.02	OPERATION OF PLANT - HOSPITAL & OFFS	12,826					7.02
8.00	LAUNDRY & LINEN SERVICE	176	78,892				8.00
9.00	HOUSEKEEPING	179	2,833	94,506			9.00
10.00	DIETARY	118	89	1,091	56,876		10.00
11.00	CAFETERIA	399	299	3,687	0	191,000	11.00
13.00	NURSING ADMINISTRATION	0	0	0	0	5,088	13.00
14.00	CENTRAL SERVICES & SUPPLY	134	1,112	1,236	0	0	14.00
15.00	PHARMACY	95	0	876	0	3,997	15.00
16.00	MEDICAL RECORDS & LIBRARY	205	0	1,895	0	9,955	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,048	20,673	9,692	53,214	24,680	30.00
31.00	INTENSIVE CARE UNIT	209	1,404	1,936	3,662	3,920	31.00
43.00	NURSERY	65	2,913	604	0	4,741	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	277	9,841	2,560	0	12,708	50.00
52.00	DELIVERY ROOM & LABOR ROOM	377	405	3,483	0	1,043	52.00
54.00	RADIOLOGY-DIAGNOSTIC	1,850	6,221	17,110	0	20,137	54.00
60.00	LABORATORY	460	0	4,254	0	14,796	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	94	358	873	0	0	65.00
66.00	PHYSICAL THERAPY	288	5,639	2,662	0	0	66.00
67.00	OCCUPATIONAL THERAPY	101	0	936	0	0	67.00
68.00	SPEECH PATHOLOGY	46	0	425	0	0	68.00
69.00	ELECTROCARDIOLOGY	378	564	3,498	0	5,671	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	143	2,808	1,323	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	859	7,180	7,945	0	9,203	90.00
90.01	WOUND CLINIC	57	0	531	0	2,048	90.01
91.00	EMERGENCY	781	16,553	7,222	0	15,892	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	317	0	0	0	11,117	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	0	0	0	0	6,509	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	8,656	78,892	73,839	56,876	151,505	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	3,966	0	18,782	0	33,997	192.00
192.01	PRIVATE DUTY	0	0	0	0	17	192.01
194.00	COMMUNITY RELATIONS	39	0	360	0	1,383	194.00
194.01	COMMUNITY BENEFITS	165	0	1,525	0	3,787	194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	EMS	0	0	0	0	311	194.03
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)	12,826	78,892	94,506	56,876	191,000	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151329		Period: From 01/01/2011 To 12/31/2011		Worksheet B Part II Date/Time Prepared: 5/30/2012 3:28 pm	
Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
7.01	OPERATION OF PLANT -OFFSITE						7.01
7.02	OPERATION OF PLANT - HOSPITAL & OFFS						7.02
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	19,859					13.00
14.00	CENTRAL SERVICES & SUPPLY	0	68,370				14.00
15.00	PHARMACY	0	10,129	87,381			15.00
16.00	MEDICAL RECORDS & LIBRARY	0	15	0	121,307		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	10,763	483	0	73,617	692,735	30.00
31.00	INTENSIVE CARE UNIT	1,710	103	0	0	111,946	31.00
43.00	NURSERY	0	0	0	0	47,718	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	18,576	0	9,843	224,000	50.00
52.00	DELIVERY ROOM & LABOR ROOM	455	726	0	0	170,911	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	22,476	0	20,934	987,634	54.00
60.00	LABORATORY	0	8,251	0	0	276,820	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	648	0	0	51,598	65.00
66.00	PHYSICAL THERAPY	0	126	0	0	151,097	66.00
67.00	OCCUPATIONAL THERAPY	0	444	0	0	56,342	67.00
68.00	SPEECH PATHOLOGY	0	15	0	0	23,294	68.00
69.00	ELECTROCARDIOLOGY	0	137	0	1,386	187,439	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	77,949	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	87,381	0	87,381	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	0	1,196	0	10,120	428,005	90.00
90.01	WOUND CLINIC	0	2,221	0	0	37,749	90.01
91.00	EMERGENCY	6,931	668	0	4,714	426,660	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	0	166	0	0	72,231	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	0	706	0	0	22,670	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	19,859	67,086	87,381	120,614	4,134,179	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	0	1,232	0	693	852,004	192.00
192.01	PRIVATE DUTY	0	0	0	0	55	192.01
194.00	COMMUNITY RELATIONS	0	0	0	0	24,816	194.00
194.01	COMMUNITY BENEFITS	0	52	0	0	88,161	194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	637	194.02
194.03	EMS	0	0	0	0	1,483	194.03
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	19,859	68,370	87,381	121,307	5,101,335	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151329	Period: From 01/01/2011 To 12/31/2011	Worksheet B Part II Date/Time Prepared: 5/30/2012 3:28 pm
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Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	25.00	26.00	
GENERAL SERVICE COST CENTERS			
1.00 NEW CAP REL COSTS-BLDG & FIXT			1.00
1.01 NEW CAP REL COSTS-OFFSITE BLDG			1.01
2.00 NEW CAP REL COSTS-MVBLE EQUIP			2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT			2.01
4.00 EMPLOYEE BENEFITS			4.00
5.00 ADMINISTRATIVE & GENERAL			5.00
7.00 OPERATION OF PLANT			7.00
7.01 OPERATION OF PLANT -OFFSITE			7.01
7.02 OPERATION OF PLANT - HOSPITAL & OFFS			7.02
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
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS	0	692,735	30.00
31.00 INTENSIVE CARE UNIT	0	111,946	31.00
43.00 NURSERY	0	47,718	43.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	0	224,000	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	170,911	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	987,634	54.00
60.00 LABORATORY	0	276,820	60.00
60.01 BLOOD LABORATORY	0	0	60.01
65.00 RESPIRATORY THERAPY	0	51,598	65.00
66.00 PHYSICAL THERAPY	0	151,097	66.00
67.00 OCCUPATIONAL THERAPY	0	56,342	67.00
68.00 SPEECH PATHOLOGY	0	23,294	68.00
69.00 ELECTROCARDIOLOGY	0	187,439	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	77,949	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	87,381	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00 CLINIC	0	428,005	90.00
90.01 WOUND CLINIC	0	37,749	90.01
91.00 EMERGENCY	0	426,660	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS			
101.00 HOME HEALTH AGENCY	0	72,231	101.00
SPECIAL PURPOSE COST CENTERS			
113.00 INTEREST EXPENSE			113.00
116.00 HOSPICE	0	22,670	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	4,134,179	118.00
NONREIMBURSABLE COST CENTERS			
192.00 PHYSICIANS' PRIVATE OFFICES	0	852,004	192.00
192.01 PRIVATE DUTY	0	55	192.01
194.00 COMMUNITY RELATIONS	0	24,816	194.00
194.01 COMMUNITY BENEFITS	0	88,161	194.01
194.02 OTHER NONREIMBURSABLE COST CENTERS	0	637	194.02
194.03 EMS	0	1,483	194.03
200.00 Cross Foot Adjustments	0	0	200.00
201.00 Negative Cost Centers	0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	5,101,335	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151329

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

Worksheet B-1
Date/Time Prepared:
5/30/2012 3:28 pm

Cost Center Description	CAPITAL RELATED COSTS				EMPLOYEE BENEFITS (GROSS SALARIES)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSITE (SQUARE FEET)		
	1.00	1.01	2.00	2.01		
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	150,674				1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	37,210			1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP			150,674		2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSITE			0	37,210	2.01
4.00	EMPLOYEE BENEFITS	1,550	0	1,550	0	4.00
5.00	ADMINISTRATIVE & GENERAL	24,129	0	24,129	0	5.00
7.00	OPERATION OF PLANT	24,117	0	24,117	0	7.00
7.01	OPERATION OF PLANT -OFFSITE	0	0	0	0	7.01
7.02	OPERATION OF PLANT - HOSPITAL & OFFS	0	0	0	0	7.02
8.00	LAUNDRY & LINEN SERVICE	1,900	0	1,900	0	8.00
9.00	HOUSEKEEPING	1,930	0	1,930	0	9.00
10.00	DIETARY	1,270	0	1,270	0	10.00
11.00	CAFETERIA	4,293	0	4,293	0	11.00
13.00	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	1,439	0	1,439	0	14.00
15.00	PHARMACY	1,020	0	1,020	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	2,206	0	2,206	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	11,284	0	11,284	0	30.00
31.00	INTENSIVE CARE UNIT	2,254	0	2,254	0	31.00
43.00	NURSERY	703	0	703	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	2,980	0	2,980	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	4,055	0	4,055	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC	19,920	0	19,920	0	54.00
60.00	LABORATORY	4,953	0	4,953	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	1,016	0	1,016	0	65.00
66.00	PHYSICAL THERAPY	3,099	0	3,099	0	66.00
67.00	OCCUPATIONAL THERAPY	1,090	0	1,090	0	67.00
68.00	SPEECH PATHOLOGY	495	0	495	0	68.00
69.00	ELECTROCARDIOLOGY	4,073	0	4,073	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	1,540	0	1,540	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	9,250	0	9,250	0	90.00
90.01	WOUND CLINIC	618	0	618	0	90.01
91.00	EMERGENCY	8,408	0	8,408	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	3,415	0	3,415	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
116.00	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	139,592	3,415	139,592	3,415	118.00
NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	8,887	33,795	8,887	33,795	192.00
192.01	PRIVATE DUTY	0	0	0	0	192.01
194.00	COMMUNITY RELATIONS	419	0	419	0	194.00
194.01	COMMUNITY BENEFITS	1,776	0	1,776	0	194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.02
194.03	EMS	0	0	0	0	194.03
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,178,147	276,088	2,577,869	69,231	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	14.456024	7.419726	17.108917	1.860548	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)					204.00
205.00	Unit cost multiplier (Wkst. B, Part II)					205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151329

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

Worksheet B-1
Date/Time Prepared:
5/30/2012 3:28 pm

Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT -OFFSITE (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL & OFFS (SQUARE FEET)	
	5A	5.00	7.00	7.01	7.02	
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG					1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT					2.01
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL	-8,324,110	48,432,432			5.00
7.00	OPERATION OF PLANT	0	2,162,272	100,878		7.00
7.01	OPERATION OF PLANT -OFFSITE	0	61,129	0	37,210	7.01
7.02	OPERATION OF PLANT - HOSPITAL & OFFS	0	741,626	0	0	138,088
8.00	LAUNDRY & LINEN SERVICE	0	227,786	1,900	0	1,900
9.00	HOUSEKEEPING	0	900,801	1,930	0	1,930
10.00	DIETARY	0	325,115	1,270	0	1,270
11.00	CAFETERIA	0	1,019,789	4,293	0	4,293
13.00	NURSING ADMINISTRATION	0	854,602	0	0	0
14.00	CENTRAL SERVICES & SUPPLY	0	574,698	1,439	0	1,439
15.00	PHARMACY	0	1,959,569	1,020	0	1,020
16.00	MEDICAL RECORDS & LIBRARY	0	1,304,692	2,206	0	2,206
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	3,129,580	11,284	0	11,284
31.00	INTENSIVE CARE UNIT	0	589,540	2,254	0	2,254
43.00	NURSERY	0	683,283	703	0	703
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	3,173,476	2,980	0	2,980
52.00	DELIVERY ROOM & LABOR ROOM	0	268,946	4,055	0	4,055
54.00	RADIOLOGY-DIAGNOSTIC	0	6,895,108	19,920	0	19,920
60.00	LABORATORY	0	3,246,621	4,953	0	4,953
60.01	BLOOD LABORATORY	0	0	0	0	0
65.00	RESPIRATORY THERAPY	0	560,320	1,016	0	1,016
66.00	PHYSICAL THERAPY	0	1,184,971	3,099	0	3,099
67.00	OCCUPATIONAL THERAPY	0	692,711	1,090	0	1,090
68.00	SPEECH PATHOLOGY	0	191,084	495	0	495
69.00	ELECTROCARDIOLOGY	0	892,843	4,073	0	4,073
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	IMPL. DEV. CHARGED TO PATIENT	0	814,305	1,540	0	1,540
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	1,578,259	9,250	0	9,250
90.01	WOUND CLINIC	0	514,916	618	0	618
91.00	EMERGENCY	0	2,481,104	8,408	0	8,408
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	1,685,997	0	3,415	3,415
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					
116.00	HOSPICE	0	913,006	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	-8,324,110	39,628,149	89,796	3,415	93,211
NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	0	7,544,894	8,887	33,795	42,682
192.01	PRIVATE DUTY	0	2,289	0	0	0
194.00	COMMUNITY RELATIONS	0	397,192	419	0	419
194.01	COMMUNITY BENEFITS	0	751,334	1,776	0	1,776
194.02	OTHER NONREIMBURSABLE COST CENTERS	0	36,858	0	0	0
194.03	EMS	0	71,716	0	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)		8,324,110	2,533,904	71,635	869,090
203.00	Unit cost multiplier (Wkst. B, Part I)		0.171871	25.118500	1.925155	6.293740
204.00	Cost to be allocated (per Wkst. B, Part II)		768,425	795,559	970	12,826
205.00	Unit cost multiplier (Wkst. B, Part II)		0.015866	7.886348	0.026068	0.092883

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151329

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

Worksheet B-1

Date/Time Prepared:
5/30/2012 3:28 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
7.01	OPERATION OF PLANT -OFFSITE						7.01
7.02	OPERATION OF PLANT - HOSPITAL & OFFS						7.02
8.00	LAUNDRY & LINEN SERVICE	393,626					8.00
9.00	HOUSEKEEPING	14,135	110,027				9.00
10.00	DIETARY	442	1,270	18,203			10.00
11.00	CAFETERIA	1,493	4,293	0	591,739		11.00
13.00	NURSING ADMINISTRATION	0	0	0	15,763	141,070	13.00
14.00	CENTRAL SERVICES & SUPPLY	5,546	1,439	0	0	0	14.00
15.00	PHARMACY	0	1,020	0	12,384	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	2,206	0	30,842	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	103,150	11,284	17,031	76,460	76,460	30.00
31.00	INTENSIVE CARE UNIT	7,005	2,254	1,172	12,145	12,145	31.00
43.00	NURSERY	14,535	703	0	14,688	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	49,099	2,980	0	39,372	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM	2,022	4,055	0	3,230	3,230	52.00
54.00	RADIOLOGY-DIAGNOSTIC	31,037	19,920	0	62,388	0	54.00
60.00	LABORATORY	0	4,953	0	45,841	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	1,788	1,016	0	0	0	65.00
66.00	PHYSICAL THERAPY	28,134	3,099	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	1,090	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	495	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	2,815	4,073	0	17,570	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	14,012	1,540	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	35,823	9,250	0	28,511	0	90.00
90.01	WOUND CLINIC	0	618	0	6,344	0	90.01
91.00	EMERGENCY	82,590	8,408	0	49,235	49,235	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	0	0	0	34,443	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
116.00	HOSPICE	0	0	0	20,166	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	393,626	85,966	18,203	469,382	141,070	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	0	21,866	0	105,320	0	192.00
192.01	PRIVATE DUTY	0	0	0	54	0	192.01
194.00	COMMUNITY RELATIONS	0	419	0	4,285	0	194.00
194.01	COMMUNITY BENEFITS	0	1,776	0	11,734	0	194.01
194.02	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	EMS	0	0	0	964	0	194.03
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)	326,619	1,127,978	434,273	1,375,164	1,038,115	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.829770	10.251829	23.857221	2.323937	7.358864	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	78,892	94,506	56,876	191,000	19,859	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.200424	0.858935	3.124540	0.322777	0.140774	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151329

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

Worksheet B-1
Date/Time Prepared:
5/30/2012 3:28 pm

Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (100% PHARMACY)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS				
1.00 NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01 NEW CAP REL COSTS-OFFSITE BLDG				1.01
2.00 NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01 NEW CAP REL COSTS-MVBLE EQUIP OFFSIT				2.01
4.00 EMPLOYEE BENEFITS				4.00
5.00 ADMINISTRATIVE & GENERAL				5.00
7.00 OPERATION OF PLANT				7.00
7.01 OPERATION OF PLANT -OFFSITE				7.01
7.02 OPERATION OF PLANT - HOSPITAL & OFFS				7.02
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	7,798,428			14.00
15.00 PHARMACY	1,155,366	100		15.00
16.00 MEDICAL RECORDS & LIBRARY	1,698	0	875	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS	55,086	0	531	30.00
31.00 INTENSIVE CARE UNIT	11,776	0	0	31.00
43.00 NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	2,118,802	0	71	50.00
52.00 DELIVERY ROOM & LABOR ROOM	82,781	0	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	2,563,565	0	151	54.00
60.00 LABORATORY	941,174	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
65.00 RESPIRATORY THERAPY	73,904	0	0	65.00
66.00 PHYSICAL THERAPY	14,340	0	0	66.00
67.00 OCCUPATIONAL THERAPY	50,635	0	0	67.00
68.00 SPEECH PATHOLOGY	1,737	0	0	68.00
69.00 ELECTROCARDIOLOGY	15,640	0	10	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	100	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 CLINIC	136,421	0	73	90.00
90.01 WOUND CLINIC	253,293	0	0	90.01
91.00 EMERGENCY	76,241	0	34	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS				
101.00 HOME HEALTH AGENCY	18,949	0	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00 INTEREST EXPENSE				113.00
116.00 HOSPICE	80,577	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	7,651,985	100	870	118.00
NONREIMBURSABLE COST CENTERS				
192.00 PHYSICIANS' PRIVATE OFFICES	140,506	0	5	192.00
192.01 PRIVATE DUTY	0	0	0	192.01
194.00 COMMUNITY RELATIONS	2	0	0	194.00
194.01 COMMUNITY BENEFITS	5,935	0	0	194.01
194.02 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.02
194.03 EMS	0	0	0	194.03
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)	738,029	2,476,982	1,692,678	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.094638	24,769.820000	1,934.489143	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	68,370	87,381	121,307	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.008767	873.810000	138.636571	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151329	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/30/2012 3:28 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		6,402,274	0	0	30.00
31.00	INTENSIVE CARE UNIT		937,261	0	0	31.00
43.00	NURSERY		876,204	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM		4,313,169	0	0	50.00
52.00	DELIVERY ROOM & LABOR ROOM		524,905	0	0	52.00
54.00	RADIOLOGY-DIAGNOSTIC		9,615,587	0	0	54.00
60.00	LABORATORY		4,206,586	0	0	60.00
60.01	BLOOD LABORATORY		0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	707,431	0	0	65.00
66.00	PHYSICAL THERAPY	0	1,542,451	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	861,973	0	0	67.00
68.00	SPEECH PATHOLOGY	0	244,714	0	0	68.00
69.00	ELECTROCARDIOLOGY		1,279,988	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT		1,030,049	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS		2,476,982	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC		2,485,020	0	0	90.00
90.01	WOUND CLINIC		667,878	0	0	90.01
91.00	EMERGENCY		3,876,097	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		873,467	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY		2,085,674		0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
116.00	HOSPICE		1,124,416		0	116.00
200.00	Subtotal (see instructions)	0	46,132,126	0	0	200.00
201.00	Less Observation Beds		873,467		0	201.00
202.00	Total (see instructions)	0	45,258,659	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 151329	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/30/2012 3:28 pm
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Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	6,076,737		6,076,737			30.00
31.00 INTENSIVE CARE UNIT	914,536		914,536			31.00
43.00 NURSERY	1,511,392		1,511,392			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	2,916,968	11,651,374	14,568,342	0.296065	0.000000	50.00
52.00 DELIVERY ROOM & LABOR ROOM	700,105	76,954	777,059	0.675502	0.000000	52.00
54.00 RADIOLOGY-DIAGNOSTIC	1,295,655	34,308,360	35,604,015	0.270070	0.000000	54.00
60.00 LABORATORY	2,362,705	14,418,009	16,780,714	0.250680	0.000000	60.00
60.01 BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00 RESPIRATORY THERAPY	1,758,632	444,385	2,203,017	0.321119	0.000000	65.00
66.00 PHYSICAL THERAPY	198,684	2,190,444	2,389,128	0.645613	0.000000	66.00
67.00 OCCUPATIONAL THERAPY	87,372	1,057,017	1,144,389	0.753217	0.000000	67.00
68.00 SPEECH PATHOLOGY	62,274	119,507	181,781	1.346202	0.000000	68.00
69.00 ELECTROCARDIOLOGY	464,796	2,724,909	3,189,705	0.401287	0.000000	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	886,669	651,298	1,537,967	0.669747	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	3,224,315	4,089,299	7,313,614	0.338681	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	183,009	4,033,119	4,216,128	0.589408	0.000000	90.00
90.01 WOUND CLINIC	2,863	1,220,572	1,223,435	0.545904	0.000000	90.01
91.00 EMERGENCY	301,289	5,616,208	5,917,497	0.655023	0.000000	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	29,456	1,355,540	1,384,996	0.630664	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
116.00 HOSPICE	0	0	0			116.00
200.00 Subtotal (see instructions)	22,977,457	83,956,995	106,934,452			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	22,977,457	83,956,995	106,934,452			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151329	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/30/2012 3:28 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
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
60.00	LABORATORY	0.000000		60.00
60.01	BLOOD LABORATORY	0.000000		60.01
65.00	RESPIRATORY THERAPY	0.000000		65.00
66.00	PHYSICAL THERAPY	0.000000		66.00
67.00	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	SPEECH PATHOLOGY	0.000000		68.00
69.00	ELECTROCARDIOLOGY	0.000000		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0.000000		90.00
90.01	WOUND CLINIC	0.000000		90.01
91.00	EMERGENCY	0.000000		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE			113.00
116.00	HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151329

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

Worksheet C
Part I
Date/Time Prepared:
5/30/2012 3:28 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	6,402,274		6,402,274	0	0 30.00
31.00	INTENSIVE CARE UNIT	937,261		937,261	0	0 31.00
43.00	NURSERY	876,204		876,204	0	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	4,313,169		4,313,169	0	0 50.00
52.00	DELIVERY ROOM & LABOR ROOM	524,905		524,905	0	0 52.00
54.00	RADIOLOGY-DIAGNOSTIC	9,615,587		9,615,587	0	0 54.00
60.00	LABORATORY	4,206,586		4,206,586	0	0 60.00
60.01	BLOOD LABORATORY	0		0	0	0 60.01
65.00	RESPIRATORY THERAPY	707,431	0	707,431	0	0 65.00
66.00	PHYSICAL THERAPY	1,542,451	0	1,542,451	0	0 66.00
67.00	OCCUPATIONAL THERAPY	861,973	0	861,973	0	0 67.00
68.00	SPEECH PATHOLOGY	244,714	0	244,714	0	0 68.00
69.00	ELECTROCARDIOLOGY	1,279,988		1,279,988	0	0 69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0 71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	1,030,049		1,030,049	0	0 72.00
73.00	DRUGS CHARGED TO PATIENTS	2,476,982		2,476,982	0	0 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	2,485,020		2,485,020	0	0 90.00
90.01	WOUND CLINIC	667,878		667,878	0	0 90.01
91.00	EMERGENCY	3,876,097		3,876,097	0	0 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	873,467		873,467	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	2,085,674		2,085,674		0 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
116.00	HOSPICE	1,124,416		1,124,416		0 116.00
200.00	Subtotal (see instructions)	46,132,126	0	46,132,126	0	0 200.00
201.00	Less Observation Beds	873,467		873,467		0 201.00
202.00	Total (see instructions)	45,258,659	0	45,258,659	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 151329	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/30/2012 3:28 pm
	Title XIX	Hospital	Cost

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	6,076,737		6,076,737			30.00
31.00 INTENSIVE CARE UNIT	914,536		914,536			31.00
43.00 NURSERY	1,511,392		1,511,392			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	2,916,968	11,651,374	14,568,342	0.296065	0.000000	50.00
52.00 DELIVERY ROOM & LABOR ROOM	700,105	76,954	777,059	0.675502	0.000000	52.00
54.00 RADIOLOGY-DIAGNOSTIC	1,295,655	34,308,360	35,604,015	0.270070	0.000000	54.00
60.00 LABORATORY	2,362,705	14,418,009	16,780,714	0.250680	0.000000	60.00
60.01 BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00 RESPIRATORY THERAPY	1,758,632	444,385	2,203,017	0.321119	0.000000	65.00
66.00 PHYSICAL THERAPY	198,684	2,190,444	2,389,128	0.645613	0.000000	66.00
67.00 OCCUPATIONAL THERAPY	87,372	1,057,017	1,144,389	0.753217	0.000000	67.00
68.00 SPEECH PATHOLOGY	62,274	119,507	181,781	1.346202	0.000000	68.00
69.00 ELECTROCARDIOLOGY	464,796	2,724,909	3,189,705	0.401287	0.000000	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	886,669	651,298	1,537,967	0.669747	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	3,224,315	4,089,299	7,313,614	0.338681	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	183,009	4,033,119	4,216,128	0.589408	0.000000	90.00
90.01 WOUND CLINIC	2,863	1,220,572	1,223,435	0.545904	0.000000	90.01
91.00 EMERGENCY	301,289	5,616,208	5,917,497	0.655023	0.000000	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	29,456	1,355,540	1,384,996	0.630664	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
116.00 HOSPICE	0	0	0			116.00
200.00 Subtotal (see instructions)	22,977,457	83,956,995	106,934,452			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	22,977,457	83,956,995	106,934,452			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151329	Period: From 01/01/2011 To 12/31/2011	Worksheet C Part I Date/Time Prepared: 5/30/2012 3:28 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
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
60.00 LABORATORY	0.000000		60.00
60.01 BLOOD LABORATORY	0.000000		60.01
65.00 RESPIRATORY THERAPY	0.000000		65.00
66.00 PHYSICAL THERAPY	0.000000		66.00
67.00 OCCUPATIONAL THERAPY	0.000000		67.00
68.00 SPEECH PATHOLOGY	0.000000		68.00
69.00 ELECTROCARDIOLOGY	0.000000		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS			
90.00 CLINIC	0.000000		90.00
90.01 WOUND CLINIC	0.000000		90.01
91.00 EMERGENCY	0.000000		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS			
101.00 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS			
113.00 INTEREST EXPENSE			113.00
116.00 HOSPICE			116.00
200.00 Subtotal (see instructions)			200.00
201.00 Less Observation Beds			201.00
202.00 Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151329		Period: From 01/01/2011 To 12/31/2011		Worksheet D Part II Date/Time Prepared: 5/30/2012 3:28 pm	
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	224,000	14,568,342	0.015376	949,570	14,601	50.00
52.00	DELIVERY ROOM & LABOR ROOM	170,911	777,059	0.219946	4,314	949	52.00
54.00	RADIOLOGY-DIAGNOSTIC	987,634	35,604,015	0.027739	698,355	19,372	54.00
60.00	LABORATORY	276,820	16,780,714	0.016496	1,275,134	21,035	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	51,598	2,203,017	0.023422	1,103,915	25,856	65.00
66.00	PHYSICAL THERAPY	151,097	2,389,128	0.063244	128,107	8,102	66.00
67.00	OCCUPATIONAL THERAPY	56,342	1,144,389	0.049233	57,771	2,844	67.00
68.00	SPEECH PATHOLOGY	23,294	181,781	0.128143	54,208	6,946	68.00
69.00	ELECTROCARDIOLOGY	187,439	3,189,705	0.058764	301,000	17,688	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	77,949	1,537,967	0.050683	537,933	27,264	72.00
73.00	DRUGS CHARGED TO PATIENTS	87,381	7,313,614	0.011948	1,797,617	21,478	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	428,005	4,216,128	0.101516	120,864	12,270	90.00
90.01	WOUND CLINIC	37,749	1,223,435	0.030855	1,915	59	90.01
91.00	EMERGENCY	426,660	5,917,497	0.072101	17,033	1,228	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,384,996	0.000000	0	0	92.00
200.00	Total (Lines 50-199)	3,186,879	98,431,787		7,047,736	179,692	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151329

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

Worksheet D
Part IV
Date/Time Prepared:
5/30/2012 3:28 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)	
		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
60.00	LABORATORY	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO 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							
90.00	CLINIC	0	0	0	0	0	90.00
90.01	WOUND CLINIC	0	0	0	0	0	90.01
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151329

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

Worksheet D
Part IV
Date/Time Prepared:
5/30/2012 3:28 pm

Cost Center Description		Title XVIII			Hospital		
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	14,568,342	0.000000	0.000000	949,570	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0	777,059	0.000000	0.000000	4,314	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0	35,604,015	0.000000	0.000000	698,355	54.00
60.00	LABORATORY	0	16,780,714	0.000000	0.000000	1,275,134	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	RESPIRATORY THERAPY	0	2,203,017	0.000000	0.000000	1,103,915	65.00
66.00	PHYSICAL THERAPY	0	2,389,128	0.000000	0.000000	128,107	66.00
67.00	OCCUPATIONAL THERAPY	0	1,144,389	0.000000	0.000000	57,771	67.00
68.00	SPEECH PATHOLOGY	0	181,781	0.000000	0.000000	54,208	68.00
69.00	ELECTROCARDIOLOGY	0	3,189,705	0.000000	0.000000	301,000	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	1,537,967	0.000000	0.000000	537,933	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	7,313,614	0.000000	0.000000	1,797,617	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	0	4,216,128	0.000000	0.000000	120,864	90.00
90.01	WOUND CLINIC	0	1,223,435	0.000000	0.000000	1,915	90.01
91.00	EMERGENCY	0	5,917,497	0.000000	0.000000	17,033	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,384,996	0.000000	0.000000	0	92.00
200.00	Total (Lines 50-199)	0	98,431,787			7,047,736	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151329

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

Worksheet D
Part IV
Date/Time Prepared:
5/30/2012 3:28 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	Cost
		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
60.00	LABORATORY	0	0	0		60.00
60.01	BLOOD LABORATORY	0	0	0		60.01
65.00	RESPIRATORY THERAPY	0	0	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	SPEECH PATHOLOGY	0	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0		90.00
90.01	WOUND CLINIC	0	0	0		90.01
91.00	EMERGENCY	0	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Total (Lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151329	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/30/2012 3:28 pm
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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	
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.296065	0	2,399,473	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0.675502	0	1,722	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0.270070	0	13,946,665	9,127	54.00
60.00 LABORATORY	0.250680	0	3,061,558	0	60.00
60.01 BLOOD LABORATORY	0.000000	0	0	0	60.01
65.00 RESPIRATORY THERAPY	0.321119	0	186,221	0	65.00
66.00 PHYSICAL THERAPY	0.645613	0	561,671	0	66.00
67.00 OCCUPATIONAL THERAPY	0.753217	0	233,101	0	67.00
68.00 SPEECH PATHOLOGY	1.346202	0	37,022	0	68.00
69.00 ELECTROCARDIOLOGY	0.401287	0	1,085,853	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.669747	0	228,797	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.338681	0	1,230,491	738	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	0.589408	0	1,218,479	2,004	90.00
90.01 WOUND CLINIC	0.545904	0	468,490	343	90.01
91.00 EMERGENCY	0.655023	0	1,667,238	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.630664	0	592,466	0	92.00
200.00 Subtotal (see instructions)		0	26,919,247	12,212	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	26,919,247	12,212	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151329	Period: From 01/01/2011 To 12/31/2011	Worksheet D Part V Date/Time Prepared: 5/30/2012 3:28 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	710,400	0	50.00
52.00 DELIVERY ROOM & LABOR ROOM	0	1,163	0	52.00
54.00 RADIOLOGY-DIAGNOSTIC	0	3,766,576	2,465	54.00
60.00 LABORATORY	0	767,471	0	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
65.00 RESPIRATORY THERAPY	0	59,799	0	65.00
66.00 PHYSICAL THERAPY	0	362,622	0	66.00
67.00 OCCUPATIONAL THERAPY	0	175,576	0	67.00
68.00 SPEECH PATHOLOGY	0	49,839	0	68.00
69.00 ELECTROCARDIOLOGY	0	435,739	0	69.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	153,236	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	416,744	250	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 CLINIC	0	718,181	1,181	90.00
90.01 WOUND CLINIC	0	255,751	187	90.01
91.00 EMERGENCY	0	1,092,079	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	373,647	0	92.00
200.00 Subtotal (see instructions)	0	9,338,823	4,083	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	9,338,823	4,083	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151329	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/30/2012 3:28 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)		5,380	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,380	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,380	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,250	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			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)		6,402,274	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,402,274	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		9,246,596	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		9,246,596	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.692393	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,718.70	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,402,274	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,190.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,677,523	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,677,523	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151329	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/30/2012 3:28 pm		
Cost Center Description			Title XVIII		Hospital Cost		
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	937,261	469	1,998.42	264	527,583	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)					2,519,314	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,724,420	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)					734	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,190.01	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					873,467	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151329		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 5/30/2012 3:28 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: 151329	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/30/2012 3:28 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)		5,380	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,380	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,380	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		191	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)		769	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)		6,402,274	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,402,274	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		9,246,596	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		9,246,596	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.692393	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,718.70	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,402,274	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,190.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		227,292	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)		227,292	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151329	Period: From 01/01/2011 To 12/31/2011	Worksheet D-1 Date/Time Prepared: 5/30/2012 3:28 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)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	876,204	769	1,139.41	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	937,261	469	1,998.42	15	29,976	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)					154,313	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					411,581	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)					734	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,190.01	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					873,467	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151329		Period: From 01/01/2011 To 12/31/2011		Worksheet D-1 Date/Time Prepared: 5/30/2012 3:28 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: 151329	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/30/2012 3:28 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		2,968,441		30.00
31.00	INTENSIVE CARE UNIT		541,822		31.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.296065	949,570	281,134	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.675502	4,314	2,914	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.270070	698,355	188,605	54.00
60.00	LABORATORY	0.250680	1,275,134	319,651	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0.321119	1,103,915	354,488	65.00
66.00	PHYSICAL THERAPY	0.645613	128,107	82,708	66.00
67.00	OCCUPATIONAL THERAPY	0.753217	57,771	43,514	67.00
68.00	SPEECH PATHOLOGY	1.346202	54,208	72,975	68.00
69.00	ELECTROCARDIOLOGY	0.401287	301,000	120,787	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.669747	537,933	360,279	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.338681	1,797,617	608,819	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0.589408	120,864	71,238	90.00
90.01	WOUND CLINIC	0.545904	1,915	1,045	90.01
91.00	EMERGENCY	0.655023	17,033	11,157	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.630664	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		7,047,736	2,519,314	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)		7,047,736		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151329	Period: From 01/01/2011 To 12/31/2011	Worksheet D-3 Date/Time Prepared: 5/30/2012 3:28 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		349,279		30.00
31.00	INTENSIVE CARE UNIT		53,714		31.00
43.00	NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.296065	36,434	10,787	50.00
52.00	DELIVERY ROOM & LABOR ROOM	0.675502	32,914	22,233	52.00
54.00	RADIOLOGY-DIAGNOSTIC	0.270070	41,093	11,098	54.00
60.00	LABORATORY	0.250680	102,340	25,655	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
65.00	RESPIRATORY THERAPY	0.321119	44,904	14,420	65.00
66.00	PHYSICAL THERAPY	0.645613	2,240	1,446	66.00
67.00	OCCUPATIONAL THERAPY	0.753217	1,536	1,157	67.00
68.00	SPEECH PATHOLOGY	1.346202	8,066	10,858	68.00
69.00	ELECTROCARDIOLOGY	0.401287	10,901	4,374	69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.669747	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.338681	112,388	38,064	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0.589408	2,118	1,248	90.00
90.01	WOUND CLINIC	0.545904	0	0	90.01
91.00	EMERGENCY	0.655023	19,806	12,973	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.630664	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		414,740	154,313	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)		414,740		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151329	Period: From 01/01/2011 To 12/31/2011	Worksheet E Part B Date/Time Prepared: 5/30/2012 3:28 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			9,342,906 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)			9,342,906 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)			9,436,335 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)			103,746 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			4,732,458 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)			4,600,131 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)			4,600,131 30.00
31.00	Primary payer payments			1,943 31.00
32.00	Subtotal (line 30 minus line 31)			4,598,188 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)			713,489 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			713,489 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			655,460 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			5,311,677 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)			5,311,677 40.00
41.00	Interim payments			5,558,683 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)			-247,006 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: 151329

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

Worksheet E-1
Part I
Date/Time Prepared:
5/30/2012 3:28 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		4,661,723		5,114,936	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	12/12/2011	452,801	09/20/2011	469,659	3.01	
3.02			73,108		508,304	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	09/20/2011	506,654	12/12/2011	534,216	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)		19,255		443,747	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)		4,680,978		5,558,683	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		573,250		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		247,006	6.02	
7.00	Total Medicare program liability (see instructions)		5,254,228		5,311,677	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151329	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part V Date/Time Prepared: 5/30/2012 3:28 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			5,724,420 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)			5,724,420 4.00
5.00	Primary payer payments			2,027 5.00
6.00	Total cost (line 4 less line 5) . For CAH (see instructions)			5,779,637 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)			5,779,637 19.00
20.00	Deductibles (exclude professional component)			605,472 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			5,174,165 22.00
23.00	Coinsurance			14,150 23.00
24.00	Subtotal (line 22 minus line 23)			5,160,015 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			94,213 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			94,213 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			81,107 27.00
28.00	Subtotal (sum of lines 24 and 25 or 26)			5,254,228 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)			5,254,228 30.00
31.00	Interim payments			4,680,978 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)			573,250 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: 151329	Period: From 01/01/2011 To 12/31/2011	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2012 3:28 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		411,581	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)		411,581	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)		411,581	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		402,992	8.00
9.00	Ancillary service charges		414,740	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)		817,732	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)		817,732	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		406,151	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)		411,581	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.		411,581	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)		411,581	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)		411,581	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		411,581	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)		411,581	40.00
41.00	Interim payments		228,716	41.00
42.00	Balance due provider/program (line 40 minus 41)		182,865	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: 151329

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

Worksheet G

Date/Time Prepared:
5/30/2012 3:28 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	7,250,911	0	0	0	1.00
2.00	Temporary investments	19,688	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	11,639,301	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,552,348	0	0	0	6.00
7.00	Inventory	2,964,851	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,147,585	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)	18,469,988	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,371,158	0	0	0	12.00
13.00	Land improvements	372,269	0	0	0	13.00
14.00	Accumulated depreciation	-363,183	0	0	0	14.00
15.00	Buildings	65,775,364	0	0	0	15.00
16.00	Accumulated depreciation	-26,911,076	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	6,337,858	0	0	0	19.00
20.00	Accumulated depreciation	-5,203,818	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	31,462,822	0	0	0	23.00
24.00	Accumulated depreciation	-22,511,112	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)	51,330,282	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	41,655,857	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	433,737	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	42,089,594	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	111,889,864	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,596,127	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,620,574	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,147,585	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	1,384,170	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,748,456	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	32,634,488	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,364,601	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	35,999,089	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	44,747,545	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	67,142,319				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)	67,142,319	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	111,889,864	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151329

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

Worksheet G-1

Date/Time Prepared:
5/30/2012 3:28 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		63,813,686	
2.00	Net income (loss) (From Wkst. G-3, line 29)		5,516,057			2.00
3.00	Total (sum of line 1 and line 2)		69,329,743		0	3.00
4.00	CONTRIBUTIONS	120,873		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)		120,873		0	10.00
11.00	Subtotal (line 3 plus line 10)		69,450,616		0	11.00
12.00	UNREALIZED LOSS ON INVESTMENTS	2,308,297		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		2,308,297		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		67,142,319		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151329

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

Worksheet G-1

Date/Time Prepared:
5/30/2012 3:28 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: 151329

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

Worksheet G-2 Parts

Date/Time Prepared:
5/30/2012 3:28 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	7,588,128		7,588,128	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	7,588,128		7,588,128	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	914,536		914,536	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)	914,536		914,536	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,502,664		8,502,664	17.00
18.00	Ancillary services	14,288,921	78,710,332	92,999,253	18.00
19.00	Outpatient services	185,872	5,253,691	5,439,563	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,539,285	1,539,285	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	1,970,373	1,970,373	26.00
27.00	PROFESSIONAL FEES	188,320	4,917,291	5,105,611	27.00
27.01	PHYSICIAN OFFICES	0	10,693,283	10,693,283	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	23,165,777	103,084,255	126,250,032	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		60,543,476		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	CLASSIFICATION DIFFERENCE	368			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)		368		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		60,543,108		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151329

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

Worksheet G-3

Date/Time Prepared:
5/30/2012 3:28 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	126,250,032	1.00
2.00	Less contractual allowances and discounts on patients' accounts	54,513,116	2.00
3.00	Net patient revenues (line 1 minus line 2)	71,736,916	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	60,543,108	4.00
5.00	Net income from service to patients (line 3 minus line 4)	11,193,808	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,192,144	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	970,085	24.00
25.00	Total other income (sum of lines 6-24)	2,162,229	25.00
26.00	Total (line 5 plus line 25)	13,356,037	26.00
27.00	UNREALIZED LOSS ON DERIVATIVE	1,515,098	27.00
27.01	BAD DEBT EXPENSE	6,324,882	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	7,839,980	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,516,057	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151329

Period: From 01/01/2011

Worksheet H

HHA CCN: 157143

To 12/31/2011

Date/Time Prepared: 5/30/2012 3:28 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
2.00	Capital Related - Movable Equipment			0		0
3.00	Plant Operation & Maintenance	0	0	0	0	0
4.00	Transportation	0	0	0	0	0
5.00	Administrative and General	323,665	0	0	0	206,017
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	424,040	0	0	0	0
7.00	Physical Therapy	194,932	0	0	0	0
8.00	Occupational Therapy	67,133	0	0	0	0
9.00	Speech Pathology	3,434	0	0	0	0
10.00	Medical Social Services	11,404	0	0	0	0
11.00	Home Health Aide	43,285	0	0	0	0
12.00	Supplies (see instructions)	0	0	0	0	0
13.00	Drugs	0	0	0	0	0
14.00	DME	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0
18.00	Clinic	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0
22.00	Homemaker Service	13,083	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0
24.00	Total (sum of lines 1-23)	1,080,976	0	0	0	206,017

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: 151329

Period: From 01/01/2011

Worksheet H

HHA CCN: 157143

To 12/31/2011

Date/Time Prepared: 5/30/2012 3:28 pm

Home Health Agency I

PPS

		Total (sum of col.s. 1 thru 5)	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	529,682	0	529,682	0	529,682	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	424,040	0	424,040	0	424,040	6.00
7.00	Physical Therapy	194,932	0	194,932	0	194,932	7.00
8.00	Occupational Therapy	67,133	0	67,133	0	67,133	8.00
9.00	Speech Pathology	3,434	0	3,434	0	3,434	9.00
10.00	Medical Social Services	11,404	0	11,404	0	11,404	10.00
11.00	Home Health Aide	43,285	0	43,285	0	43,285	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	13,083	0	13,083	0	13,083	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,286,993	0	1,286,993	0	1,286,993	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: 151329	Period: From 01/01/2011	Worksheet H-1 Part I Date/Time Prepared: 5/30/2012 3:28 pm
	HHA CCN: 157143	To 12/31/2011	
		Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	
		Bldgs & Fixtures	Movable Equipment			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	529,682	0	0	0	5.00
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	424,040	0	0	0	6.00
7.00	Physical Therapy	194,932	0	0	0	7.00
8.00	Occupational Therapy	67,133	0	0	0	8.00
9.00	Speech Pathology	3,434	0	0	0	9.00
10.00	Medical Social Services	11,404	0	0	0	10.00
11.00	Home Health Aide	43,285	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	13,083	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,286,993	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 151329	Period: From 01/01/2011	Worksheet H-1
		HHA CCN: 157143	To 12/31/2011	Part I
			Home Health Agency I	Date/Time Prepared: 5/30/2012 3:28 pm
				PPS

	Subtotal (col s. 0-4) 4A.00	Administrative & General 5.00	Total (col s. 4A + 5) 6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures	0		1.00
2.00	Capital Related - Movable Equipment	0		2.00
3.00	Plant Operation & Maintenance	0		3.00
4.00	Transportation			4.00
5.00	Administrative and General	529,682	529,682	5.00
HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	424,040	296,584	720,624
7.00	Physical Therapy	194,932	136,340	331,272
8.00	Occupational Therapy	67,133	46,954	114,087
9.00	Speech Pathology	3,434	2,402	5,836
10.00	Medical Social Services	11,404	7,976	19,380
11.00	Home Health Aide	43,285	30,275	73,560
12.00	Supplies (see instructions)	0	0	0
13.00	Drugs	0	0	0
14.00	DME	0	0	0
HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0	0
16.00	Respiratory Therapy	0	0	0
17.00	Private Duty Nursing	0	0	0
18.00	Clinic	0	0	0
19.00	Health Promotion Activities	0	0	0
20.00	Day Care Program	0	0	0
21.00	Home Delivered Meals Program	0	0	0
22.00	Homemaker Service	13,083	9,151	22,234
23.00	All Others (specify)	0	0	0
24.00	Total (sum of lines 1-23)	757,311		1,286,993

COST ALLOCATION - HHA STATISTICAL BASIS		Provider CCN: 151329 HHA CCN: 157143		Period: From 01/01/2011 To 12/31/2011		Worksheet H-1 Part II Date/Time Prepared: 5/30/2012 3:28 pm	
				Home Health Agency I		PPS	
		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)				
		1.00	2.00	3.00	4.00	5A.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation (see instructions)	0	0	0	0	0	4.00
5.00	Administrative and General	0	0	0	0	-529,682	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	-529,682	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: 151329	Period: From 01/01/2011	Worksheet H-1 Part II Date/Time Prepared: 5/30/2012 3:28 pm
	HHA CCN: 157143	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	757,311	5.00
HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	424,040	6.00
7.00	Physical Therapy	194,932	7.00
8.00	Occupational Therapy	67,133	8.00
9.00	Speech Pathology	3,434	9.00
10.00	Medical Social Services	11,404	10.00
11.00	Home Health Aide	43,285	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	13,083	22.00
23.00	All Others (specify)	0	23.00
24.00	Total (sum of lines 1-23)	757,311	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	529,682	25.00
26.00	Unit Cost Multiplier	0.699425	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151329

Period: From 01/01/2011

Worksheet H-2

HHA CCN: 157143

To 12/31/2011

Part I
Date/Time Prepared:
5/30/2012 3:28 pm

Home Health
Agency I

PPS

		CAPITAL RELATED COSTS					
		HHA Trial Balance (1)	NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSITE	
		0	1.00	1.01	2.00	2.01	
1.00	Administrative and General	0	0	25,338	0	6,354	1.00
2.00	Skilled Nursing Care	720,624	0	0	0	0	2.00
3.00	Physical Therapy	331,272	0	0	0	0	3.00
4.00	Occupational Therapy	114,087	0	0	0	0	4.00
5.00	Speech Pathology	5,836	0	0	0	0	5.00
6.00	Medical Social Services	19,380	0	0	0	0	6.00
7.00	Home Health Aide	73,560	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	22,234	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)	1,286,993	0	25,338	0	6,354	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: 151329

Period: From 01/01/2011

Worksheet H-2

HHA CCN: 157143

To 12/31/2011

Part I
Date/Time Prepared:
5/30/2012 3:28 pm

Home Health Agency I

PPS

		EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	
		4.00	4A	5.00	7.00	7.01	
1.00	Administrative and General	367,312	399,004	68,577	0	6,574	1.00
2.00	Skilled Nursing Care	0	720,624	123,855	0	0	2.00
3.00	Physical Therapy	0	331,272	56,936	0	0	3.00
4.00	Occupational Therapy	0	114,087	19,608	0	0	4.00
5.00	Speech Pathology	0	5,836	1,003	0	0	5.00
6.00	Medical Social Services	0	19,380	3,331	0	0	6.00
7.00	Home Health Aide	0	73,560	12,643	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	22,234	3,821	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)	367,312	1,685,997	289,774	0	6,574	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: 151329	Period: From 01/01/2011 To 12/31/2011	Worksheet H-2 Part I Date/Time Prepared: 5/30/2012 3:28 pm			
		HHA CCN: 157143	Home Health Agency I	PPS			
	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
	7.02	8.00	9.00	10.00	11.00		
1.00	Administrative and General	21,493	0	0	0	80,043	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)	21,493	0	0	0	80,043	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: 151329

Period:

Worksheet H-2

HHA CCN: 157143

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

Part I
Date/Time Prepared:
5/30/2012 3:28 pm

Home Health
Agency I

PPS

		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
1.00	Administrative and General	0	1,793	0	0	577,484	1.00
2.00	Skilled Nursing Care	0	0	0	0	844,479	2.00
3.00	Physical Therapy	0	0	0	0	388,208	3.00
4.00	Occupational Therapy	0	0	0	0	133,695	4.00
5.00	Speech Pathology	0	0	0	0	6,839	5.00
6.00	Medical Social Services	0	0	0	0	22,711	6.00
7.00	Home Health Aide	0	0	0	0	86,203	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	26,055	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	1,793	0	0	2,085,674	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: 151329	Period: From 01/01/2011	Worksheet H-2
		HHA CCN: 157143	To 12/31/2011	Part I
				Date/Time Prepared: 5/30/2012 3:28 pm
			Home Health Agency I	PPS

	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
	25.00	26.00	27.00	28.00	
1.00	Administrative and General	0	577,484		1.00
2.00	Skilled Nursing Care	0	844,479	323,350	2.00
3.00	Physical Therapy	0	388,208	148,644	3.00
4.00	Occupational Therapy	0	133,695	51,192	4.00
5.00	Speech Pathology	0	6,839	2,619	5.00
6.00	Medical Social Services	0	22,711	8,696	6.00
7.00	Home Health Aide	0	86,203	33,007	7.00
8.00	Supplies (see instructions)	0	0	0	8.00
9.00	Drugs	0	0	0	9.00
10.00	DME	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	13.00
14.00	Clinic	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	15.00
16.00	Day Care Program	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	17.00
18.00	Homemaker Service	0	26,055	9,976	18.00
19.00	All Others (specify)	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	2,085,674	577,484	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.			0.382899	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: 151329
HHA CCN: 157143

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

Worksheet H-2
Part II
Date/Time Prepared:
5/30/2012 3:28 pm

Home Health Agency I PPS

		CAPITAL RELATED COSTS				EMPLOYEE BENEFITS (GROSS SALARIES)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSITE (SQUARE FEET)		
		1.00	1.01	2.00	2.01	4.00	
1.00	Administrative and General	0	3,415	0	3,415	1,080,976	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	3,415	0	3,415	1,080,976	20.00
21.00	Total cost to be allocated	0	25,338	0	6,354	367,312	21.00
22.00	Unit cost multiplier	0.000000	7.419619	0.000000	1.860615	0.339797	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151329
HHA CCN: 157143

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

Worksheet H-2
Part II
Date/Time Prepared:
5/30/2012 3:28 pm

		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT -OFFSITE (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL & OFFS (SQUARE FEET)	
		5A	5.00	7.00	7.01	7.02	
1.00	Administrative and General	0	399,004	0	3,415	3,415	1.00
2.00	Skilled Nursing Care	0	720,624	0	0	0	2.00
3.00	Physical Therapy	0	331,272	0	0	0	3.00
4.00	Occupational Therapy	0	114,087	0	0	0	4.00
5.00	Speech Pathology	0	5,836	0	0	0	5.00
6.00	Medical Social Services	0	19,380	0	0	0	6.00
7.00	Home Health Aide	0	73,560	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	22,234	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)		1,685,997	0	3,415	3,415	20.00
21.00	Total cost to be allocated		289,774	0	6,574	21,493	21.00
22.00	Unit cost multiplier		0.171871	0.000000	1.925037	6.293704	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151329
HHA CCN: 157143

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

Worksheet H-2
Part II
Date/Time Prepared:
5/30/2012 3:28 pm
PPS

		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
		8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	0	0	34,443	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	0	0	34,443	0	20.00
21.00	Total cost to be allocated	0	0	0	80,043	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	2.323926	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 151329 HHA CCN: 157143	Period: From 01/01/2011 To 12/31/2011	Worksheet H-2 Part II Date/Time Prepared: 5/30/2012 3:28 pm PPS
		Home Health Agency I	

	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (100% PHARMACY)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
	14.00	15.00	16.00	
1.00 Administrative and General	18,949	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	2.00
3.00 Physical Therapy	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	4.00
5.00 Speech Pathology	0	0	0	5.00
6.00 Medical Social Services	0	0	0	6.00
7.00 Home Health Aide	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	8.00
9.00 Drugs	0	0	0	9.00
10.00 DME	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	13.00
14.00 Clinic	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	15.00
16.00 Day Care Program	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	17.00
18.00 Homemaker Service	0	0	0	18.00
19.00 All Others (specify)	0	0	0	19.00
20.00 Total (sum of lines 1-19)	18,949	0	0	20.00
21.00 Total cost to be allocated	1,793	0	0	21.00
22.00 Unit cost multiplier	0.094622	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 151329 HHA CCN: 157143		Period: From 01/01/2011 To 12/31/2011		Worksheet H-3 Parts I-II Date/Time Prepared: 5/30/2012 3:28 pm	
		Title XVIII		Home Health Agency I		PPS	
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	
		0	1.00	2.00	3.00	4.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,167,829		1,167,829	5,506	1.00
2.00	Physical Therapy	3.00	536,852	0	536,852	1,980	2.00
3.00	Occupational Therapy	4.00	184,887	0	184,887	566	3.00
4.00	Speech Pathology	5.00	9,458	0	9,458	43	4.00
5.00	Medical Social Services	6.00	31,407		31,407	22	5.00
6.00	Home Health Aide	7.00	119,210		119,210	1,312	6.00
7.00	Total (sum of lines 1-6)		2,049,643	0	2,049,643	9,429	7.00
				Program Visits			
				Part B			
				Not Subject to Deductibles & Coinsurance			
				Subject to Deductibles			
		0	1.00	2.00	3.00	4.00	
Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	1,099	811		8.00
8.01	Skilled Nursing Care		17140	826	384		8.01
9.00	Physical Therapy		99915	364	248		9.00
9.01	Physical Therapy		17140	382	224		9.01
10.00	Occupational Therapy		99915	101	74		10.00
10.01	Occupational Therapy		17140	116	95		10.01
11.00	Speech Pathology		99915	9	19		11.00
11.01	Speech Pathology		17140	10	5		11.01
12.00	Medical Social Services		99915	8	2		12.00
12.01	Medical Social Services		17140	3	1		12.01
13.00	Home Health Aide		99915	156	110		13.00
13.01	Home Health Aide		17140	37	67		13.01
14.00	Total (sum of lines 8-13)			3,111	2,040		14.00
				3,111			
				2,040			
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	
		0	1.00	2.00	3.00	4.00	
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	16.00
				0			
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	0.645613	0	0	1.00
2.00	Occupational Therapy		67.00	0.753217	0	0	2.00
3.00	Speech Pathology		68.00	1.346202	0	0	3.00
4.00	Cost of Medical Supplies		71.00	0.000000	0	0	4.00
5.00	Cost of Drugs		73.00	0.338681	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS	Provider CCN: 151329	Period: From 01/01/2011	Worksheet H-3 Parts I-III Date/Time Prepared: 5/30/2012 3:28 pm
	HHA CCN: 157143	To 12/31/2011	
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 & Coinsurance	Subject to Deductibles & Coinsurance	
	5.00	6.00	7.00	8.00	

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION					
Cost Per Visit Computation					
1.00	Skilled Nursing Care	212.10	1,925	1,195	1.00
2.00	Physical Therapy	271.14	746	472	2.00
3.00	Occupational Therapy	326.66	217	169	3.00
4.00	Speech Pathology	219.95	19	24	4.00
5.00	Medical Social Services	1,427.59	11	3	5.00
6.00	Home Health Aide	90.86	193	177	6.00
7.00	Total (sum of lines 1-6)		3,111	2,040	7.00
Cost Center Description					
		5.00	6.00	7.00	8.00

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

Cost Center Description	Ratio (col. 3 ÷ col. 4)	Part A	Program Covered Charges		
			Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	5.00	6.00	7.00	8.00	

Supplies and Drugs Cost Computations					
15.00	Cost of Medical Supplies	0.000000	0	23,394	15.00
16.00	Cost of Drugs	0.000000	0	0	16.00

Cost Center Description		Transfer to Part I as Indicated		
		4.00		

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS					
1.00	Physical Therapy	col. 2, line 2.00			1.00
2.00	Occupational Therapy	col. 2, line 3.00			2.00
3.00	Speech Pathology	col. 2, line 4.00			3.00
4.00	Cost of Medical Supplies	col. 2, line 15.00			4.00
5.00	Cost of Drugs	col. 2, line 16.00			5.00

APPORTIONMENT OF PATIENT SERVICE COSTS	Provider CCN: 151329	Period: From 01/01/2011	Worksheet H-3 Parts I-III Date/Time Prepared: 5/30/2012 3:28 pm
	HHA CCN: 157143	To 12/31/2011	
	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 & Coi nsurance	Subject to Deductibles & Coi nsurance			
	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	408,293	253,460		661,753	1.00
2.00	Physical Therapy	202,270	127,978		330,248	2.00
3.00	Occupational Therapy	70,885	55,206		126,091	3.00
4.00	Speech Pathology	4,179	5,279		9,458	4.00
5.00	Medical Social Services	15,703	4,283		19,986	5.00
6.00	Home Health Aide	17,536	16,082		33,618	6.00
7.00	Total (sum of lines 1-6)	718,866	462,288		1,181,154	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
9.00	Physical Therapy					9.00
9.01	Physical Therapy					9.01
10.00	Occupational Therapy					10.00
10.01	Occupational Therapy					10.01
11.00	Speech Pathology					11.00
11.01	Speech Pathology					11.01
12.00	Medical Social Services					12.00
12.01	Medical Social Services					12.01
13.00	Home Health Aide					13.00
13.01	Home Health Aide					13.01
14.00	Total (sum of lines 8-13)					14.00
Cost of Services						
Cost Center Description	Part A	Part B				
		Not Subject to Deductibles & Coi nsurance	Subject to Deductibles & Coi nsurance			
	9.00	10.00	11.00			
Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies	0	0	0		15.00
16.00	Cost of Drugs	0	0	0		16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 151329 HHA CCN: 157143	Period: From 01/01/2011 To 12/31/2011	Worksheet H-4 Part I-II Date/Time Prepared: 5/30/2012 3:28 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	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
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		524,361	336,311
12.00	Total PPS Reimbursement - Full Episodes with Outliers		2,070	4,528
13.00	Total PPS Reimbursement - LUPA Episodes		12,577	10,504
14.00	Total PPS Reimbursement - PEP Episodes		6,753	1,634
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		1,546	355
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)		547,307	353,332
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		547,307	353,332
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		547,307	353,332
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)		547,307	353,332
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		547,307	353,332
32.00	Interim payments (see instructions)		547,306	353,332
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 32 and 33)		1	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: 151329
HHA CCN: 157143

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

Worksheet H-5
Date/Time Prepared: 5/30/2012 3:28 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		547,306		353,332	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)		547,306		353,332	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		1		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		547,307		353,332	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151329

Period: From 01/01/2011

Worksheet K

Hospice CCN: 151551

To 12/31/2011

Date/Time Prepared: 5/30/2012 3:28 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	159,886	0	430	0	195,226	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	217,689	0	17,562	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	3,542	0	97	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	42,251	0	4,547	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	75,008	0	25,581	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	488	0	1,187	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)	498,864	0	49,404	0	195,226	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151329

Period: From 01/01/2011

Worksheet K

Hospice CCN: 151551

To 12/31/2011

Date/Time Prepared: 5/30/2012 3:28 pm

		Total (col. 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	355,542	0	355,542	0	355,542	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	235,251	0	235,251	0	235,251	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	3,639	0	3,639	0	3,639	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	46,798	0	46,798	0	46,798	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	100,589	0	100,589	0	100,589	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	1,675	0	1,675	0	1,675	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)	743,494	0	743,494	0	743,494	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151329

Period: From 01/01/2011

Worksheet K-1

Hospice CCN: 151551

To 12/31/2011

Date/Time Prepared: 5/30/2012 3:28 pm

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	159,886	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	217,689	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	42,251	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	159,886	42,251	0	217,689	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151329

Period: From 01/01/2011

Worksheet K-1

Hospice CCN: 151551

To 12/31/2011

Date/Time Prepared: 5/30/2012 3:28 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	159,886	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	217,689	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	3,542	0	0	3,542	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services		0	0	42,251	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		75,008	0	75,008	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	488	488	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)	3,542	75,008	488	498,864	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151329

Period: From 01/01/2011

Worksheet K-4

Hospice CCN: 151551

To 12/31/2011

Part I
Date/Time Prepared:
5/30/2012 3:28 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	355,542	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	235,251	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	3,639	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	46,798	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	100,589	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	1,675	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)	743,494	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151329

Period: From 01/01/2011

Worksheet K-4

Hospice CCN: 151551

To 12/31/2011

Part I
Date/Time Prepared:
5/30/2012 3:28 pm

		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	355,542				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	235,251	215,598		450,849	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	3,639	3,335		6,974	13.00
14.00	Speech/ Language Pathology	0	0	0		0	14.00
15.00	Medical Social Services	0	46,798	42,888		89,686	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	100,589	92,186		192,775	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0		0	20.00
21.00	Other	0	1,675	1,535		3,210	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	387,952	355,542		743,494	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151329

Period: From 01/01/2011

Worksheet K-4

Hospice CCN: 151551

To 12/31/2011

Part II
Date/Time Prepared:
5/30/2012 3:28 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: 151329

Period: From 01/01/2011

Worksheet K-4

Hospice CCN: 151551

To 12/31/2011

Part II
Date/Time Prepared:
5/30/2012 3:28 pm

Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	
		6A	6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0		1.00
2.00	Capital Related Costs-Movable Equip.	0		2.00
3.00	Plant Operation and Maintenance	0		3.00
4.00	Transportation - Staff	0		4.00
5.00	Volunteer Service Coordination			5.00
6.00	Administrative and General	-355,542	387,952	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	235,251	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	3,639	13.00
14.00	Speech/ Language Pathology	0	0	14.00
15.00	Medical Social Services	0	46,798	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	100,589	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00	Other	0	1,675	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)		355,542	39.00
40.00	Unit Cost Multiplier		0.916459	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151329

Period: From 01/01/2011

Worksheet K-5

Hospice CCN: 151551

To 12/31/2011

Part I
Date/Time Prepared:
5/30/2012 3:28 pm

Hospice I

Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSITE	
		1.00	1.01	2.00	2.01	
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	450,849	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	6,974	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	89,686	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	192,775	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	3,210	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)	743,494	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: 151329

Period:

Worksheet K-5

Hospice CCN: 151551

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

Part I
Date/Time Prepared:
5/30/2012 3:28 pm

Cost Center Description		EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	
		4.00	4A	5.00	7.00	7.01	
1.00	Administrative and General	169,512	169,512	29,134	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	450,849	77,488	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	6,974	1,199	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	89,686	15,414	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	192,775	33,132	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	3,210	552	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)	169,512	913,006	156,919	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)		0.000000				35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151329

Period: From 01/01/2011

Worksheet K-5

Hospice CCN: 151551

To 12/31/2011

Part I
Date/Time Prepared:
5/30/2012 3:28 pm

Cost Center Description		Hospice I						
		OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
		7.02	8.00	9.00	10.00	11.00		
1.00	Administrative and General	0	0	0	0	46,865	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	46,865	34.00	
35.00	Unit Cost Multiplier (see instructions)						35.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151329

Period:

Worksheet K-5

Hospice CCN: 151551

From 01/01/2011

Part I

To 12/31/2011

Date/Time Prepared:

5/30/2012 3:28 pm

Cost Center Description		Hospice I				Subtotal (col s. 4A-23)	
		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY		
		13.00	14.00	15.00	16.00	24.00	
1.00	Administrative and General	0	7,626	0	0	253,137	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	528,337	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	8,173	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	105,100	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	225,907	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	3,762	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	7,626	0	0	1,124,416	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS		Provider CCN: 151329	Period: From 01/01/2011	Worksheet K-5 Part I Date/Time Prepared: 5/30/2012 3:28 pm
		Hospice CCN: 151551	To 12/31/2011	

Cost Center Description		Hospice I					
		Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (col.s. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (col.s. 26 ± 27)		
		25.00	26.00	27.00	28.00		
1.00	Administrative and General						1.00
2.00	Inpatient - General Care	0	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0	0		3.00
4.00	Physician Services	0	0	0	0		4.00
5.00	Nursing Care	0	528,337	153,500	681,837		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	8,173	2,375	10,548		8.00
9.00	Speech/ Language Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	105,100	30,535	135,635		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	225,907	65,634	291,541		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00
16.00	Other	0	3,762	1,093	4,855		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	1,124,416		1,124,416		34.00
35.00	Unit Cost Multiplier (see instructions)			0.290535			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151329
Hospice CCN: 151551

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

Worksheet K-5
Part II
Date/Time Prepared:
5/30/2012 3:28 pm

Cost Center Description	CAPITAL RELATED COSTS				EMPLOYEE BENEFITS (GROSS SALARIES)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSITE (SQUARE FEET)		
	1.00	1.01	2.00	2.01		
1.00 Administrative and General	0	0	0	0	498,864	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	498,864	34.00
35.00 Total cost to be allocated	0	0	0	0	169,512	35.00
36.00 Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.000000	0.339796	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151329
Hospice CCN: 151551

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

Worksheet K-5
Part II
Date/Time Prepared:
5/30/2012 3:28 pm

Cost Center Description	Reconciliation	Hospice I					
		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - OFFSITE (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL & OFFS (SQUARE FEET)		
	5A	5.00	7.00	7.01	7.02		
1.00 Administrative and General	0	169,512	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	450,849	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	6,974	0	0	0	8.00	
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00	
10.00 Medical Social Services	0	89,686	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	192,775	0	0	0	14.00	
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00	
16.00 Other	0	3,210	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)		913,006	0	0	0	34.00	
35.00 Total cost to be allocated		156,919	0	0	0	35.00	
36.00 Unit Cost Multiplier (see instructions)		0.171871	0.000000	0.000000	0.000000	36.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151329

Period:

Worksheet K-5

Hospice CCN: 151551

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

Part II
Date/Time Prepared:
5/30/2012 3:28 pm

Cost Center Description		Hospice I					
		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
		8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	0	0	20,166	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	20,166	0	34.00
35.00	Total cost to be allocated	0	0	0	46,865	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	2.323961	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151329
Hospice CCN: 151551

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

Worksheet K-5
Part II
Date/Time Prepared:
5/30/2012 3:28 pm

Cost Center Description		Hospice I			
		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (100% PHARMACY)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		14.00	15.00	16.00	
1.00	Administrative and General	80,577	0	0	1.00
2.00	Inpatient - General Care	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	3.00
4.00	Physician Services	0	0	0	4.00
5.00	Nursing Care	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	6.00
7.00	Physical Therapy	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	9.00
10.00	Medical Social Services	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	12.00
13.00	Counseling - Other	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	15.00
16.00	Other	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	17.00
18.00	Analgesics	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	19.00
20.00	Other - Specify	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	21.00
22.00	Patient Transportation	0	0	0	22.00
23.00	Imaging Services	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	24.00
25.00	Medical Supplies	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	27.00
28.00	Chemotherapy	0	0	0	28.00
29.00	Other	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	31.00
32.00	Fundraising	0	0	0	32.00
33.00	Other Program Costs	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	80,577	0	0	34.00
35.00	Total cost to be allocated	7,626	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.094642	0.000000	0.000000	36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS		Provider CCN: 151329	Period: From 01/01/2011	Worksheet K-5		
		Hospice CCN: 151551	To 12/31/2011	Part III Date/Time Prepared: 5/30/2012 3:28 pm		
Cost Center Description		Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1.00	2.00	3.00	
ANCI LLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.645613	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.753217	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	1.346202	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.338681	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.250680	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.000000	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00				8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00				9.00
10.00	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: 151329

Period: From 01/01/2011

Worksheet K-6

Hospice CCN: 151551

To 12/31/2011

Date/Time Prepared: 5/30/2012 3:28 pm

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				1,124,416	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				5,446	2.00
3.00	Average cost per diem (line 1 divided by line 2)				206.47	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	4,700				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	970,409				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		169			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		34,893			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	4,417				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	911,978				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		32			10.00
11.00	Aggregate NF cost (line 3 times line 10)		6,607			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			577		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			119,133		13.00